2009 HOUSE APPROPRIATIONS

HB 1012

General Discussion
(Check appropriate box)

- ☐ Committee on Committees
- ☐ Rules Committee
- ☐ Confirmation Hearings
- ☐ Delayed Bills Committee
- ☒ House Appropriations
- ☐ Senate Appropriations
- ☐ Other

Date of meeting/discussion: January 9, 2009

Recorder Job Number: 6730

Committee Clerk Signature Holly N. Sand

Minutes:

Chm. Svedjan called the meeting to order. Clerk, Holly Sand, called the roll and a quorum was declared.

Carol Olson, Executive Director, North Dakota Department of Human Services took the podium and distributed written testimony (Exhibit A). Ms. Olson reviewed her written testimony.

Chm. Svedjan: What do you consider being "at capacity?" (Referring to Ms. Olson's testimony on p. 2, Exhibit A). (4:45)

Ms. Olson: To draw that conclusion, when we're at 100 percent capacity, that's full. We have been at 103 percent for months and months at a time at the state hospital for our traditional in-patient.

Chm. Svedjan: What does that translate into in terms of beds?

Ms. Olson: 132 beds. And many times we are over that amount. Not only has it been putting a crunch on the capacity of the State Hospital but also our private providers in the communities have felt the same capacity issues.

Ms. Olson continued. (6:12)

Chm. Svedjan: Another issue that relates to this, is that the Human Service Center psychiatrists are unwilling to take a call for patients who are admitted into the private provider's institution which is creating a problem up there and is posing the question of whether or not the private provider will continue to take those patients. This could put even greater pressure on the state hospital. I think somebody needs to look into that. (7:05)

Ms. Olson: Nancy McKenzie will have additional information on that in her testimony and we are working with the hospitals on those issues.

Rep. Nelson: Can you go into detail on why the Dickinson unit was closed? Was it staffing? Was it reimbursement? (8:11)

Ms. Olson: It was a decision made for financial reasons.

Rep. Nelson: Reimbursement?

Ms. Olson: Financial reasons. I don't believe reimbursement had anything to do with it. I don't know for sure. If you were to go back in history of St. Joe's the restructuring they did was based on financial reasons.

Rep. Wald: As I understood it, that place lost money from the day it opened. (9:05)

No comment from Ms. Olson.

Ms. Olson continued her testimony. She explained that in short, the budget allows the Department of Human Services to address capacity concerns and to provide behavioral health services in a variety of settings to meet individual needs. (9:21)

Ms. Olson moved on to the Impact of Aging Population (p. 4, Exhibit A).

Chm. Svedjan: In prior biennia we've had instances where we've over appropriated for SPED and Expanded SPED. Are you confident that these projections are solid? (12:52)

Ms. Olson: Yes I am confident that they are solid. You are accurate in your memory on that. We did see a biennium where the appropriation didn't match the numbers that came onto SPED. We feel there were probably a number of reasons for that. One is that we had gone through a period of time where we had to reduce program eligibility levels and cut back a little bit on the program because of budget constraints. I think that because of that we dropped off some of the population that normally would have come on to SPED. I think there were other factors that came into play. We have seen the growth in this program come back on so we have put what we feel is the accurate data to support the additional numbers.

Rep. Delzer: You are changing the eligibility criteria, are you not? (14:27)

Ms. Olson: We have tweaked the program some, yes.

Rep. Delzer: I'd like to know how much you've changed that.

Chm. Svedjan: Can you give us a brief description of how eligibility levels are changing? Where are they now? Where are they going to?

Ms. Olson deferred to Brenda Weisz.

Brenda Weisz, Chief Financial Officer, Department of Human Services: The change we're making is just with the sliding fee scale. The sliding fee scale was put into

place in 2003 for the SPED program that would be contingent on individuals' income levels and how much they would contribute to their care. That's the only change to the eligibility. (15:06)

Chm. Svedjan: Does that mean that people can qualify with higher incomes? (15:38)

Ms. Weisz: It means people will contribute less to their cost of care with the change of the sliding fee scale. We will add 22 more people. It doesn't greatly impact as far as how many will come on. It will impact how much they'll pay. What the increase is more attributed to (with SPED) is an increase in the caseload itself before the sliding fee scale change. The utilization is actually driving the increase in the SPED program itself more so than the eligibility change.

Ms. Olson continued her testimony, (p. 4, Exhibit A, last paragraph). (16:33)

Chm. Svedjan: As we go through this I would like you to identify what is new. I think the ADRC that you referenced is new. (17:37)

Ms. Olson: The ADRC (Aging and Disability Resource Center) is new. The Executive Budget does have $600,000 appropriation for the DHS to put out a pilot project. The ADRC is a central place for families to find out about choices for long-term care support and care services for people who are older or disabled. We have found that there isn't a single point of entry to go to in the state that allows access to this information.

Rep. Kempenich: Are you thinking of one center? Internet? A call center? What are you envisioning? (19:12)

Ms. Olson: We haven't come up with a proposal yet. We don't know if it will be web-based, an 800 number. There are details that we haven't worked out yet but we have enough information that we've put together to put the outline out there to get started

immediately. We would like to try this in a rural area and an urban area to see what works best.

Rep. Kempenich: I know there's a need for this. It is a problem because there is an array of programs and to have any knowledge of them. . .

Rep. Ekstrom: Would this be similar to the single point of entry Washington state has implemented? (21:01)

Ms. Olson: Yes.

Chm. Svedjan: There are FTEs attached to the ADRC? (21:31)

Ms. Olson: No. This would be an RFP so that it would be a proposal, a contract that would be issued.

Ms. Olson continued. (P. 5, Exhibit A) (21:49)

Chm. Svedjan: What percentage are we at today? (Relating to the medically needy income level) (23:14)

Ms. Olson: We're at 100 percent of the federal poverty level for the household -- $867 per month. Eighty-three percent of that is $720.

Chm. Svedjan: You're going to 83 percent. Where are we now?

Ms. Weisz: We are at 58 percent of poverty; household size of two is at 44 percent.

Ms. Olson: I didn't know that.

Ms. Olson continued her testimony and moved on to "Services for Children" (p. 5, Exhibit A). (24:00)

Rep. Kempenich: On SCHIP, the 6,021 children (referred to on the top of p. 6, Exhibit A) how many more is that going to add? Where are we at today? (26:04)

Ms. Weisz: That budget plans to add 1,158 kids.

Rep. Skarphol: There are states that have done something similar to this and it has resulted in people dropping their insurance and transferring over to this program. Are you making any effort to follow to track that? The people who drop their personal insurance that covers their children in order to take on this because of the change in the income level? (26:45)

Ms. Olson: That has been a concern ever since the SCHIP program came into existence. I believe there are safeguards in the SCHIP program for that but I don't know the specifics for those safeguards.

Maggie Anderson, Medical Services Division, Department of Human Services: We have something called the crowd out provision. In North Dakota we have a policy that says that a child cannot come on the SCHIP program for six months if the family drops coverage. That tends to be a disincentive for a family because that child would go without coverage for those six months.

Rep. Skarphol: Do you track that to see whether or not that is happening?

Ms. Anderson: We have a mechanism to track the six months. We don't have a formalized system to capture that and report that but we could do that.

Ms. Olson continued and moved on to "Efficiency and Effectiveness." (Page 7, Exhibit A) (28:27)

Rep. Wald: At what point would some of these kids be candidates for Home on the Range or Dakota Boys Ranch, etc.? (33:05)

Ms. Olson: Those would be some of the children that come into our foster care system and would have behavioral problems or substance abuse problems.

Rep. Wald: So are you saying that would not be the proper setting for these kids?

Ms. Olson: I am. Definitely. You mean when they transition out? When they age out of the foster care system, there's no real transitioning place for them. They become of age and after that period of time they are sent out into the world and some simply are not equipped. They may have lost all connections with family. They aren't trained for a job. They need additional case management or counseling. It's a weaning off process to help them move forward in life.

Rep. Wald: What age spread are we talking about?

Ms. Olson: Twenty-one and over.

Rep. Kaldor: I thought it was 18. They can stay in the foster home until age 21? (35:17)

Ms. Olson: It is 21. Yes.

Ms. Olson continued with the "Overview of Department Budget Changes" (Page 8, Exhibit A) and concluded her testimony. (35:45)

Rep. Kaldor: Regarding Temporary Assistance for Needy Families (TANF), during the interim we had discussions about the educational provision – the 12-month eligibility requirement or allowance. Did the department discuss or debate or consider extending that to 24 months from 12 as was suggested during the interim? (38:06)

Ms. Olson: I believe those are federal regulations that prohibit us from doing that. Yes. That's true. TANF is highly regulated from the feds and it doesn't have the flexibility we were originally told it would have.

Rep. Kaldor: During the interim, I got the impression that states either seek waivers or make other provisions because the testimony we had indicated there were other states that were going beyond the twelve months.

Carol Cartledge, Director of Public Assistance, Department of Human Services: Under federal rules someone can receive 12 months of education as a work activity. However, we could instead of a waiver we could try to make it work within the structure of the other work activities. For example, someone could go to school part-time and meet the other work activities in another core activity, where we could allow them to go on for two years potentially even three years, but they would have to meet the requirement in another work activity. (39:42)

Rep. Kaldor: So right now within the rules we have if you work with employers they can develop a plan or find a way to make that provision possible so that they can get a higher level of education?

Ms. Cartledge: Yes.

Rep. Pollert: Why is DHS having to fund compulsive gambling when the Attorney General has the lottery and the funding from the lottery and I think there's $400,000 that comes out of the Attorney General's budget and I see where we're going to have an increase of $300,000 General Fund, $700,000 total for compulsive gambling. I feel if there's gambling going on it should be taken care of where the lottery's coming from. (41:17)

Rep. Delzer: I don't think I can remember that.

Chm. Svedjan: I would also like to pose this question and the Section can deal with this when they get into it. One thing I wonder about often is that your department serves 1 out of 5 North Dakotans. It would seem to me that our goal ought to be to raise that to 1 in 6 or 1 in 7 and so on. How does the Department know that what you are doing is working? Do you do any kind of outcome analyses by program that suggest to you that

we're not just growing programs but these programs are in fact working and that we're actually helping people become more productive citizens? I'm not expecting an answer right now. I know within the TANF program we measure how many are coming in and how many are getting off and that's good. But what else are we doing in the department to help demonstrate that we're not just appropriating more money to satisfy more emerging needs and to help these people be more comfortable and be more productive in their lives. But are we actually getting people off the caseloads and is it working for us? It can't keep growing as it is at an exponential rate.

Rep. Kaldor: That's exactly why I asked the question about TANF. The NCSL did an analysis that was reported to our interim committee on the value of providing TANF recipients with a higher level of education so that they could migrate up rather than stay at a level income and hopefully get off sooner and be taxpaying citizens sooner. I'm interested in how that's perceived by the department and how it's managed so employers understand and recipients understand that there are options. (44:21)

Rep. Kempenich: So far North Dakota has been isolated, but nationally the use of TANF and food stamps is rising. Have you built anything in on this? How would you adjust that if there was a rise in that? (45:09)

Chm. Svedjan: Do you mean federal government bailout?

Rep. Kempenich: Yes. How would you ask for that? Emergency Commission?

Ms. Olson: It would depend on what program and the circumstances you are talking about. I would be hesitant to say we would go to the Emergency Commission. (46:00)

Chm. Svedjan: That's an important issue. We don't know what the feds are going to do. The prospect of something happening after we're out of session is pretty good. There could be an infusion of cash that we're not expecting at this point. (46:55)

Ms. Olson: We will be giving examples of outcomes of the Department. The current biennium in our budget was $1.1 billion of the $1.9 billion was Medicaid. If you think about that in conjunction with our budget that puts into perspective how much is going into healthcare. Healthcare is really what we do. Our challenge in the department is how do we get our arms around the healthcare issue. We know we shouldn't just be coming back every biennium just asking for more money to fund programs that we have no idea if it's doing any good. We're looking at the data and we will be delivering that information to the Sections. (47:42)

Brenda Weisz, Chief Financial Officer, Department of Human Services took the podium and distributed her written testimony (Exhibit B). Ms. Weisz presented an overview of the Department's 2009-2011 budget request included in HB 1012 along with related fiscal information. (50:16)

Rep. Delzer: What was your underfunding on the salary line in 07-09? (54:14)

Ms. Weisz: I'll have to get that for you.

Rep. Pollert: Last session there were amendments to the bill at the end of the session about the DD providers and the need to borrow money and could we get a loan from the Bank of North Dakota. I'm assuming that's not going to happen, if you've got turn back.

Ms. Weisz: That's correct.

Ms. Weisz continued on p. 2 of Exhibit B. Ms. Weisz moved to the "Major Policy Changes in Developing 2009-2011 Budget on p. 4, Exhibit B (54:58).

Ms. Weisz reviewed the chart on p. 5 which compares the 2009-2011 Executive Budget request to the 2007-2009 budget.

Chm. Svedjan: Some of the analyses we received from Legislative Council have that General Fund increase at $135 million. I don't know that it's the $10 million FMAP. (62:44)

Ms. Weisz: I have not seen any of Legislative Council's documents so I can't explain any difference.

Allen Knudson, Legislative Council: If you just look at the ongoing spending, the one--time items . . .

Ms. Weisz continued. (63:22)

Chm. Svedjan: What's the current status of the Intergovernmental Transfer (IGT)? (64:06)

Ms. Weisz: IGTs are no longer being processed. There's $1.375 million left in that fund.

Chm. Svedjan: So what does that mean?

Ms. Weisz: That means from a fiscal standpoint is that there's not a lot of money left and we will not be regenerating that money.

Rep. Kreidt: There are dollars that go into that fund every biennium with repayments of loans from facilities so there's about $1 million that goes into there every year. There was $4.5 million in it and $3 million was taken out for the Medicaid budget this time. We have a $1.3 million budget, why are we robbing that fund for $3 million when we have a lot of cash on hand? (64:41)

Rep. Svedjan: You might think we have a lot of cash on hand.

Ms. Weisz: I had forgotten about the loan rate payments. What's bigger in my mind is the fact that we don't generate the revenue we used to with the IGT process. We work very closely with OMB and the Governor's office as to how we fund our budget. Those funds are generated from the nursing facilities and looking at it from that perspective that's where the funding should go back in. And from that perspective, that's why the funding was put there. (65:24)

Rep. Kreidt: I guess I didn't mean there's a lot of money but then the Governor's budget he said we weren't going to increase taxes or take money out of Special Funds to do the budget for this time so that was the way I wanted to state my question.

Ms. Weisz continued her review at the bottom of p. 5. She reviewed the "Explanation of Major Budget Changes."

Chm. Svedjan: How much lag time is there in basing these FMAP percentages? (Referring to the FMAP percentages on the top of p. 7, Exhibit B) (70:43)

Ms. Weisz: It's a three-year lag.

Chm. Svedjan: So chances are it's apt to get worse instead of better.

Ms. Weisz: That would be my assumption as well.

Ms. Weisz continued with her testimony on p 7, Exhibit B. (71:11)

Rep. Delzer: The $4 million for IT costs, how much of that is related to the time lag MMIS is taking? And how much more is that MMIS going to cost us as a state? (72:34)

Ms. Weisz: None of it is attributed to the lag. We do have built in our built in our budget in 09-11 the costs to run our old system for ten months. The delay at this point is ten months. Completion of that project, right now we are estimating to stay within our

budget for that project. The costs that we have reflected in our budget are the costs that were identified to us when we were making the decision to go with a new MMIS. The only change in that is a license fee that we weren't aware of with the MMIS.

Ms. Weisz directed the Committee to Attachment A of Exhibit B, the "Department of Human Services 2009-2011 Budget to House Detail of Specific Increases." (73:44).

Chm. Svedjan: So does this relate then to some kind of formula that relates to federal funds? Why a third of it in General Funds and two thirds in Special Funds? (Ms. Weisz had just discussed the 'Hospice for Children Waiver"). (76:40)

Ms. Weisz: Yes. It is paid on the FMAP.

Ms. Weisz continued her review of Attachment A, Exhibit B. (76:55)

Chm. Svedjan: Are most of these expansions based on increased utilization or increased cost? (This question followed Ms. Weisz's conclusion of the discussion on "Home and Community Based Services Changes" on Attachment A, Exhibit B. (79:19)

Ms. Weisz: It's both. It depends on the service and they type of area we are talking about. These numbers are separate from the cost changes I mentioned earlier and the utilization separated these out as specific program changes.

Ms. Weisz continued her review of Attachment A, Exhibit B. (80:08)

Rep. Skarphol: I notice the drug funding for drug courts in the southeast and I would like Legislative Council to provide us with some kind of document that indicates where the funding is for drug courts because I know there is some in the Courts' Budget and there's probably some in the Attorney General's Budget. We need a spreadsheet that delineates where it is. (83:01)

Ms. Weisz continued with her discussion of the "DD Grant Changes" at the bottom of Attachment A, Exhibit B. (83:30)

Chm. Svedjan: So in one case you are standardizing it and in one case you are not. (Question follows Ms. Weisz's discussion of the "Increase Personal Needs Allowance for ICF/MR -- $50 to $60").

Ms. Weisz: I'm not sure what you are asking. We're standardizing an SSI so that all the nursing facilities are the same which is what I think you are referring to and then we're taking this one and increasing it, keeping it less than consistent with the nursing homes.

Chm. Svedjan: Yes.

Ms. Weisz: We are making it consistent with basic care which is by statute at $60 per month.

Ms. Weisz directed the committee back to her testimony on p. 8, Exhibit B. (85:05)

Rep. Kempenich: That addiction case manager, will it be associated with the hospital too? (Referring to the addiction case manager in the Jamestown region that Ms. Weisz discussed). (87:13)

Ms. Weisz: It will actually be located and associated with the Human Service Center and assist the Addiction Counselors for those coming in through the community for treatment.

Rep. Kempenich: So that person is basically going to manage the counselors?

Ms. Weisz: There are various things that need to be documented, various roles that need to happen when we're working with the addiction counselor. We have many things that need to occur when working with our addiction clients. There's actual treatment then there's follow-up and the documentation of the treatment plans. Instead of hiring

the addiction counselor we're having the addiction counselor provide the actual service and the addiction counseling and with some of the other requirements of their job we'll have the case manager assist with that.

Ms. Weisz continued with p. 8 then moved to p. 9 to review the FTE Changes. There is a net increase of 14 FTEs. (88:32)

Rep. Nelson: The childcare provider background checks will be done in-house? (92:29)

Ms. Weisz: No. We don't actually handle the background check itself. We handle the managing of the paperwork. There will be money in the Attorney General's budget for the actual payment to FBI for the checks.

Rep. Nelson: So that will be handled with law enforcement. We had an issue last year with nurses background checks and that got to be a blown up situation. This isn't going to be nearly as cumbersome as that.

Ms. Weisz: We do not believe so.

Rep. Delzer: Have we requested a vacant FTE list? (93:26)

Chm. Svedjan: Yes.

Rep. Delzer: When will we have that do you think?

Chm. Svedjan: It takes a while.

Allen Knudson, Legislative Council: It will be ready at the end of the month.

Ms. Weisz continued at the top of p. 10, Exhibit B, "Key Points in Developing the Budget." (93:48)

Rep. Pollert: With the budget that's being submitted with the increase in rebasing, to hospitals, to basically everybody, shouldn't we see health insurance premiums drop before giving this kind of money to the healthcare industry? I know that's a loaded

question but maybe that's something we'll have to answer in the session, but yet I think it's a legitimate question. (94:47)

Ms. Weisz: I can't answer that. Are you talking about SCHIP premium?

Rep. Pollert: I'm talking everything. That's a generalization question but it's going to be asked in the Section so you might as well be ready for it.

Ms. Weisz: O.K. We can't set the premiums though. We get those passed on to us.

Rep. Pollert: I understand that but insurance premiums are raised because of costs from the industry. So if we increase the rebasing that should drop the cost from Blue Cross Blue Shield or whoever and that should lower premiums. I'm just wondering if there's a correlation.

Chm. Svedjan: Brenda is looking at me as though I should answer this. And if I'm not mistaken, you and I talked about this yesterday.

Rep. Pollert: We'll further the discussion later I suspect.

Chm. Svedjan: Your question has some legitimacy in that the assumption would be that that if someone is going to pay more, then someone else should pay less. But you have a situation here where healthcare facilities are eating a lot of costs that currently is not being reimbursed. I'd like to know how many industries in this state would stay in business if they were getting paid at 22 percent below their costs. Is there an expectation that other premiums could be reduced? Maybe, but I would say probably not. (96:08)

Ms. Weisz directed the Committee to and explained Attachments B and C of Exhibit B, "Department of Human Services 2009-2011 Budget to House, Where Does the Money Go? Long-Term Care Continuum." (97:13)

Ms. Weisz directed the Committee back to p. 10, Exhibit B and picked up her testimony with "Institutions." (99:18)

Chm. Svedjan: Are you seeing any reductions at the Developmental Center?

Ms. Weisz: Yes. Alex Schweitzer will be discussing this.

Ms. Weisz directed the Committee to Attachment D and explained "Where Does the Money Go? Department-Wide Total Funds $2,262,086,961." (100:45) $.83 of every dollar goes out to providers or grant recipients.

Ms. Weisz concluded her remarks.

Rep. Kaldor: I want to applaud this presentation. This is one of the best budget presentations I have seen in a long time in terms of detailing how things changed, where they were, where they are going and programmatic dollars. (102:29)

Ms. Weisz pointed out an error on the Fiscal note and explained that she would be providing a revised Fiscal Note.

Chm. Svedjan adjourned the meeting. The Full Committee will not meet next week. The sections will be meeting.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/12/09

Recorder Job Number: 6781

Committee Clerk Signature

Minutes:

Chairman Pollert: Opened Hearing for overview of Department of Human Services

Brenda Weisz: Handed out testimony (Attachment A).

Chairman Pollert: Asked about tabs for the budget book.

Brenda Weisz: They will be here and I will get them at break. Read testimony.

Chairman Pollert: Are you saying that is the 5&5?

Brenda Weisz: That is the 5&5 and the health insurance coverage. Throughout everybody's testimony I believe the very first bullet for everybody will identify for you the Governor's salary package which will be that 5&5 and health insurance.

Chairman Pollert: Will you have a list of what the equity distributions will be in each department?

Brenda Weisz: That is my next bullet on my testimony. Continued with testimony.

Chairman Pollert: So when you write grants does each separate division in your department write grants by themselves? Do you just have one office or how do you go about that?

Brenda Weisz: What we are looking at doing is that we have a point person in our executive office that works with the public information officer and works closely with fiscal for the budget piece of it. Then works very closely with a specific division in which the program resides. What

we are finding is pressures to get grant awards in and the timeline to do it. We don't have the resources to dedicate towards the grant writing. It is pretty intense for a period of time until you get the grant application in. The other problem is that you aren't notified of the grant award or application. There is not a lot of time given to apply for that grant so your window is short. This additional resource will help us and actually focus in that area and become more of an expert.

Chairman Pollert: Have you ever been short on grant writing? Missed the time lines?

Brenda Weisz: There are grants that we didn't apply for because we didn't have resources to do the work.

Chairman Pollert: If you have that information you should bring that forward later.

Representative Ekstrom: Would this individual also work on the waiver processes that we are continuing?

Brenda Weisz: Specifically working on the waiver, that would be no. We would keep that to the experts in the Medicaid division. It would help us when we do see a Medicaid competitive grant out there. This person can do a lot of the formulating and pulling together relying on that expertise in the Medicaid division. They could supply it but not be charged with the actually writing. That sort of works so it should help in that regard.

Brenda Weisz: Continued testimony.

Representative Nelson: Are we going to be seeing this 31% increase in the Attorney General's budget or in the cost analysis of all areas?

Brenda Weisz: Those were in the budget instructions for us that Office of Management and Budget issued. You should see them in every agency because we were told what rate to budget at.

Brenda Weisz: Continued testimony.

Chairman Pollert: When my son got his Blackberry they promised us that our telephone bill would go down which it did. Once he leaves the plan, his blackberry is $100 or so a month for internet access. Are you saying that the department is paying the extra increase because of the Blackberry's for internet access?

Brenda Weisz: We have not budgeted for any Blackberries. They are just tied to cabinet members to be in touch. Some have actually purchased their own phone but the only thing they are paying is the $17 a month. Some have chosen to just do that. Some have chosen to just do the data mechanism in order to just access email. A lot of times you can't and it's getting more difficult to haul a computer through an airport. For the part you are talking about there are some that specifically use the phone, voice, and data and they would have the full cost. Some have elected to not go that route and just pay for their own data and voice. We have a combination. Continued testimony.

Chairman Pollert: Any questions from the committee? You and I had talked last week and just for the committee's knowledge, when we get the spend downs, at first the Governor requested a hold even budget. That increase was in one column. After that, the Executive Budget came out and there was another increase. What we had talked about last week is to put all the changes in one column. Then you will see all the changes that would have been done from the hold even plus the changes in the other column for the Executive Budget. We just threw them all in one. When we had the spend downs they would be segregated out. Then if you have to ask if this is from the hold even or the Executive Budget then you can find that out . Am I correct?

Brenda Weisz: Yes. We did leave out one column that was the salary package. We left the Governor's salary package because that is the sizeable increase in the salaries. We left the

Governor's salary package, the 5&5, and the insurance in their own column. We combined every other change into the single column so it's easier for you to follow.

Chairman Pollert: The changes will be segregated out so you will be able to find out which changes are what. Otherwise you would have been adding and so we thought it was better.

Chairman Pollert: We are going to go through the sections of the overview then we will split out in about three days with the spend downs and detailing. I just want to say one more thing before you start. If you ask for any other information when going through this testimony, ask for it before detail. Will the OAR's be in a separate slip somewhere? Will you have a listing of what the OAR's were?

Brenda Weisz: We can make copies so you will have those and bring them down.

Chairman Pollert: We will need those at some time, especially when we get into the Medical Assistance part and the Long Term Care.

Jennifer Witham: Testimony attached (Attachment B).

Representative Nelson: Would you explain that?

Jennifer Witham: Last legislative session had requested that we take a 10% across the board decrease in our salary and benefit area. In the ITD that was supposed to be attrition or the capability to reduce our costs in that area. Our division was not able to meet that reduction because we actually had an increase in demands in our division .We didn't have a great deal of turnover. It represents our ability to meet that decrease.

Representative Nelson: I thought we added some staff for MMIS to do some of the manual work as far as the charges for Medicaid services.

Brenda Weisz: We didn't add any staff for MMIS at all. We are doing it with current and existing staff.

Representative Nelson: There wasn't any temps added?

Brenda Weisz: Not within the budget. We didn't have specific temps added. We had contracted staff that we added to the budget process. We split it out between divisions in proportion to their general fund. Some areas of the budget have more turnover than others. When we had the attrition going on often times the newer people are hired at a lower level than the ones that are left. We had a couple retirements. I had the easy part within my budget because I didn't have to explain the need to put the general funds back into fund my salary plan. You will notice that in another division or two that they weren't able, with the attrition, to accommodate the underfunding in those areas.

Representative Nelson: You anticipate a lower salary person coming on when there is turnover. When it doesn't happen is when you ask for this?

Brenda Weisz: That is correct.

Chairman Pollert: That was a total of $1 million for DHS?

Brenda Weisz: It's just over a million.

Chairman Pollert: I noticed that the $40 million, that must deal with MMIS? Was that under one time funding? Can we get a list of all the one time funding?

Brenda Weisz: That is on page one of your appropriation bill.

Chairman Pollert: Is there a detail broke down if it is a total dollar number.

Brenda Weisz: The bill only has it by general funds. I'll take that same schedule and just put total.

Jennifer Witham: Continued testimony.

Chairman Pollert : When is the implementation date for MMIS? Has all the money that has been incurred going to be incurred?

Jennifer Witham: The goal is set for May of 2010. This week we are closing down and finalizing the design sessions which have been going on for a year. Then we will move into the

construction phase where ACS, our primary vendor that's building our MMIS, will modify their system to incorporate all the changes for ND specific processing. That has begun and will continue until they are ready to begin testing the system. They are going to be starting system integration tests in June. That is a large part of the process, to make sure that all of the customizations that we have requested are incorporated into the new system. In the fall we will be going through user acceptance testing. We are expecting the provider enrollment which will be a live provider enrollment that will be happening in January 2010. Then the full system be implemented the following May 2010. Continued testimony.

Chairman Pollert: Will there be increases in every ITD department in the DHS budget? Is ITD charging you more money for the services they will provide you.

Jennifer Witham: In some of their areas they are. The next bullet talks about their rate increase for their labor or senior developer staff.

Chairman Pollert: I was going to ask if we could have what that number is for every department. So we can talk to the Government Operations people who are doing the IT budget.

Jennifer Witham: Continued testimony.

Chairman Pollert: Any questions for Jennifer. Any information you want her to bring forward when we go to detailing?

Tove Mandigo: Testimony attached (Attachment C)

Representative Nelson: These last two programs, are they both new?

Tove Mandigo: The diversion was new this biennium. With the changes in the DRA which became effective in October of this past year, the requirements were far more strict. So we moved to Pay after Performance.

Representative Nelson: We have been doing that in a different area?

Tove Mandigo: The TANF diversion we have been doing along, the Pay after Performance is a new program. Continued testimony.

Chairman Pollert: The $100 million increase in food stamps is all federal. What happens in our current environment if that money drops? If the federal government drops that money what will happen?

Tove Mandigo: The money is already appropriated. We have that money already for the 09-11 budgets. It can't change because it's open ended funding.

Chairman Pollert : What do you mean by open ended funding?

Brenda Weisz: There are certain grants that are open ended funding for the department meaning whoever is eligible they will provide funding. That is Medicaid, Food Stamps, Child Support, as well as Foster Care IV-E. No matter what they will give us that money.

Chairman Pollert: When we get to the detail I take it we will get our listing of what the grants all were and how much is federal and general. Can I get an explanation on the PRIDE?

Tove Mandigo: It's a continuation of the same program, just extending it state wide.

Chairman Pollert: Can you tell me what PRIDE is?

Tove Mandigo: Currently it is serving Bismarck, Dickinson, Fargo, Grand Forks, and Minot. We will be adding Devils Lake and Jamestown. PRIDE is a program that will take individuals in the child support area clients that will normally face jail sentencing and bring them into wrap around services in order to find them jobs. Hopefully they can be closer to their children. So far this program has won national awards. People are coming to ND to see what we are doing and seeing if they can duplicate it.

Chairman Pollert: Is there overlap in programs? We started Healthy Families with a $300,000 appropriation to that program. There seems that there are so many programs in the DHS

arena. Do any of them overlap and is it possible to get a listing of all those programs. Two sessions ago we got a listing of all the programs that DHS has. It was a color graph matrix of everything DHS does.

Brenda Weisz: I'll look at my stuff from two sessions ago. Many of the programs in our agency do overlap and do coordinate. A lot of our programs should and better collaborate or else we shouldn't be operating. To take your example of the Healthy Families, it does coordinate with our Child Welfare Services and it should. We should be working Child Support with our other agencies because it is public assistance. Child support collections do impact what we draw down from our federal grants for TANF. The more support we can get and retain, the lower our grant costs are going to be in our draw from the Federal Government.

Chairman Pollert: The SNAP has given us information on the Great Plains Food Bank. Are those interrelated or do they have nothing to do with each other. I know there is no general funds in the Great Foods Food Bank.

Tove Mandigo: There isn't but we do have someone who goes to the meetings.

Chairman Pollert: It's indirectly related?

Tove Mandigo: It's indirectly because it's a concern for people who are in need of food. There is a move to try and make sure there is a duplication of coverage and so we know what they are doing. We have somebody who sits at the table to let us know. I think the Great Plains is more food banks and places in the communities where people can go and get food. It is more of a sharing of information than any other sort of interaction.

Chairman Pollert: At that time nobody from the food banks would be asking if they are on assistance or not. Would they have to qualify to get food from that food bank?

Tove Mandigo: I don't think they would be allowed to be asking that question.

Chairman Pollert: The committee wants information on these programs and how they are related or indirectly related. Is there any easy way to do that without making it long.

Brenda Weisz: I will look at what I have from two sessions ago.

Chairman Pollert: I'm going to want to have a graph of what we got two sessions ago. I should have asked for that information. We weren't going to use it last session but I think it's important for the committee to have all that information of the programs. This other information I'm asking about is if we want to know as a committee, all the programs that DHS is offering. Or should we go through detail and just wait to see what they are.

Brenda Weisz: Chart handout (Attachment D). I will tell you a little about what this chart means.

Chairman Pollert: Representative Ekstrom has a list of what abbreviations means. Can the committee get that listing again?

Brenda Weisz: I will bring copies down.

Chairman Pollert: Any questions on the OAR chart? We will then move to child support.

Mike Schwindt: Handout Testimony (Attachment E)

Chairman Pollert: Of the FTE's it shows you decreased 7.5%, is that including all of the regional supports? Are those classified as state employees now?

Mike Schwindt: Yes they are state employees. Some are at the state office and some are at the regional office.

Chairman Pollert: When SB 2205 passed it was going to be a cost savings of $7-9 million. Are you saying it is $3.2 million?

Mike Schwindt: The fiscal note for 2205 included a whole bunch of stuff besides child support. The stuff you are seeing here pertains to only the child support budget.

Chairman Pollert: Has the mail levy's dropped to $3.2 million in the counties? So the $7-9 million, do you remember what the other $4-5 million was?

Mike Schwindt: Part pertained to foster care. There were a couple of pieces on admin costs. I'd have to dig out the fiscal note in order to answer that.

Chairman Pollert: I'd like you to bring that to us when we get into the detail.

Mike Schwindt: Sure.

Chairman Pollert: We will stand in recess until 2:30.

Best copy

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012- Medical Assistance

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/12/09

Recorder Job Number: 6853,6854,6855

Committee Clerk Signature

Minutes:

Maggie Anderson: Testimony Handout (Attachment A)

Chairman Pollert: Is this the section where we get into continuous eligibility?

Maggie Anderson: Yes, I will cover that in testimony and be happy to answer any questions.

Chairman Pollert: Are we going to get to numbers like 150 net compared to 200.

Maggie Anderson: This is actual enrollment. Continued testimony.

Chairman Pollert: Are you saying that people don't want to enroll in healthy steps because it's easier just to do continuous eligibility in Medicaid?

Maggie Anderson: When we process an application for health care coverage. An application comes into our office or into the county office, we test for Medicaid first. It's not that the family doesn't necessarily want it, but if they are eligible for Medicaid they will be on Medicaid. If they fail Medicaid we will test them for Health Steps. If they fail Health Steps we send a file to Blue Cross blue Shield for their Caring for Children program. We really test for all three programs and send that information if appropriate. Healthy Steps has a 12 month continuous eligibility. As the families come off of Healthy Steps and apply for coverage, if their incomes have decreased they are now going to show up in Medicaid enrollment because they will test eligible for Medicaid because we test that first. Along with that we had expected an enrollment

increase with continuous eligibility because one of the reasons the legislature wanted continuous eligibility and one of the purposes of that is for families who failed to report and their children would lose coverage. It's a combination of applications coming due, the family being tested, and now qualifying for Medicaid instead of Healthy Steps. Plus, the intended purpose of continuous eligibility taking place.

Chairman Pollert: Didn't we tweak the Medicaid coverage last session?

Maggie Anderson: In 2007, HB 1463 proposed to increase the income level from 6-19 year olds to 133% of poverty instead of 100% of poverty. We were unable to make that change because the federal law did not change. That bill had several contingencies in it. One was contingent on congress making a change to the 1997 statute on SCHIP that would allow that expansion. That fix was in the SCHIP reauthorization bill. That bill was never finalized between Congress and the President.

Chairman Pollert: Was there a dollar appropriation on that SB tweaking?

Maggie Anderson: There was.

Brenda Weisz: It was in the bill. We got the increase for Healthy Steps and then we got the reduction going to 133 . Actually by moving to 150% net and expanding to 133% of the poverty, we should have seen people shifting from SCHIP over to the Medicaid program. That didn't happen but our budget was reduced for that impact.

Chairman Pollert: So the dollars for 1463 were given back and not used? We would have had a separate appropriation from going to 150 net on Healthy Steps.

Brenda Weisz: Our budget was reduced but we didn't see the reduction in the expenditures because it did not happen.

Maggie Anderson: The SCHIP reauthorization is a hot topic in Congress. They expect a vote on that this week and the details of that are that it is intended to look a lot like the bills that

went through during 2007. They may or may not be able to extend that to five years. That is a bit uncertain at this time.

Chairman Pollert: Did we get a final cost of what continuous eligibility would cost us for this session. There was this argument amongst a few of us on what the cost was going to be. Do you have that figure or will you present it?

Maggie Anderson: I will provide that.

Chairman Pollert: Did we only fund it for the 07-09 biennium and we are going to have to reauthorize it, or is it in the budget for 09-11 already?

Maggie Anderson: When it was funded it was not funded for the entire 24 months. The hold even of bringing that forward to fund it for the entire 24 months

Chairman Pollert: Did we have to make up any dollars from the 07-09 in there? Did we appropriate $1.9 million?

Maggie Anderson: I don't have that on the top of my head. We can put a sheet together for you for the detail and get you all that information.

Chairman Pollert: So they have to reauthorize for continuous eligibility once every twelve months.

Maggie Anderson: The families need to apply for Medicaid coverage once every twelve months. They have no reporting during that time with very few exceptions. It's like the family says to dis-enroll the child. They move out of state or there is a death. Other than that it's a no ask don't report policy. They receive coverage for twelve months. At the end of those twelve months, just like with Healthy Steps, the family receives a notice and they will need to reapply.

Roxanne Woeste: Just so you know that the 2007 legislative assembly appropriated $4.4 million for continuous eligibility . $1.5 of that was from the general fund.

Chairman Pollert: Can you let us know if you needed the $1.5 million? That was for the beginning of January 2008.

Maggie Anderson: Continued Testimony

Chairman Pollert: If it doesn't get authorized we just ate 150 net, is that correct?

Maggie Anderson: Yes.

Chairman Pollert: I will want numbers for 165, 175, 185, and 200 net too.

Representative Nelson: You point out that we went to 150% in October of this past year. When you anticipate the 6,021 children increase was that based on the previous eligibility of where we are at after October of 2008. How did you come to that number?

Maggie Anderson: We built what we would call the base budget based on a 150% of poverty. We had an approved state plan for the Centers of Medicaid and Medicare Services. We had implemented that October 1. We assumed carrying forward 150.That budget was built at 150 and an OAR was submitted for 200%. The Governor funded that program at 200%. The 6,021 is a combination of that base budget plus the number of additional children that we would expect to serve at 200% of poverty.

Representative Nelson: When you went to 150% what kind of numbers did the program increase as far as eligibility as of October 1. Did you track that ?

Maggie Anderson; We estimated an additional 800 children would be eligible based on going from 140-150 net. Some of that fluctuation is captured in that increases and decreases in attachment D. We are tracking that and should have some final reports yet this week and we will be able to provide that. The numbers are around 800. Continued testimony.

Chairman Pollert: For healthy steps, is the income level for a family of 4 about $42,000? If not, can you get us that number?

Maggie Anderson: For a family of 4 at 200% net, it is $42,400 per year.

Chairman Pollert: But at net, what do you add back in?

Maggie Anderson: We have a list of all the deductions and disregards that we have for both Medicaid and SCHIP. It's quite lengthy.

Chairman Pollert: The $42,400 is kind of deceiving if you really add in what everyone is gross.

Maggie Anderson: Continued testimony.

Representative Nelson: Are you aware of states that pay at costs?

Maggie Anderson : I'm aware of people telling me that there are other states that pay at cost. I have not personally investigated that. It has come up multiple times with CMS. The general counsel from CMS has indicated that they fall back and say the Social Security Act prohibits it. If they find out other states are doing it they will make them stop.

Representative Nelson: I have heard from the grapevine that there are states that are paying at cost. It gets brought to our attention as to why we aren't able to follow along with that. I'm sure you have made your position apparent to those people who are asking those questions.

Brenda Weisz: We had direction from CMS that they would not entertain any change for us to be able to pay those services at cost because those acts prohibited it. It didn't seem to be needed.

Representative Nelson: So in the case of lab, you are paying the lab at Medicare rates?

Maggie Anderson: At the Medicare fee schedule.

Chairman Pollert: So you are saying for critical access, some of what we appropriated to use at hospitals was used and some wasn't.

Maggie Anderson: I don't think we would get down to the exact appropriation. There was an understanding that all services of the critical access hospital would reimburse that cost. There wasn't a lot of discussion about that where the opportunity presented itself for us to be able to

talk about the items that weren't prohibited. The third item is the swing bed services. We are continuing to work with CMS on trying to identify what we can and can't do in that area. No one has really asked them that question before. The regulations are pretty specific about how we pay for swing bed services. It is roughly $800,000 general funds.

Chairman Pollert: Was it all appropriated and used up?

Maggie Anderson: It was all appropriated. We would have to run a schedule as to what the cost of critical access has been compared to the appropriation. Keeping in mind when that was appropriated that it was based on the number of critical access hospitals that were approved at that time. There have been additional ones that have switched from the general acute PPS hospitals to critical access. It may also turn out where we have spent more than that on the particular area.

Representative Nelson: As I remember as the fiscal note was prepared for this, I believe I did the analysis for that. To the best of my recollection they did include 100% costs and analysis in there. Where was the balance of that fiscal note last session and where we were now?

Maggie Anderson: Continued testimony.

Chairman Pollert: We increase the level to 150 net and tweak with the Medicaid at 133 at poverty. With continuous eligibility we increase 4,500 people to which program?

Maggie Anderson: Between both of them. Looking at attachment D will be the easiest way to look at it. You can go back to November of 2007 when we had 4,019 children enrolled in SCHIP. We had 27,438 children in Medicaid. That totals 31,457 children. Then in November of 2008 we had seen a decline in enrollment in Healthy Steps down to 3,568. However, Medicaid increased to 32,479 for a total of 36,047. We did see growth in the early part of the biennium for Healthy Steps and then somewhat of a plateau. Then we saw a little bit more of a growth until June. Then they declined relating to the continuous eligibility. When you look at the

numbers between the programs on how many children are receiving health care coverage it is a net increase of 4,590 children.

Chairman Pollert: That is where my question is coming at. Aren't the services under Healthy Steps better than the services under Medicaid? Are they the same or doesn't it matter?

Maggie Anderson: The benefit package under Medicaid is more comprehensive than the benefit package under Healthy Steps. The benefit package under Healthy Steps mirrors the state employee package with the addition of vision and dental benefits. Medicaid is a much more comprehensive package. Continued testimony.

Chairman Pollert: What would be the percentage increase of re-basing?

Maggie Anderson: It's a 14.05 % increase for hospitals.

Chairman Pollert: It is based off of the rebasing and is 7% the second year?

Maggie Anderson: Continued testimony.

Chairman Pollert: It rebases to January 1, 2009?

Maggie Anderson: The optional adjustment request that were submitted would rebase anything for costs as of July 1, 2009. The OAR sheets that were handed out in my testimony you will see where some of the items were funded at levels different at 100% of cost. It would be cost at July 1, 2009. They were inflated forwards so when we start the biennium they would be rebased to cost.

Chairman Pollert: When was the last time we rebased hospitals?

Maggie Anderson: It was in 1994 using 1992 data. For the other services there hasn't been a rebasing to my knowledge. It is something that is more common with your institutional type services. Continued testimony.

Chairman Pollert: What do you mean by the rebase of 25%?

Maggie Anderson: When the rebasing report came in with the total amount the department was requested to send in information on Office of Management and Budget. It was 25% of the number so it was around $53 million.

Chairman Pollert: So hospitals are being projected for July 1, 2009. So you could say that Physicians aren't being rebased.

Maggie Anderson: Physicians are receiving an increase of 25% of their rebase amount that was calculated. This number reflects rebasing at cost in hospitals.\

Chairman Pollert: Two biennium's ago we had inflationary increase of 2.65%. Last year we had 4 and 5%. Now this year it is 7 and 7. When you do your budget, doe the 2.65 and the 4 and 5 added on to the top or is it eliminated out and we start from 7 and 7?

Maggie Anderson: The 2.65 and 2.65 from the prior biennium was included in the cost to continue as we built our budget for the current biennium. As we built the budget for 09-11 we knew that we already had the dates of service that included the 4% from the first year of the biennium as we were building. When we project what that cost person service is we have to put the 5% on that. As we get into going through the detail and you look at our spend down reports, the cost was only showing this in April. You may ask why it is 5% higher. It is because the fee schedule goes up July 1, 2008 with an additional 5%. We have to build that 5% increase on their This budge t would hold the 4 and the 5 in place and add an additional 7 and 7 each year of the biennium noting the exceptions for the 7%. Continued testimony.

Chairman Pollert: I take it hospitals aren't going to be rebased to the Medicare levels. If I looked at hospitals where does it put them at compared to Medicare?

Maggie Anderson: We would have to put out a map to that. It's not a distinct comparison. It has to do with a lot of factors that we pay. We pay off different groupers and we weigh things differently. Medicare doesn't pay for a lot of births where Medicaid does. We group and weigh

things differently between the two programs. The directive of the study was not to pay at Medicare. It was to figure out what it costs to rebase them and that is what the rebasing study was about. An ambulance service goes out on a call and delivers a service and bills a code to the department. It's an A code for transportation that is billed to Medicare. Those are easy to see. There is not that distinct of a comparison for hospital services. In the rebasing study that the consultant did, they provided what it would cost to rebase at cost. They put it as the last page of their report. Should that not be selected, here is an alternate step.

Representative Nelson: Why are the dentists the only ones who are in the 7 and 7 inflator category?

Maggie Anderson: During the course of the actual rebasing study we weren't able to actually complete the study for the dentists. There was quite a bit of difficulty with completing the cost reports and those being able to provide the information in the way that the consultants needed to do a study. An OAR was submitted at 65% of average bill charges. You will notice on the OAR sheet that it is one of those that were funded at a different level. It was funded at 75% and the 7 and 7 inflation was included on that.

Representative Nelson: So when the inflator is added to the 75% they won't be at charge rate but certainly a lot closer than the 75% in some cases?

Maggie Anderson: That is correct because it is a minimum of 75% is where the fee schedule would be established. There are some above that. The 7% would be added on to that.

Representative Nelson: Could we also see if that 75% of average bill charges was taken out and what that number would look like rather if they would just follow along with the rest of the reimbursement?

Maggie Anderson: So you would like to see what the 7&7 inflation would be on the Medical Services budget without the increase of 75%?

Representative Nelson: Correct. Wasn't the language in last session to rebase hospitals and inpatient services at Medicaid rates? There was an amendment to the Human Service bill that raised that for critical access hospitals.

Maggie Anderson: It was to pay them at 100% of cost, not the Medicare costs.

Representative Nelson: That is bringing the big hospitals up to 100% of costs.

Chairman Pollert: That is a better way of saying what I was trying to say. So the rebasing is 100% of costs, is that what you are saying?

Maggie Anderson: Yes for the hospitals it is. A comparison to bill charges/costs or what comparison would you like to make. This study would certainly be the exception to that.

Chairman Pollert : If I would compare the dentist reimbursement schedule to hospital reimbursement schedule, who is getting a better percentage and how big of a difference is it?

Maggie Anderson: What comparison would you like to make?

Chairman Pollert: My guess is that we are treating dentist reimbursements better than we are treating hospitals. I am trying to find out what is that correlation? Is it drastically better? Why would we do that as compared to hospitals? Is it 125% of costs, is it 133% of costs if you would try to base it to hospitals?

Maggie Anderson: We don't have cost information for the dentist. We were unable to complete that because of the difficulty that the dental providers were having in completing the cost collection tool. The only comparison we would be able to make is a comparison to build charges. As we have talked about in previous bienniums there is always a concern of making that comparison. Bill charges for a dental practice to a hospital to an ambulance provider and what is in that difference are very different things.

Chairman Pollert: But bill charges will have a percentage of profit in?

Maggie Anderson: Certainly and for each provider that is a different percentage. They also have overhead costs and things that may not be allowed to be counted as costs per federal guidelines on what can be included in costs.

Chairman Pollert: So what is 100% of costs to hospitals? Is it just bill costs?

Maggie Anderson: No. Currently they bill us bill charges. What will happen on July 1, 2009 with this rebasing is each hospital receives what is called a base rate that is hospital specific to their costs. That base rate is included in the formula that determines their final cost. They are still going to bill us. Based on our new base rate plugged into our funding formula, they will receive a payment that will be less than our bill charges. Same goes with dentists.

Chairman Pollert: Could it be said that critical access hospitals do not have the revenue stream that urban hospitals have because of heart surgeries and stuff. If you say that, do urban hospitals have a better chance of revenue gathering than critical access hospitals?

Maggie Anderson: I would be uncomfortable answering that question. Continued testimony.

Chairman Pollert: The current budget for inpatient hospital was $106 million. Are you saying we are going to go up over 100%. Are we adding them together?

Maggie Anderson : No. Our budget request is $142.3. It's the difference. Continued testimony.

Representative Nelson: In this area, did you give any consideration to the debate regarding the pharmacy ownership law. I've seen some numbers that will say the department will save some money if it passes. Was that considered in part of your budget?

Maggie Anderson: That would be part of a fiscal note that the agency would prepare. If and when the bill was introduced we would provide the fiscal note. We have done a fiscal impact projection at the request of individuals who are sponsoring that legislation. It was not included in this budget because it would need to be handled through that separate legislative process.

Representative Nelson: So it is prepared at this time?

Maggie Anderson: The estimate is prepared. It is not in any of my budget information for these materials because it would need to be handled through that bill. Should that bill not pass and we would have made a change in our budget, then we would have been short those dollars. Continued Testimony.

Chairman Pollert: The Executive Budget requests $74.3 million for Physician services. What was that from last biennium?

Maggie Anderson: It is attachment G in my testimony. It would be $64.1 million. That will show you the 07-09 budget, the projected need, and the 09-11 budget to the house. Then we did a bit of an add on due to the rebasing to show you how much of that 09-11 was related to rebasing. Continued testimony.

Chairman Pollert: When you get to ambulance services, our current budget is $3.7?

Maggie Anderson: It is $2,964,019.

Chairman Pollert: So you are telling me that the ambulance services have a $2.7 million increase total?

Maggie Anderson: Correct.

Recorder stopped working so started new job.

Representative Nelson: Are all the ambulance services given the same rate? Whether it is rural, urban, air? Is that formula the same for all of them?

Maggie Anderson: We have base rates and there are base rates for air ambulance, both rotary and fixed wing ambulances. Then there are mileage codes.

Recorder stopped working so started new job.

Maggie Anderson: So what you would like to see on rotary wing ambulance.

Representative Nelson: Is Medicaid paid on each of those categories you just explained? Is there another way to be able to delineate those differences in the payment schedules?

Maggie Anderson: I'm not sure I understand the question.

Chairman Pollert: I would like to know if a fixed wing or rotary, when they bill you is it by bill charges. You pay them off the bill schedule right?

Maggie Anderson: Absolutely.

Representative Pollert: So that percentage of bill charges versus what you pay versus basic life support and what they are paid off a bill schedule. I would be interested in comparing the different types of ambulances and where the dept pays in those categories.

Maggie Anderson: So what you would like to see is rotary wing air ambulance, we pay 42% of bill charges. ELS, ground ambulance we are paying 65%. Continued testimony on bottom of page 15.

Chairman Pollert: Go back to chiropractic serves. The total request is $987.5. You are telling me that their base budget before we started this was $573,000?

Maggie Anderson: The rebasing for chiropractic services was 91.4%. The 2007-2009 appropriation for chiropractic services was $455,167.

Chairman Pollert: So you are telling me that Chiropractic's base was $455 but they are requesting $987 for an increase of $532,000.It is a 117% increase.

Maggie Anderson: That includes the rebasing of the 7% the second year as well as cost and utilization changes. Continued testimony.

Chairman Pollert: Are there any questions for Maggie? Our meeting is adjourned until tomorrow morning.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/13/09

Recorder Job Number: 6911, 6912, 6913, 6914, 6915, 6916,

Committee Clerk Signature

Minutes:

Chairman Pollert: Called the meeting to order and took roll. Every member was present.

Maggie Anderson: Testimony handout. (Attachment A)

Representative Metcalf: Concerning Hospice, I see you have a special chart. Is there a special reason. Are you trying to show that there is a correlation there or that there are more costs involved in that particular operation? What is the purpose of this particular information?

Maggie Anderson: No specific reason. It is a service that we pay the room and board component. Individuals receiving Hospice, they are likely Medicaid and Medicare eligible so they receive Hospice benefits through those two programs. What we are paying for in the nursing home is the room and board component. It's just information purposes.

Representative Ekstrom: In terms of the bed shifting that is going on throughout the state. As we get into detail I would like to see geographically how the shifts are occurring. I'm increasingly concerned that we are pooling more and more of those to the urban centers. But that isn't necessarily the best long term solution for the folks that are living in rural areas because of them distancing themselves from relatives.

Maggie Anderson: We will pull something together. Continued testimony.

Representative Ekstrom: As we get into detail on this subject, I'll assume we'll have that schedule. I'd like to see how it is applied across the board.

Maggie Anderson: We have the sliding fee schedule the way that it exists today where there is a 0% share all the way up to a 90% share, then all the way up. Is that what you are seeking?

Brenda Weisz: The sliding fee scale back in 2003 was established at that time. It wasn't a new methodology but rather duplicated something that already existed.

Maggie Anderson: Continued testimony.

Representative Ekstrom: 24:30 Do we have a sense of the population census?

Maggie Anderson: We have estimated about 27 slots. Individuals that we have identified that may currently be at a max and need that extra care.

Representative Wieland: Define a slot

Maggie Anderson: It's how we build a budget. We estimate a number of people who may utilize the service and an average cost of care. We wouldn't be limited to 27. We are estimated about 27 people may use the service. It could be 24, it could be 32.

Maggie Anderson: Continued testimony.

Representative Ekstrom $30.58 In terms of personal need allowance. How much are they each allowed to hang on to? If they don't use the entire

Representative Kreidt: Going back to page 4, is there any follow up on the training received by the nurse? After the training is done are they able to do the service or procedure that is asked?

Maggie Anderson: The nurse has to certify that they have been trained to do what they indicated should be done. They need to review the client's needs every six months. They can review more often than that but they need to review every six months.

Karen Tescher:

Representative Kreidt: How did you determine that the 30 slots for the Autism. This is becoming a big problem for children under 5.

Maggie Anderson: It was through identification of children. Continued testimony, talked about Handout B

Representative Ekstrom: Could we also get a breakdown geographically?

Started new job (6912). Recorder stopped working.

Representative Ekstrom: Do you see where I'm going with my line of questioning? I'm trying to see how we can keep more folks in the rural communities if it's less expensive for us to do so.

Maggie Anderson: You would like to see by facility the lowest and highest rate because they will be by the classifications? Continued testimony.

Representative Wieland: We are paying for 62 people who live out of state?

Maggie Anderson: Yes that is correct. We have a reciprocity agreement with MN. For the first two years they live in MN they remain on ND Medicaid and vice versa. That is just because of the proximity of our border. You have people who may want to go to Wahpeton and Breckenridge. Their family may live in one town but they want to be with their family in the other town. We also have other individuals who are further in to the border of MN. After two years they avert to that state's Medicaid.

Representative Wieland: Is the costs similar for the out of state people as it is for in state?

Maggie Anderson: It is comparable. It is not the exact same payment methodology. For example we pay an all inclusive rate in ND including therapies. In MN we pay for the therapies separate from that rate. MN agrees to our payment methodology when they have a client here.

Maggie Anderson: Continued testimony

Started new job because recorder quit working.

Chairman Pollert: On the 22 addition, is that for people that fall between the cracks? Are there people who fall between the cracks?

Maggie Anderson: Those 22 additional individuals could be one of two things. Because it is a sliding fee schedule they may be at the point where they are beyond the 90/10 split where we pay 10% of their care and they pay 90%. They are revising the schedule where they may move it up enough where they now fall into one of the areas where we will pay for a portion of their care. The other thing is that we have heard from the county case managers who work with clients and authorize these services that when a client has to pay a portion of their care whether that be 10% or 80% that they may not seek that care because they are unable to afford that care. We expect some of those individuals who may otherwise have had to pay a portion of their care or pay a higher portion that they were unable to pay to come on who are not currently receiving any services. Continued testimony.

Representative Wieland: When we talk about the 7% inflationary increase throughout the budget is there any portion that is required or dedicated to salaries specifically, or is it discretionary for the provider?

Maggie Anderson: There is nothing mandated for that. With the program often times it is QSP's doing that so that 7% directly goes to increase the fee schedule. Within a nursing home or basic care facility they are provided a 7% inflationary increase and then it is within the nursing facility or the facility for the developmentally disabled to determine how to apportion that increase that they need to cover all of their costs that are inflating.

Chairman Pollert: What is targeted case management?

Maggie Anderson: Case management is assisting individual's access services and coordinate those services and make the right connections in order to assure that whatever is in their particular care plan. That they can access those services that they can get the transportation,

that there is follow up with what is recommended. Targeted case management is targeted at a population like individuals in need of long term care services. Within the traditional Medicaid grants yesterday I talked about targeted case management for pregnant women. Pregnant women would be a target group. They are a very specific group. We don't provide case management for the Medicaid population as a whole. We have targeted groups who have been identified as needing that specific additional service. We have targeted case management that you will hear about in the CFS area.

Chairman Pollert: Are you saying that this targeted case management might be for clientele that doesn't fit into home community based. Does this fit to a certain group of people or for those who have a special need so that they are taken care of?

Maggie Anderson: It does have a specific purpose. For example we do not provide targeted case management for individuals in a nursing facility. Again that is included in that daily rate that they receive. They are supposed to do the case management for the individuals living in the nursing facility. They would not provide targeted case management for individuals receiving SPED or expanded SPED specifically for their services. If they are Medicaid eligible and they need personal care, they need to receive that care through the Medicaid state plan not through SPED because we receive the federal match. Specifically the people who are receiving this service are receiving Medicaid state plan personal care and the targeted case management. The individuals in the waiver also receive case management through the waiver.

Started new job because recorder stopped working.

Maggie Anderson: Continued testimony.

Chairman Pollert: What is a technology dependant waiver?

Maggie Anderson: The criteria for this waiver is an individual is ventilator dependent for more than 20 hours a day. They are medically stable and they or their family members is capable of directing their own care. That is the criteria.

Representative Wieland: Can we get a chart that would show us where these PACE people are coming from? You said it's a shifting so I assume these people are coming off of a program so that we can find out where they are coming from.

Maggie Anderson: We can do two things. One of them is building a budget. These people so to speak who are in PACE aren't in PACE yet. We built a growth in there. What we can show you is where we move the dollars from. For example we had to reduce nursing facility costs. Then we can tell you in general the nine individuals who are currently enrolled in the PACE program where they were previously receiving service.

Representative Ekstrom: I'd like a broad overview of particularly nursing care and all types of senior care. Where we are today in terms of population is some of the information I would like. We all know the demographics are shifting towards to the older. I'd like to see a five year projection as to how many folks could be reasonably expected to be coming into the system and accessing all types of care.

Maggie Anderson: I will certainly visit with our Aging Services division, the Medical Services division. They are working on a report. Between all of us we should be able to provide some information for you on that.

Chairman Pollert: Program for all inclusive care. Do these individuals not really fit into other areas so you started the PACE program?

Maggie Anderson: The purpose of the PACE program is to offer an alternative service for individuals in home and community based care. It is really a single point of entry where they can go into the PACE program. If they are living in a home, apartment, or community setting

now the PACE program will provide them any services they need to remain in their home for as long as they need. If they do need to go into a nursing home the PACE program is also responsible for paying the costs of the nursing home care. It is truly a home and community based care. It is an option for people who choose to remain in the community versus choosing to go to an institutional setting. It's not that they didn't fit somewhere else because very likely these people receiving PACE are receiving home delivered meals. They are receiving personal care services. They are receiving home makers services. All of that has to be provided by the PACE program through this comprehensive capitated program that they have to provide all the Medicare and Medicaid services. Nationwide it has proven to be a very effective program for allowing individuals to remain in their home and community.

Chairman Pollert: I would like to have a further explanation of this so I have an idea.

Maggie Anderson: We can put something together that would be basic information. I'm sure someone who is running the local PACE program would be willing to provide information through the subcommittee or the public testimony.

Brenda Weisz: Would it help if we said it is managed care. It is a managed care program rather than individual services. You have health insurance or managed care.

Representative Bellew: What is the difference between PACE and SPED

Maggie Anderson: If someone has to be Medicaid eligible in order to qualify for PACE. Medicare pays a portion of the fee and Medicaid pays a portion of the fee. With SPED someone may be SPED and not be Medicaid eligible.

Representative Bellew: Do they provide the same services?

Maggie Anderson: No. The services in SPED are home and community based services. Where within the PACE program they are responsible for all Medicaid services. So if that person falls and breaks their arm they need to get them to the Dr. and pay for all the bills. In

SPED we pay just for home and community based services and typically those are from an agency or an individual QSP.

Representative Kerzman: How does PACE really differ when the counties were doing most of this?

Maggie Anderson: I can honestly say I don't have the answer.

Brenda Weisz: Pre-Swap was that basically the counties paid for a portion of the grants. PACE actually is providing the services. It is an actual facility that is going to take them to the doctor. PACE will bring all those costs together as one.

Representative Kerzman: How is that going to affect the counties?

Brenda Weisz: I don't believe there is an impact to the counties eligibilities with Northland. They handle the managed care program. They will still determine the eligibility as they do today. As far as the administration, that is all handled by Northland.

Maggie Anderson: Because PACE is required to provide all Medicaid and Medicare services, that is a Medicaid service so they have to provide that. They sometimes are contracting with the county to provide that service. In some ways the counties are actually assisting in that service.

Representative Kreidt: The PACE program is something that private pay can participate in correct?

Maggie Anderson: That is the design of the program. Right now the PACE program in ND has a waiver from that. It has to do with the amount of reserves that they need to be able to document in order to insure because it is a managed care. They have a waiver on that right now. I am uncertain as to how they are going to move forward with that.

Representative Nelson: When we think of managed care, often times they get the tag that there are some deficiencies. I am wondering from a client base. Is there a slower movement

when there are more services required? Is your department involved in that process. What are you hearing from the clients and clients' families? Is it successful?

Maggie Anderson: I believe that we do have the safeguards in place. Not only if you are written appeals or people calling our office. Every one of the care plans for the individuals is reviewed by a nurse on our staff as well as our medical doctor who is under contract with us to make sure the appropriate cares are provided. I believe it all goes through our screening process too. These individuals need to meet nursing facility level of care. So based on what is identified in that we make sure that the care plan is following through with those needs. What I can tell you from the family members as well as the recipients to date is that they are very excited about the program. We have had a couple of little issues in regard to eligibility. Where we needed to work them out with recipient liability and some of those things with clients and the clients want to get in and don't want delays. They want immediate decisions.

Chairman Pollert: So PACE is a person on SPED but who is requiring Medicaid services to be enrolled in the PACE program. They are still accessing SPED?

Maggie Anderson: They are Medicaid eligible. They are at the point where they enroll in PACE. They become eligible for all the Medicaid and Medicare services. Those services look a lot like the SPED services. Only the people who are on SPED don't necessarily quality for Medicaid. It is more about individuals over the age of 55 who are Medicaid eligible and meet nursing home level of care.

Chairman Pollert: They are getting SPED equivalent services but because of the Medicaid wise it is further enhanced.

Maggie Anderson: They are receiving quite a bit more than what they would from SPED

Representative Metcalf: Northland PACE is basically limited to two communities, Bismarck and Dickinson. When will that be expanded across the state or will it not be?

Maggie Anderson: We have had no conversations. It is certainly a new thing that we implemented in August of 2008. They have discussed looking at the Garrison area. I know that when the PACE program has been discussed that the Medicaid medical advisory committee that there is a great interest. There is no additional areas of the state or expansions into other regions of the state that are included in our budget.

Representative Metcalf: What is the cost of PACE in comparison to the average cost of individual services. Is the cost higher or lower?

Maggie Anderson: When we do that breakdown for the detail of where we took the pace money from the different areas of the budget. This is the monthly amount that we are paying and how we pulled that from the other areas based on the dollars of services we were paying.

Representative Metcalf: If you would show me a comparison saying this would be higher or lower.

Maggie Anderson: We don't have enough claims data to show that pace is lower or higher because we implemented it in August and it takes awhile for the claims to get through the system but we will be able to tell you how we built the budget based on our current expenditures in those areas.

Chairman Pollert: On something like PACE, did we authorize a PACE creation program the last biennium?

Maggie Anderson: Not specifically. There was language in the 2005 HB 1459 that directed the department to review and consider and explore managed care. So this is not new money. It is the shifting of money to the other services and we have been working on a variety of conversations in the managed care area based on that 2005 HB 1459.

Chairman Pollert: So you have the authority to start new programs or whatever you want to say.

Maggie Anderson: Based on that we will continue to look at these managed care situations.

Representative Wieland: So who or what is Northland Pace?

Maggie Anderson: Northland is Northland Healthcare Alliance. They are an alliance of a variety of medical facilities across the state. It is a healthcare organization.

Representative Bellew: Would it be possible to get a copy of their budget? I would like to know how they are planning on spending it. I see what you guys are projecting but what are they projecting? You built a budget in conjunction with them I assume?

Maggie Anderson: We built the budget based on the actuary rates that we got back from our actuary contractor for the services. We certainly have the information from Northland about their projected expenditures on costs. Continued testimony.

Representative Kreidt: The attachment D in your testimony, if you would go back 50 years or so when I got into the business. My first job was a nursing home administrator. Our daily rate was $5 a day compared to $205 now. I began working and my first appointment was we needed an increase in our daily rate. It was a tough decision and we decided to go up 50 cents a day. I had to go around and see the residents and I thought the earth was going to come to an end because 50 cents a day was a lot.

Andrea Pena: Handout testimony (Attachment B)

Started a new job.

Linda Wright: Testimony handout (Attachment C)

Representative Ekstrom: I would like to see the service areas broken down into urban and rural. In other words how are we doing in getting these services out to the rural parts of the world and what kind of trend line there has been in terms of 2003-present. How has that trend changed and are we seeing a migration to the urban centers.

Linda Wright: We will be happy to provide that information. Continued testimony.

Representative Bellew: What would be the difference between the ADRC and the resource link?

Linda Wright: The resource link is manned by one person in our office that is certified. She answers the phone Monday through Friday office hours. She also provides basic information to folks when they call and ask for information. An ADRC would be additionally able to provide benefits counseling, assess eligibility for various programs, be able to link people to services one on one in a more direct way by meeting with individuals and families if possible. The resource link is kind of a little bit of a gateway but a small part.

Representative Nelson: What do you envision the need for ADRC? What kind of FTE or facility do you think will be needed to man that type of center?

Linda Wright: We envision that this would involve existing agencies by getting them together to agree to share information. It really has varied from state to state. I talked to by counterpart in Montana and he said that one of their most successful ADRC's was located in the shopping mall right across from a pharmacy. They had a lot of visibility in the mall and then various agencies would be accessible in that ADRC at various times. If you had a legal problem you would have a legal person there. If you wanted to know if you qualified for a county social service program you would have an eligibility person there at the ADRC. It's a way for people to go to one spot instead of having to go to many different agencies and organizations to determine what kind of services they might be eligible for.

Representative Nelson: So you are envisioning a contracting service with legal matters. It would be someone that would be accessible but wouldn't necessarily be spending the entire day at the center. Are you looking at location like Bismarck?

Linda Wright: What we are envisioning to begin with is a pilot site to see how well it works. It would have to be a site that has both an urban center and rural areas to serve. We want to see

that we are able to provide services to rural individuals as well as those who might live in an urban center.

Chairman Pollert: I struggle with the one stop center. The reason why I do is because you have social services out there providing services. Are you saying that eventually the one stop centers, if that's what is adopted, would you say the heck with services offered by Social Services. If we are going to put money into one place it should be taken from somewhere else otherwise you will continue to have the same overlap for the same information. How is that going to solve all the problems if we have a lack of information?

Linda Wright: I know the vision of the assistance secretary for aging is that there be an ADRC in every community. As I said, different states have implemented this in different ways. An ADRC is meant to serve all individuals that might need some information and need some type of long term care. County Social Services do a great job but in most cases they are serving a limited portion of the population. An ADRC is meant to serve not only individuals that would qualify for public assistance, but also individuals that are private pay. There would be a fee for those individuals to access the ADRC.

Representative Wieland: I was a County Commissioner for 20 years so I have a little background on what the services that they provide are. I am sorry to hear that anyone would feel that they would not be comfortable calling Social Services to get that information. They don't only serve people that feel they can't afford something but they serve anybody. You would have the same thing with an ADRC. At the ADRC they aren't going to be able to qualify an individual. They are going to have to make a referral. If you can refer it from one agency why not the other agency? I think we already have this type of thing in place.

Linda Wright: There are some counties that do serve other individuals but there are some that don't. There are some Social Service offices that only serve individuals that qualify for SPED

or expanded SPED. That is a choice they have made because of their limited resources. Probably more in some of the rural areas. The purpose of this is to get those folks together and then to be able to do the eligibility to be able to share an assessment documents. An individual that qualifies for services doesn't have to get the same information to five different agencies at five different times. Instead they can give their information once. From there they can determine if they are eligible for SPED or waivers. A variety of entities to come together. In 45 states this has been found to be a good model. It really assists people. An example would be when Maggie was up here providing testimony. The system is very complicated. The number of funding sources are very complicated. It really takes a lot for people to try to find out what services they can get that they need. We are trying to simplify that process.

Chairman Pollert: That is fully understandable but as far as legislators go, I look at it as there has to be a drop in FTE's somewhere else.

Linda Wright: That certainly has been true in other states. They found greater efficiencies and effectiveness. Instead of 5 people taking down information and determining of people are eligible for services there is one stop to do this. Eventually it resolves to greater efficiencies.

Chairman Pollert: Would you be able to forward us of what they've done to see if there has been savings?

Linda Wright: Yes. Continued testimony.

Chairman Pollert: Has every section of DHS seen rent increases?

Brenda Weisz: Actually for Facilities Management where we pay rent for the Judicial Wing, that is a slight decrease. I will have that in my detail. However, at Prairie Hills Plaza that was a 54 cent increase. Century Center there was no increase there.

Representative Nelson: Will you be giving us the cost per square foot for that rent?

Brenda Weisz: Yes when we present our detail. Do you want one that pulls it all together?

Linda Wright: Continued testimony.

Representative Nelson: Is this only for the training that takes place at Lake Region State College?

Linda Wright: They have trained 64 nurses statewide. If someone wants to be trained they can access a very local person to get the training and to have the documentation signed off.

Representative Nelson: So the Lake Region program trains the nurses and they train people in their local communities?

Linda Wright: That is correct. Continued testimony.

Chairman Pollert: When you say direct service providers, who are you talking about?

Linda Wright: The entities that we contract with that provide the services.

Chairman Pollert: So will the 7&7 go to the QSP's as well?

Linda Wright: Yes that is in the Medical Services budget. Continued testimony.

Representative Wieland: How many center would you be able to open with $600,000?

Linda Wright: We would start with one center as a pilot and see who that works and expand from there. It would be a request for proposals and it would depend on the interest that there is statewide. I understand that there are some rural counties that are interested in getting together to present a proposal if this is funded.

Chairman Pollert: You will set the criteria? Is this center depending on the population as to where it goes? Is it going to be three people there? So in essence you really aren't asking for FTE's but you are asking for FTE's.

Linda Wright: There would need to be someone to administer the program. There are no additional FTE's built into the $600,000.

Chairman Pollert: So that $600,000 will do what?

Linda Wright: It will provide the funding to establish the ADRC's to increase the licenses that we need for the data base and the assessment to fund some of the technology that would be required to do some of the assessments. I would be happy to provide the grant budget that was submitted that would give you a breakdown what was envisioned.

Chairman Pollert: At some point you are going to hire FTE's but it's not in this budget?

Linda Wright: That would be part of the RFP. So whatever agency would submit a proposal would most likely have staff.

Chairman Pollert: Are you looking at it as a private contractor is going to offer the RDC's?

Linda Wright: County Social Services could apply as well as a number of non profits.

Chairman Pollert: So you are saying that no state employee's would be hired for this.

Linda Wright: There are no FTE's included in the $600,000.

Representative Nelson: So the 600,000 that's in the general fund money in this budget, is it for a one year period in next biennium. How does it work in the scheme of 24 months?

Linda Wright: We would propose to roll out the request for proposals as soon as possible after the beginning of the new biennium.

Representative Nelson: In that regard, that $600,000 you would envision that they would have to operate on a $300,000 yearly budget at that point?

Linda Wright: I believe that would be correct. Continued testimony.

Started new job because recorder quit working.

Chairman Pollert:

Tara Lea Muhlhauser: Testimony Handout (Attachment D) 1:00-5:24

Representative Wieland: Out of the 4,011 assessments, how many of those resulted in some sort of arrest or removal of a child?

Tara Lea Muhlhauser: I don't have that number off the top of my hand. We just had some recent data that was published last week. It's hard for us to track criminal prosecutions because we are in between two systems of data that we keep and data that is kept between the State's Attorney's offices. I can tell you the number of situations that have emerged in a child removal and placement. Continued testimony.

Representative Wieland: Are these mostly being resettled in Fargo and Bismarck areas as before?

Tara Lea Muhlhauser: Bismarck has some, Fargo has the majority. I believe there is some resettlement in Grand Forks. It was high and had gone done but are starting it more. Continued testimony.

Chairman Pollert: How do most states qualify for the first time around when you have to have a model of someone? The program was set up by the federal government and no states. It seems incomprehensible that something like that could happen.

Tara Lea Muhlhauser: It's been a bit of a national trend. Child welfare leaders across the country have said to listen. It's important to know where the bar is and to have a high set of standards. If you set a bar that no one can reach, does that really help us maintain good quality in our service delivery programs? In the last review after 2001 we went around saying we are the best of the worst. We are at the top of the country but we failed like everyone else. This year we have some inkling that we aren't at the top. In other words we feel like we have a good child welfare system but we aren't meeting the bar that the federal government has set for the measurement of child welfare programs.

Chairman Pollert: I take it the program is not set up with input from the state governments and that someone in federal government is saying where we need to be without any input?

Tara Lea Muhlhauser: For the most part that is correct. We did have some input in a federal process. They did take comments from states and from lots of providers throughout the country. We did provide comment from ND. They considered our comments and took some of them but rejected many others. Continued testimony.

Representative Bellew: What is Title IV-E?

Tara Lea Muhlhauser: A portion of the Social Security Administration Act. It is used to name a large federal source of funding for children who are in foster care and many of our child welfare programs. It's our largest federal stream of funding for child welfare.

Continued testimony.

Chairman Pollert: The .5 FTE is that one position or is it temporary?

Tara Lea Muhlhauser: They are both permanent positions. We anticipate that we will need them after this additional bubble of providers flows through. The administrative assistance position will be to coordinate the passing of paper and some of the duties that go with that. The .5 program administrator position will be to supervise the work of our background check staff. One of the things that we learned in the last two years is that it takes us a fair bit of time by professional personal to sort through the number of hits or the negative feedback we get from the FBI checks. It takes a lot of discretion for this person to sort through the hits and determine whether they are offenses that should keep someone out of the category or whether we can look to indications of rehabilitation. There is lots of sorting and discretionary work to see if they have met the standards of rehabilitation. Continued testimony.

Representative Kerzman: Why would therapeutic foster care be cheaper than regular foster care? It seems like it would be the opposite to me.

Tara Lea Muhlhauser: When I was working with our fiscal analyst I asked the same thing because I didn't understand how they separated these rates. That is actually a partial rate.

That is only a portion of the rate. As I understand it, the $553 would be added to that for providing therapies. That is only a portion of the rate that you see here under $1,011 a month. It's actually a higher cost than family foster care would be. If you want us to break that down in another way for you I can do that.

JoeAnne Hoesel: Testimony Handout (Attachment E).

Chairman Pollert: The $300,000 for gambling, has anybody ever talked about why it doesn't come out of the Attorney General's revenues for the lottery? There is $400,000 that comes from the Attorney General's office. I don't know if that was part of the deal structure when it was all done. I know we were asked last session by a group to fund the compulsive gambling. I told them politely to get it out of the Attorney General's budget. Now I see it is coming back to here again. Has there been discussions about this in this biennium?

Brenda Weisz: When the lottery was put into place, there was designated in the ND Century Code that there is $400,000 that goes for addiction services each biennium. That $400,000 remains and stays in statute. Whatever is not used for the lottery fund that is not designated for a specific service goes to the state's general fund and used to fund budgets? This additional $300,000 to help with treatment services is from the general fund. So indirectly it's the same thing. You either change statute or you just take it out of the general fund. There are $700,000 of addiction treatment services here for that gambling addiction. That is why the addiction is in our budget. This way there is not a statute change but there is an increase in services.

Representative Nelson: Wasn't there some gambling addiction money that was part of the gaming compact with the tribes as well? Is that ongoing or what is the status of that?

Roxanne Woeste: It does seem to me that the Budget and Finance committee this interim did receive some information testimony from the ND Mental Health Association regarding some

money that the tribes are putting forth. I will see if I can locate that testimony and give it to the committee.

JoeAnne Hoesel: Continued testimony.

Chairman Pollert: Back on page 6, if I look at that budget and see the increase of $255,000 over your previous budget which is a 2% increase, I just figured I'd say that. The total DHS budget is 21.5% and this is 2%. It is a 4.4% increase in general funds. Another other questions for JoeAnne? We will be adjourned until 2:30.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/13/09

Recorder Job Number: 6940

Committee Clerk Signature

Minutes:

Chairman Pollert: Called the meeting to order. Before we get started on disability services we have some info from legislative council on compulsive gambling.

Roxanne Woeste: Handouts from L.C pertaining to Compulsive Gambling Treatment (Attachment A)

JoeAnne Hoesel: Testimony Handout (Attachment B)

Representative Kerzman: Going back to page 3 when you talk about the portion of our population that we serve per capita based against the national numbers. Do we have more people with problems than the national average? Or are we just taking care of them better?

JoeAnne Hoesel: I'm certainly not going to say that ND has a higher incidence. I do know that how we license certainly has an impact on how the numbers play out. An example is in the first bullet they are talking about residential settings. Residential settings are considered RCFMR's. We have many RCFMR's in ND compared to other surrounding states. Our RCMFR's are small numbers so they are counted as institutions. You really couldn't tell. If you and I were to go tour an RCFMR or a waiver group home, we probably couldn't tell the difference. They are licensed differently and are counted as institutions. So much of it has to do with how the system evolved over time.

Representative Kerzman: If our population ratio is basically the same as the national, how are other states addressing that population? How are they caring for them? Is most of it done in home?

JoeAnne Hoesel: Certainly there is a national trend to serve people in their homes. The self directed supports, in which we have two waivers, is certainly becoming increasingly popular, as are individual service specialized living arrangements (ISLA), which is where individuals can live in their own apartment. So it's really trying to normalize as much as possible. It is certainly prompting our transition initiative from these developmental centers as well.

Representative Wieland: You make reference on page 6 to $87,000 total funds to fund the governor's salary package. The general fund portion is about 50%. The next line, the cost to continue the 4% salary is $49,827, which all most all of it is general fund. Is there a change in policy regarding the amount of federal funds that is coming into that portion?

Brenda Weisz: What that is interpreted to is when we build our budget there is only so much federal fund available for the funding. Block grants are closed end funding sources. We use as much as we can from the federal funds when those run out than any other part of the increases have to go straight to general fund.

Representative Wieland: The other question I have is on page 8. Maybe it's the same answer. The grants resulted in a net decrease of $352,000 in which $95,000 is an increase in general funds. Is that the same thing?

Brenda Weisz: It's close to the same. Depending on what the services are, they are covered by different granting sources. The $95,000 increase that you are seeing on the grant side is attributed primarily to the last bullet on page 9. Those services are 100% general fund so we have an increase of $97,000 for that 100% general funded service. So when you pull it into the

big change in grants they contribute to 95%. If we would have not had that increase in the last bullet then we would have had a reduction in our general fund actually.

Chairman Pollert : The developmental center transition, is Alex going to talk about what was budgeted last biennium?

JoeAnne Hoesel: Yes, he is the chairperson of that committee.

Nancy McKenzie: Testimony Handout (Attachment C)

Chairman Pollert: What do you mean by that?

Nancy McKenzie: One of the things we have that I will be able to show you in detail is a number of positions. In DDS we had a number that the federal government asked to be reclassified so that adds some costs. It's the ups and downs of salary changes.

Chairman Pollert: Are we going to be getting a vacant FTE listing.

Nancy McKenzie: Yes. Continued testimony

Chairman Pollert: When you did your budget for this biennium were you figuring gasoline in $4.25 a gallon where it was a year ago, or were you figuring where we are at today. They could fluctuate greatly. Or is it a state fleet number that you are using?

Brenda Weisz: When we use motor pool for the state fleet, we use what motor pool has told us to budget at. Specifically now, when we budget for our travel and there is instances where there is times that we pay, where there is not a state fleet that is able to be used, we would go with what the Century Code would dictate and build what is at the Century Code at that time. If there were changes in the Century Code they wouldn't get in our budget until next cycle. We travel predominately through motor pool.

Nancy McKenzie: Because this particular travel relates mostly to required federal meetings reflects the increase we are seeing in airline rates as well as hotels, food, those kinds of things as well.

Chairman Pollert: How much of your time is spent on federal regulations and not getting actually service to the clients?

Nancy McKenzie: That is going to vary by programs and so forth. I don't think it's been looked at that way.

Brenda Weisz: Predominantly the reason that central office does exist is to carry out and enforce policy.

Chairman Pollert: If anything that is very frustrating for me when I was on the board at the hospital at Carrington. They must have had four or five different audits a year. They had staff hired just to take care of their internal audits. Then you would have the federal people come in.

Brenda Weisz: We have an increasing amount of audits done by CMS or other entities. On top of that we have the state auditors in all the time. We actually have to set up a room specifically for the state auditors because they are there so often.

Nancy McKenzie: Continued testimony

Chairman Pollert: Of the $800,000 increase that relates to the governor's budget increase for independent living services, then you go in to remain living in their homes. I thought that is why we had home and community based services?

Nancy McKenzie: We have both. They are providing different types of services. The folks in the centers for independent living who have testified before you are actively working on the transition.

Chairman Pollert: This is more with what you are working with?

Nancy McKenzie: This allows them to go further into the state than they have been able to date and to rural areas. That concludes my testimony.

Nancy McKenzie: Testimony Handout (Attachment D) 40:46-43:07

Representative Ekstrom: During the last biennium when we reviewed this budget, there was tremendous number of these individuals who had previously been incarcerated or coming in and out of incarceration. Is that trend still true? Are the vast majority of these folk's people who have been in the prison system.

Nancy McKenzie: That has stayed pretty steady to maybe slightly increasing. We continue to collaborate with the department of corrections to be sure that individuals living in the community on probation and parole are getting substance abuse services that will hopefully help prevent reoffending behaviors.

Nancy McKenzie: Continued testimony.

Representative Bellew: Do the Human Service centers go into the schools? Are these kids referred to you?

Nancy McKenzie: We do both. There are therapists and addiction counselors that sometimes work with an in school program that might be in place and actually go to the school. Kids are referred from the schools to our clinics. We see a lot of youth in our outreach rural communities for services. Continued testimony.

Representative Nelson: On the previous bullet point the salary changes to meet critical market shortages, is that in addition to the equity pool?

Nancy McKenzie: Yes it would be in addition to the equity pool.

Representative Nelson: You have intentions of accessing the equity pool in your division as well for Human Service centers?

Nancy McKenzie: Yes. This would refer primarily to some of those individual situations in which we might need to do a group salary increase for retention of people in positions.

Brenda Weisz: What that relates to is that we did have some issues with addition counselors in the past or psychologists. So what we will do is take a look at our ability to recruit and what we would be able to do to retain like bumping up salaries.

Representative Nelson: Would there be a situation where this same group might have to access the equity pool to get them to where you want them to be.

Brenda Weisz: That is what has been happening over the years. The equity pool will give agencies more flexibility with the way they appropriated the money this time. It took a look at where everybody sat in their pay range and how many years of service they had and where they fell within the quartile. What we have trouble with is competing with the private vendors. Although they might have been entitled to a $50 a month equity increase based on the quartile evaluation, we still cannot retain them in light of the competition with the private. That is where you would have a situation where they might have been entitled to equity of $50-100 a month. However, they could still go to the next provider in order to retain and serve our clients.

Representative Nelson: Would this be mostly like the situations where there are less ten year employees or is that not an issue?

Brenda Weisz: Not necessarily. We have got it all the way across the board.

Chairman Pollert: The increase in FTE's in Fargo at the Cooper House, is that part of the global health initiative that Alex is going to explain?

Nancy McKenzie: I should have explained that, yes. Of the 11 FTE increase in this package, five are part of that global health initiative. The other six are the bullet that talks about six FTE's mainly for capacity issues. Continued Testimony.

Chairman Pollert: When I'm looking under the bullet point that provides for young adult transitional and residential services, isn't there a bill laying out there about youth transitional programs? I take it that is a double up of this or is it separate?

Nancy McKenzie: This is strictly to provide eight beds in the Fargo region and eight beds in the Bismarck region for transitional youth and is separate from that particular bill.

Chairman Pollert: Do you know what bill that is?

Brenda Weisz: HB 1044 that deals with youth at risk.

Chairman Pollert: So youth at large is different than youth in transitional residential services. There is eight in Fargo and eight in Bismarck?

Nancy McKenzie: Yes

Chairman Pollert: When you talked about the psychology and psychiatry, are you privately contracting costing you more money?

Nancy McKenzie: We do whatever we have to do to make ends meet in that we have some private contracts that typically cost more than having our own employees. We have utilized some of our own staff who have retired but are willing to work part time on an hourly basis that will do some of that stuff for us. That doesn't allow us to necessarily provide the full range of psychology services but we do contract services where we need to.

Alex Schweitzer: Testimony handout (Attachment E)

Chairman Pollert: So when you are saying 307 beds you are talking the 90 beds for TRCC and 132 beds for inpatient residential and is that also included in the 85 beds for sex offenders?

Alex Schweitzer: That is correct. Testimony continued.

Representative Nelson: Your nursing staff is only 85%? How do deal with that problem?

Alex Schweitzer: The 85% worked well when we had lower occupancy. It's one of the reasons why we are asking for additional staff in this current budget, because we see an increase of occupancy. When we were down at lower levels we could manage it.

Representative Nelson: So the situation where you are at now then, where you are at the higher occupancy and you don't have the staff, are you doing it with contracted services? How do you meet the demands of the requirements?

Alex Schweitzer: We meet the requirements by staff pitching in from other departments and assisting with patients as needed. Overtime is used. We utilize a variety of creative ways to deal with patients where other departments can assist. The real issue is 85% nursing because our occupancy is a lot higher than that. Continued testimony.

Chairman Pollert: With the 85 beds, and you are currently using 60, do you see the other 25 beds getting occupied. Do you have the 17 FTE's for the additional beds on hand right now?

Alex Schweitzer: Yes we do. It's hard to tell what is going to happen in terms of occupancy. Another thing about the fourth unit is when we only had three units we were over crowded. Part of the issue with dealing with the sexually dangerous population is that there is a core group of patients that have created some real problems with us in terms of violent behavior and creating issues. To mix them with the people who are actively engaged in treatment can create some real problems. Two things about having a fourth unit is it prevents the overcrowding and helped us manage the population. Secondly we believe we have enough beds for new admissions.

Chairman Pollert: If you don't fill the 85 beds in the sex offender unit, but yet you are filled to capacity on the residential beds. If you have the FTE's for the 20 but you aren't using them, why couldn't they be used for the FTE's you need for the global health?

Alex Schweitzer: It's always a possibility in terms of looking at staffing. We certainly could not house traditional people in the sex offending unit but we could certainly look at staffing.

Representative Kreidt: Going back to the one bullet of transferring 16 seriously mentally ill to the Cheyenne Care Center, is that a special unit or do they fall under a case mix?

Alex Schweitzer: Yes. They have about 32 people there in the special unit and they have a special rate. It has been established by state law that it is a general psych unit. They require admissions to the unit have to be approved by the state hospital. Take into consideration that they have some issues along with ADL efficiencies and medical issues. Continued testimony.

Representative Wieland: That was approximately $3 million. The other part of the question is that we expect that as a turn back?

Alex: Yes, it is part of the turn back and $3.1 million.

Chairman Pollert: Didn't we use some of the money to fund the electrical phase in?

Alex Schweitzer: Yes that is correct. They approved some of the dollars for our capital needs. Some of it went back in the turn back. Continued testimony.

Chairman Pollert: Is that $3.2 million general funds?

Alex Schweitzer: Yes it is. Continued testimony.

Chairman Pollert: What we really should be doing is taking what you got from secure services which is decreases and doing them to the traditional services to find out what your total budget is as far as an increase.

Alex Schweitzer: We can provide that for you in detail. You are looking for an overall decrease for the state hospital?

Chairman Pollert: If that's what it is because your decrease in general funds is $3.96 in secured services and your general fund increase on traditional service is $3.6 because it is a net drop in general funds for the state hospital.

Alex Schweitzer: There is also a decrease overall if you combine the two budgets. Continued testimony.

Chairman Pollert: Your goal is to be 115, and your goal by 2011 is 67? I see you have 445 FTE's, are you going to need 445 coming if you get to 80 people?

Alex Schweitzer: Certainly the FTE"s would drop if we started reaching some of these milestones. Continued testimony.

Representative Nelson: You said that the executive recommendation was for bed count of 115.

Alex Schweitzer: That is correct.

Representative Nelson: If you get to 67 by the end of the biennium what happens?

Alex Schweitzer: We are looking at the end of the 2011 biennium. We will need the two year period to do that transition.

Representative Nelson: But by the end of the 09-11 biennium you will be at a lower number than 115 in all likelihood.

Alex Schweitzer: Yes. The goal is 67 it may fall in a little higher. It is a goal and we have to look at certain things. We are certainly trying to transition to that number.

Representative Nelson: As the population ramps down the 115 number is built in with staffing?

Alex Schweitzer: That is correct.

Chairman Pollert: My personal opinion is that there is no way you are going to get down until 0.

Alex Schweitzer: There are individuals that would not agree with that but there is a certain number of individuals that agree you need the center.

Chairman Pollert: As far as in the current budget, if you are looking at discharging and going down from the 115, is that in the current budget or in the 09-11 budget that we are looking at now?

Brenda Weisz: Yes in our DD grants program, even with our utilization being where it is, we are half built in our budget to move nine clients in the first year and eight in the second year for a total of 17. That is included in the executive budget.

Alex Schweitzer: Continued testimony.

Chairman Pollert: Any questions for Alex on the developmental center? Since we finished this section we will not be meeting tomorrow morning. We will be in at 2:30 unless I call an earlier time from the floor. If not we are adjourned.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/15/09

Recorder Job Number: 7077

Committee Clerk Signature

Minutes:

Chairman Pollert: Opened meeting. Took roll call and every member present.

Brenda Weisz: First of all you had asked for a few things that are more overview in nature not specific to administration and support and I will hand those out (Handout A). What the quarterly budget is, is a snapshot in time. It's just to tell you where we are at as of that date. It's the basis on how we build our budget and that is how it will be helpful to you. We are using this data to go forward to build 09-11 budget. It's a snapshot not a projection tool. It has some of the major grant programs. We covered this during the interim Human Services committee to take a look at where we are at with grants in various areas. As we go through the divisions the areas are covered during this. You had also asked for a breakdown of salary underfunding (Attachment B) and one time funding (Attachment C) with both general and federal funds. The first one I will go through is the salary underfunding. The areas where there was under funding on the salary line was in the management area of our bill which includes administration and support. It also includes program and policy. $200,000 for management that was split between administration support and ITS and program and policy that was split among economic assistance, child support, Medicaid, Aging, Mental Health, Vocational Rehab, and Developmental Disability. Then in the State Hospital and Developmental Center, they came in

with a budget that included the salary underfund already. Those numbers are also before you.

Continued testimony.

Chairman Pollert: That was an amendment put on the bill right?

Brenda Weisz: That is correct. Continued testimony.

Chairman Pollert: Does this further our discussion from yesterday?

Roxanne Woeste: I don't think this complicated that any.

Brenda Weisz: I did a worksheet of the cost to continue for the second year. (Attachment D). Continued on one time funding testimony.

Chairman Pollert: All this one time funding was achieved in the 07-09 biennium?

Brenda Weisz: MMIS, we will have a delay in that project. What we foresee happening is at the end of the biennium the ND Century Code allows that to be carried over what is unspent there. Sex offender treatment, Addition will not be carried over. We are going to spend $1.75 million and turn back the rest. We are right on schedule with everything else and we will expand the vast majority of it. Whatever will not be expanded will be returned. We will start the cost to continue. (Attachment D testimony)

Representative Wieland: What you have is fully understandable. The problem that I have is that the second year increase should be for 24 months. Why is that?

Brenda Weisz: Maybe we need to say is that the salary you are going to pay with 4 & 4 has to be paid for 24 months. If you look at the attachment I only paid my employee $1,082 for 12 months last biennium. I'm not going to drop their pay. I'm going to continue to pay them at the ending amount which includes both 4%. That is why you have a cost to continue.

Representative Wieland: You are already starting with that amount in there. When you add the second increase in there you already have it built in to the cost for the previous 12 months.

You are starting with the salary where you have the first and second 4%. It's already in there and now you are going to add another 4% before you add the next years.

Brenda Weisz: What you see in the shaded blocks is what you appropriated me. When you look at what it is actually going to cost to pay that second year salary for 24 months is what it costs me. Starting out in 09-11, I don't start out with those funds. It's the same with the provider increase when you give them the same. That is why there is always a concern of sustainability.

Representative Ekstrom: The first year you are paid $1,040 a month because you got the first 4%. You didn't get 8%, you got 4%. The second year you get the second 4% that raises your base. To fully fund that for 2 years which is a total of an 8%% increase, you've got to have a cost to continue. You have to have that first year. Now you are in a new biennium for 24 months at the full rate at $1,082. They take the $42 difference between $1,040 and $1,082 and apply it to two years.

Representative Wieland: If it is what it is we are going to have to live with it. I'm a math major in college. We are doubling up. We are talking about an appropriation as oppose to what the actual cost is. I understand that it is a difference. I don't understand why you wouldn't have appropriated. If there is going to be raises the following biennium would already be in there.

Lori Laschkewitsch: When you build in the 5&5 you are going to put the July 1, 2009 5% in for the full 24 months. You aren't going to appropriate enough for a full 2 years for that second 5% because then the agency would have all that extra money left over in the current biennium. In 2010 you only have 10 months to pay that 5%. Which in fact now that person's salary has gone up 5% twice. Their salary that they are going to start this next biennium with has to be sustained for 24 months. Because of the fact that you didn't give them the second increase until halfway through the biennium, you only had to appropriate half of the money. They didn't

have that second 5% that they have next biennium for 24 months. They only had it for 12 months so you are still short 12 months of salary money for just that 5% piece. I think that is what Brenda is showing on here. You really only need 24 months for one 5%. If you think of a biennium in the context of maybe 4 years,

Representative Wieland: Did we do this in the last biennium as well. Did we show it that way.

Lori Laschkewitsch: We have come in and tried to provide all this information to you for several bienniums. It is very confusing. If we don't give the agencies cost to continue, they have to try to absorb 12 months of salary increase for their staff. Agencies don't have that kind of extra money in their budget. So we have to give them the cost to continue or they'd have to go back and cut everybody's salaries back 5% for one year.

Representative Wieland: So you are saying that if we were to add into their appropriation this difference, the agency would have extra money and they would feel they would have to spend this somewhere else.

Lori Laschkewitsch : Well if you gave that to them at the beginning to eh biennium and funded them for two years on that second 5% increase, they would have 12 months of extra salary increase. There would be money that you have appropriated out there that would just be sitting in agency budgets and wouldn't have any purpose.

Representative Wieland: But they are going to spend it.

Lori Laschkewitsch: Not until the following biennium. You have given them enough money for this current biennium. The salary increase that agencies got on July 1 of 2008, they are only paying out of their budget for one year. Then the new biennium starts. That is when we come back and say they need to sustain that increase. We have to give them extra money in their budget because you only have that funded for half of a biennium.

Representative Nelson: Rather than doing a 4&4, but if we would give an increase between 6&7, would that eliminate the need for this process?

Lori Laschkewitsch: If you gave them a 7% on July 1 at the beginning of the biennium. There would be no cost to continue.

Representative Nelson: Why don't we do that instead?

Lori Laschkewitsch: That is up to you.

Chairman Pollert: I can see both sides of this argument, I really can. When it spelled out like this it does make a lot more sense. I

Brenda Weisz: Handout testimony (Attachment E) 25:01-27:14

Representative Bellew: Would you tell us what general funds are?

Brenda Weisz: It is on page 2 of my overview testimony, its $3,455,888 million. Every bullet breaks out how much is the Governor's salary package of 5&5 and how much is general funds. Continued testimony.

Chairman Pollert: The equity in the Governor's budget is based off of merit? Has the DHS decided how they are doing that? Is it agency wide? Have those decisions been made yet?

Lori Laschkewitsch: The equity is put in the budget so they need to look at merit as well as longevity and where their employees are falling in their years of service. It wasn't done as an across the board thing because they have other things to take into consideration.

Chairman Pollert: When we heard P&A and they had the 5&5 in there, when they did the equity it came out to just a hair under $3,200 for every employee. Besides the 5&5 and fringe benefits. That sounded a little high to me but I don't know how the formula is going to work.

Lori Laschkewitsch: There were some agencies that we found have not had much turnover in the past years. They have a significant amount of long term employees. They have not had any money to give increases so they have people who have been there 20 years and they

haven't made it to the midpoint. You will see some agencies that have long term employees. If you do the math across the board it may look like a significant increase.

Chairman Pollert: I see where P&A's budget had some longevity in theirs and their turnover was high.

Representative Bellew: On our green sheet it says our equity funding and general fund is $3458. Your testimony says your general funding is $3445. There is a $14,000 difference there.

Brenda Weisz: You will have to ask Roxanne. We provide information but we don't get it back to compare.

Chairman Pollert: So the salary budget adjustment on your detail is a 4.77. The salary increase down below is a 5&5. So the equity you are seeing is the salary budget adjustment. The 5&5 would be the salary adjustment.

Lori Laschkewitsch: The salary budget adjustment, the 5&5 is down in the salary benefit increase. The equity increase is up at the salary budget adjustment.

Brenda Weisz: The equity is 4755. The health insurance increase is going to be covered in the fringe benefit. That 755, 535 number includes the 5&5 plus the second year 5&5 in the equity money. They also provided the 5&5 on the equity. Your benefit increase is the FICA and retirement associated with the increases to employee salaries. The insurance is in one spot and benefit increase is your FICA and retirement on that salary increase.

Chairman Pollert: As an example, if we would look at the $287,264, does that equate out?

Representative Bellew: If my figures are right that is about a 13.8% increase for fringe benefits.

Chairman Pollert: That would actually be a little lower.

Lori Laschkewitsch: Part of the percentage that might not come out perfectly is the fact that workers comp benefits rates increase for some positions and decreased for some positions. In the Human Services budget it was a net decrease for the workers comp rates. That netted out of there as well. FICA increased the actual limits. You can't just do the whole percentage.

Chairman Pollert: I'm just trying to get it so we know this is how every salary and wage is going to be lined up and in there.

Brenda Weisz: The budgeting system actually is calculated by each individual agency. They provide the number to us through bars and that is how we get the number and know where it goes. Continued testimony.

Representative Wieland: Is that position funded?

Brenda Weisz: No it's not. The only thing about that position is when it is in the BARS System the increase does get thrown into that FTE because it is an FTE that exists out there. The increase of the fringe and stuff does get thrown onto that which we don't use. That is just the way the system works. Continued testimony.

Chairman Pollert: When we get the vacant FTE report can you go through that section wise?

Brenda: Yes. Continued testimony 39:49-40:32

Representative Kerzman: Can you explain the need for all the attorneys and the Attorney General increase? Are we doubling up here?

Brenda Weisz: The need for the three attorneys is because of the magnitude of programs and amount of administrative rules and appeals that come in. The work that we need to do from a legal standpoint is what the attorney work is fore. Also we have to administer the risk management component for our department. Legal advisory handles that piece of the component as well. They also take on handling the workers comp reporting. They also oversee our contracts and the approving of our contracts. With the change in the law, it has added quite

a bit of time to our service for reviewing request for proposals or RFP's. There is a huge amount of legal work. The individuals in the legal advisory unit cannot offer advice on things in the department. That is where the AG's office comes in. They are the attorney for us for opinion expressing and working with the actual advice. We do need to work hand in hand with them.

Representative Kerzman: Do you have an HR person that works with the attorneys on that or do they handle that themselves?

Brenda Weisz: Your incident reporting and all that gets handled down in the legal advisory unit and we work with them and the risk management pool of Office of Management and Budget.

Chairman Pollert: How many attorneys' are in the P&A FTE listing?

Brenda: Continued testimony.

Chairman Pollert: So I take it that they have a point to coming somewhere else?

Brenda Weisz: No they are just staffed.

Chairman Pollert: When is the breakdown just for my knowledge as far as benefits goes?

Brenda Weisz: .5

Lori Laschkewitsch: P&A has 4 attorneys.

Representative Kerzman: What do those numbers correlate to at the top?

Brenda Weisz: They are an internal tracking mechanism. The far right is pay grade. One is the class and location. I don't know what the middle one is.

Chairman Pollert: I would think we are going to want a detail on P&A and their four attorneys's compared to the size of DHS three attorneys. I'm just asking for the comparison. The reason I'm asking is that the DHS is a little bigger then P&A. I still want to see something on that.

Brenda Weisz: On your left is your class code. The middle is your position number and how we track it on our internal system, and then the People Soft number which is tracked in BARS. Our People Soft system is our other payroll number. Continued testimony.

Representative Wieland: Can we get a list of pay grades and what the pay grade ranges are and what the classifications are?

Brenda Weisz: HRMS actually has it in a page 4 document. Do you want full copies for the whole committee? Continued testimony.

Representative Kerzman: Can you give us a ball park figure on how many grants were late because you don't have the personnel to finish them.

Brenda Weisz: I don't know. I don't even have the time to go look myself to find out what we are missing. Continued testimony.

Chairman Pollert: We talked about attorneys; do you have auditors in your division?

Brenda Weisz: We do have one individual who works on the contracts. When we pass money out the door we are required to do. We do have an individual devoted to that ask. What has happened is the statement of auditing has been issued. I think you are going to see it across agencies where there is a requirement for state agencies to step up their review and analysis of internal control. We do a fair chunk of that right now based on the auditing standards require.

Chairman Pollert: How often on the biennium do you have the state auditor's office in your office?

Brenda Weisz: We have an office that is designated for them. They are there very often. Out of the 12 month period they are there 2-3 months.

Chairman Pollert: You are saying on a biennium they are there 75-80% of the time going over your agency.

Brenda Weisz: Correct. They do three kinds of audits. They do what is known as an agency audit every two years. They look at internal controls and processes. Every year they do what's called a * audit. The state issues financial statements every year. They are in evaluating and reviewing the larger transactions. Every two years they complete a single audit of all the federal programs.

Chairman Pollert: And these are all requirements by either federal or state law?

Brenda Weisz: That is correct. If they so choose we might be subject to a performance audit depending on the wishes of the committee which would be additional auditing that would occur.

Chairman Pollert: How many people do you have FTE wise that you have employed to deal with audits?

Brenda Weisz: We don't have the ability to add staff. Deb McDermott spends a great deal of time with them. A lot of our accountants will work with them when they have transaction questions and they spend quite a bit of time with our program individuals as well. They utilize or need to access all sorts of our staff. Then there are federal audits that occur as well.

Brenda Weisz: Continued testimony.

Chairman Pollert: On travel if you are at $175,000 and that is one year of the biennium so are you saying that the travel comes to $350,000. You are going to have an additional $100,000 in the second year of the biennium of the 07-09 budget. You are doing that and asking for another $70,000 increase?

Brenda Weisz: Some of the travel that we had budgeted in some of the areas didn't occur because of staff turnover. This is the first time we are fully staffed. Some of our employees that travel for some of their federal programs or oversight actually end up being on the board. Their

travel would then be covered at times by the board. For those reasons, that is why our travel is down.

Representative Ekstrom: If it is possible, as you are referring to line items on our spreadsheet, if you would refer back to the page number of your general testimony. That would help us keep up.

Brenda Weisz: The travel bullet is on page 4. It is the third bullet from the last. Continued testimony.

Representative Ekstrom: How did they arrive at the 9&9 as far as an increase?

Lori Laschkewitsch: What they looked at is what they were told by suppliers and what they accumulated all of that into that.

Brenda Weisz: Continued testimony.

Representative Wieland: You said that you have one accountant that is in an office building by themselves?

Brenda Weisz: We rent space at Prairie Hills Plaza. I also locate one accountant within all of that space. Continued testimony.

Representative Bellew: You have indirect costs reimbursement of operating. Are they federal or what are those funds? Are they federal or what are they?

Brenda Weisz: What they would be is federal funds. They are all federal open ended funding services we are able to access to pull down federal funds for the cost. For other funds if they would include other funding sources that would be allocated that would be available. An example would be the collection money or incentive money.

Brenda Weisz: Continued testimony.

Chairman Pollert: Can you give me a general overview why in 05-07 we would have been $135,000 and we budgeted $192,000. That is almost an 80-90% increase. I know you are going through that. Is there a general reason why everyone wants to raise their fees?

Brenda Weisz: No. A part of that would be due to an increase in administrative reviews that we need to do that are required by federal regulations. Also, I added additional staff last biennium. We centralized those billings clerks so I have some expenses operating services that exist because of that. It would also be the timing. If you look at the total for this request, the indirect cost reimbursement is the majority. That increase didn't exist in 05-07. That would explain the major increase.

Chairman Pollert: From the Attorney General's Office? I will be talking to Government Ops as far as the total general.

Brenda Weisz: Continued testimony.

Chairman Pollert: Office of the State Auditor, can you go over that again?

Brenda Weisz: You had asked previously how often the State Auditor's are in. We do get billed for their services. We do consult with them as far as what additional and how much they think they will be working with us. That equates to time billed. They did give us an estimate. We estimated that there would be an increase in their fees of another $55,752.

Chairman Pollert: That is $55,000 over the last biennium? What is that percentage? Is it a $55,000 increase?

Representative Ekstrom: Was the equity pool also included when you were building this budget? In other words, Auditor's office is also going to get an equity pool?

Brenda Weisz: I would imagine the rates that the built. When they set out their rates they do take in account the increases their staff have received. They would not have been able to anticipate the equity pool though. They set their rates earlier than June. They put out on the

web what rates to include in y our budget in April. They would not have any indication of the equity pool. I'm not sure if they do any sort of estimates. They take into account their actual expenses and the increases they received during the current biennium.

Brenda Weisz: Continued testimony 14:36-15:03

Representative Bellew: Last biennium we budgeted $1.82 million to our agency, but when you gave us your current budget it is $1.9. Could you refresh my memory on those? It's like a $15 million dollar difference.

Brenda Weisz: When we came out of the session it wasn't $1.9 million. Added to that, we had all the other bills in it. When you add that you add the equity that Office of Management and Budget added in a separate bill and you also add the construction carry over. That is how you get to your $1.9 million.

Carol Olson: I have a comment on the grant writer for the department. We don't have a grant writer in this agency. There are a number of state agencies that do have not only one but two or three grant writers. What we currently do right is have a process within the agency that when a grant becomes available, we actually meet to review whether or not this is something we want to go forward with and whether or not it takes emergency commission action. That is a determining factor of whether or not we apply for that grant or not. Then we look to see if it needs technology involvement and so on. We weigh whether or not we have the internal resources to put in place to apply for this grant. They are very time consuming and take a lot of effort and energy. You have to have a lot of passion when you decide to go after a grant. The ones that we do apply for, we have to be very committed. As you know in the ones that Brenda mentioned this morning, the ones we have let pass us by, have been grants that would have been very beneficial to the agency and the state because of the federal funds that now are becoming tighter. We can enhance some of our services and programs to the people without

drawing down federal funds. There is a benefit in going after grants. What we do know when we decide to go after grants is we use our existing staff. One in particular that has been involved in the grants we have gone after has been Heather Steffle (sp) who is our public information specialist. She has a full time job. She has become kind of a focal point for our grant writing. She does this over and above her full time job. There are other employees and staff in our department that do so. What it requires is a great deal of extra effort and hours past 5. I kind of would like to emphasize the importance of having a grant writer for the department. It will pay for itself and then some. We have never asked for one before. We have thought about it but have never come forward to put one in our budget. This is kind of enough is enough. We really do need one. It's time that we do take advantage of some of the grants that are out there that would help in so many areas. DHS deals with the services that deal with the amount of numbers, the population that is coming out of the state penitentiary, coming into the population. They do anything that helps with providing services and treatment for that population. That alone would be very helpful. There are many other areas that we could benefit from going after some of the grants. I just wanted to give a little extra push.

Chairman Pollert: So noted. Roxanne, under our green sheets we have the request for that FTE. Where is that bullet at? Is it part of Management I?

Roxanne Woeste: I don't show a new .5 FTE in this area. All I saw in the budget documents was that one position for the other. Perhaps it is an existing .5 position that is vacant and un-funded so they need this funding added to the budget for this intended purpose. I would have to ask the Department for a little clarification.

Brenda Weisz: What it is a current FTE that exists in the department that is realigned with the executive office to perform that function? Andrea Pena was before you to talk to you about the fact that she operates under one FTE. In her area last legislative session she had 1.4 FTE. We

combined that. The individual that was doing service was doing service for the VR area and the DD Counsel area. That .4 FTE is devoting all their time. VR had a .5 retirement. We realigned that .5 to the executive office. We'd rather dedicate that instead of the administrative work in VR. So it's not highlighted on the green sheet.

Chairman Pollert: You do have the 1 FTE for the statement of audit standards. That is one FTE. For some reason I was thinking it was .5 for the grant writer and .5 for the standard audits.

Brenda Weisz: No, and they are two separate bullets in the testimony.

Representative Wieland: Are we going to be asking for a list of vacant FTE's and those that are funded and not funded?

Brenda Weisz: A vacancy FTE report will have what funding is associated with that FTE that is correct.

Representative Kreidt; Going back to the grant writing, have you ever sat down and calculated out dollars lost by not being able to go about and pursue these grants?

Brenda Weisz: I don't have time. Nobody has. We are so busy doing everything else.

Representative Kreidt: It would be interesting to see the dollars lost by the state of ND.

Chairman Pollert: Any other questions? We will stand in recess for 10 minutes.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1012 – Information Technology Detail

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/15/09

Recorder Job Number: 7078

Committee Clerk Signature Morgan Peirce

Minutes:

Chairman Pollert: Called meeting to order

Jennifer Witham: Testimony Handout (Attachment A) 2:04-4:52

Representative Ekstrom: I would think there are a number of laptop computers that are utilized by your division. What sort of securities are in place? As those laptops move around, we have heard some horror stories about data being accessed off of laptops.

Jennifer Witham: We don't store information locally on our laptops. The hard drive is just there to hold programs. We request that people keep pictures and stuff off the servers. They are allowed to keep them on their hard drive temporarily. There is nothing that is DHS confidential on that laptop. They have to log in to the state network through a virtual private network which is a very secure connection to the state. It is password protected. Someone who got the laptop would not be able to do that if they didn't have those security gateways known to them. All the information related to all of our systems and all of our data is stored in house at ITD and is not mobile.

Jennifer Witham: Continued testimony.

Chairman Pollert: Is the ongoing support going to be something of this dollar magnitude we will see from biennium to biennium?

Jennifer Witham: There is a component that I believe that Brenda had spoken to in the overall testimony for the department of a licensing fee that we had not anticipated but is in the budget. When we first were looking at the Medicaid systems project a couple of biennium's ago, there has been a movement for these Medicaid systems projects to be licensed like a commercial off the shelf product. Rather than being one off in every state, the vendors are trying to standardize on the processes. What is included in this $9 million is $3 million in licensing fees that will be paid to ACS our primary contractor. The majority of the rest of the increase. It's what we would have expected in this first biennium after go live, which incorporates knowledge transfer, how to operate the system from ACS to ITD. As you know this is going to be operated by the state. That falls into about 5 different areas in which we will be contracting with ACS on a dispersed transition period. In future biennium's that would stabilize.

Chairman Pollert: Where is the $3 million increase for the licensing?

Jennifer Witham: It is in the $9.2 in contracts on the second page of attachment A. The very first budget code that the current biennium is $40 million. You are seeing an overall reduction of $28, which is primarily the reduction of the contract that we have in place to build the system. That's why this is a little bit hard to see. It is approximately $37 million that we are contracting then the net is the $28.

Chairman Pollert: When you are saying the licensing of the $3 million. Is it like a copyright type of thing?

Jennifer Witham: This concept is new to CMS as well. It also reflects where they are going with the Medicaid Information Technology or Architecture, or MITA. That is the movement that the feds are pushing to have them standardize these Medicaid programs. At least how they are constructed for the information systems. The vendors are saying that the majority of their funds came from customizing these systems for the state. The more those get more generalized, like

an accounting package, would be that there is not going to be as much customization needed. It's going to be more configurable than customized. They are looking at a way to say how they roll out enhancements to the product and how they roll out federal changes that are sweeping across all state Medicaid programs. Regardless of what your state law is, like ITD 10, all Medicaid agencies will have to accommodate that. From a vendors perspective they are saying that if you sign up for this license fee with us, those federal changes will be incorporated into the base product and you will not have to pay extra for that. You yourself wouldn't have to customize it.

Chairman Pollert: Are we going to recoup the $3 million back in copyright royalties?

Jennifer Witham: No. This product is going to be owned by ACS by some extent. The licensing fee is like a software maintenance licensing fee, which is very similar to what we pay for the People Soft system. The base product which can be configured, we will be licensing for and primarily what we are licensing for is for the federal changes so that our ITD staff doesn't have to make those changes in the future.

Chairman Pollert: It seems like ND was on the forefront of this thing, they shouldn't charge us the $3 million licensing. We are still being charged a user fee when basically DHS and the computer company did this thing together. The $3 million wasn't part of any costs. Now we have to pay for the heartache that you went through even though you were on the forefront.

Jennifer Witham: We have paid them to customize their system to what ND needs while we are building this system. We thought we would purchase and transfer a system from another state and customize it. When we did that RFP and the way the feds were going, the feds wanted us to invest in something that could be reused from state to state. There is a lot of work that goes into understanding how to configure this system to work like the way that we want ND to work. The state is not required to purchase this license fee. It is in our best interest

because there are two known moving large federal changes that will probably happen shortly after we go live. We will share the cost of those changes that will be future changes to the Medicaid system that all states have to implement. We will be able to share the cost of making those changes to the system with all the states that are using that same base product.

Chairman Pollert: Basically they are going to hold you ransom and say if you don't pay the $3 million we are going to ding you for $6 or 8 million down the road when we do the other changing when the other programs come on board.

Jennifer Witham: If we didn't feel we could make those changes ourselves. We own the code, not the product that is running in our hosted environment. If we see the federal changes coming, and we want to make the changes ourselves, we have the rights to do that. We could do that.

Chairman Pollert: You are saying the $3 million is going to save us money in the long run.

Representative Wieland: The $9 million in support, how much, if any is in federal funds?

Jennifer Witham: The majority of that is going to be at a 75/25 match. So 75 cents on the dollar is in federal funds.

Representative Nelson: When ACS completes our project, does the contracts and supports system have their own and then the other companies that are putting forward MMIS systems have their own? Is this a standardized contract or support system?

Jennifer Witham: That is a very good question. At this point it is not standardized across the nation. Since Medicaid is a state run program, the feds are not packaging up a standard Medicaid and shipping it out. That is not the scenario. What is true is because it is a relatively minimal, there are only 3-5 really viable vendors that sell and customize MMIS's for states. What we are moving towards is having the main system be configurable and not hard coded, and then they can spend more time actually providing more value add components. Those two

would be optional components but would be looking more at disease management. These vendors are in for the long haul. They have to be profitable. We want them to be profitable because we need them to be around. The share of the funding or money that they are receiving as a corporation to actually stand up a Medicaid in a state is trying to get that more stabilized and bring down the costs for that in the long run. There is not one standard but evolving standards are interesting. Outside of Medicaid, just information technology standards and the pressure that they are putting on all software development for making things more web based and there is just a real evolution going on in the entire information technology. More of what Maggie had said is more of a plug and play for different components and functionality. You can take it and configure it to what you need and you are ready to go. There is not an intense hard coding that is known to be done in the past.

Representative Wieland: There have been a couple of comments about the system and the delays and who we are doing business with. Just for a point of reference, how many states is ACS developing the system for in comparison to the few other companies that are out there?

Jennifer Witham: I would want to double check. I think ACS has about a third or more of the Medicaid market overall. For this new generation product they have three states that they are working with right now that are NH, ND, and Alaska. I do know that because they have existing systems in other states like Texas, they will be migrating if they are successful from their legacy systems to their new systems over time. This is their newest generation system. Three states are working with them right now on their newest generation systems. I anticipate that they will be bidding on for the replacement of new MMIS's as they come up in the future.

Representative Kreidt: Going back to the $3 million license fees, in retrospect this type of a service agreement also included with that right? You mentioned that there are going to be a

couple of major updates in Medicaid, how far out will this $3 million get us?

Jennifer Witham: It is $1.5 annually for three years.

Chairman Pollert: Would the committee like a breakdown of the IT contractual services? Do you want that breakdown as to where the $28.5 comes from? We start at $40 and go down to $12, and what comprises that. I'd like to see it. It also goes over to IT data processing. If you could give us how you got to those numbers, just so we can go through that. We have talked a lot of different numbers and taken some pretty good size decreases but added some increases in because of the licensing fees. Is it possible to say that $3 million will save us money in the future? Could you put that in hard copy?

Jennifer Witham: Sure

Chairman Pollert: If we pay the $3 million up front in one time funding basically is what we are doing, but somewhere you are telling me there is a payback?

Jennifer: I don't want to lead you down that road. It is not a onetime funding.

Chairman Pollert: The $3 million license fee is a one time.

Jennifer: No. It's $1.5 million every year. They have the right to renegotiate if. You contract for the number of years and they have the right to negotiate it. I know another area of the budget that sees a lot of these are going to be ITD. They do this type of licensing, usually it's not application software. The only other large application software that is like this is People Soft or the Connect ND system.

Chairman Pollert: When the license fee came across, did DHS have discussion with ITD to ask if it is appropriated or not.

Jennifer: Yes. It is common practice in ITD. If you bought a piece of software for 2007 and you have the option of not buying it in 2008. Or they will say that they can ship updates and it is covered. These vendors are building these for Medicaid. Part of the reason CMS is pushing for

this is because they are saying that Medicaid isn't that different from an insurance company. How many of these concepts are really repeatable. There are things that are unique for state programs and the way the funding is controlled. The actual work processes of paying a claim like any other insurance payer are very similar. The upside of us having this license fee is that I believe we will be working in the future with the states that are also using this license fee that are ACS customers. We will have a users group and be able to collectively request enhancements. That will be covered under the license fee. Shared enhancements and additional requirements that we would all have to comply with changes that the feds might make. It's a little bit of an insurance policy of itself. It's saying let's just pay the annual license fee and then we are covered for all the large system changes that every state is going to have to make.

Representative Wieland: I'm assuming that this $1.5 million per year for the first two years is subject to an arbitrary inflation rate for years after.

Jennifer Witham: Yes. That is true. Once this session is done and we are allowed to execute a contract of this sort, we will negotiate with them for how long is the fixed price. How many years will we be able to confirm that price without an escalator? We have done that with some sense of another contract that is in here which I haven't talked about which is our decision support system. We worked with CMS when we first went out for the decision support system with a part of the Medicaid systems project. CMS encouraged us to lengthen the commitment on the contract with the right to terminate the contract based on non appropriation. What we did was a five year fixed with three year optional inclusion which is all in this biennium budget but in future ones. We were able to lock those prices in when we first negotiated that contract. I think this license fee will be somewhat similar. What we have done to date is what we were estimating to be required.

Chairman Pollert: If you could, could we get a breakdown of how we get those numbers with IT date processing?

Jennifer Witham: I do have a schedule for IT Data processing that I will be walking through this morning. You may get most of your questions answered in that area. Continued testimony

Chairman Pollert: So we have the $3 million license fee under IT contractual services and then the $3.5 from ND's ITD that is under IT Data processing.

Jennifer Witham: That is correct. That $3.5 is not all associated with MMIS. The reason that there is an increase is that the current system runs on the main frame. Because it is an older system it is actually utilization. It's moving into a server environment. It is moving off a shared environment and into a dedicated server environment. Everything that is needed to run that environment is included in this increase cost of that makes sense.

Chairman Pollert: It's a big department. You are looking at a lot of money to run the systems and we are probably not done. This is going to be incurring. ITD is charging you a fee. That is how they show it as income in their department to pay for it, but it shows an expense in ours.

Jennifer Witham: If we go back to overview I'm saying that I have a $4 million increase. If you go back to the very first page of my handout and track it back to the object code of $60,100. The overall budget for ITD data processing is $27 million. This is an increase of $4 million with a total of $27 million.

Chairman Pollert: Yes Correct. It's a $2 million increase from 05-07 but a decrease from 07-09. Then you will give us a break down of where the decreases happen.

Jennifer: Taking this large product out and putting in the incremental increases of the new system make this a little bit hard to track. That is really what is going on. You are seeing a big decrease because of the work you are doing.

Chairman Pollert: Basically the next biennium, odds are is that we will see an increase to the budget instead of the decreases and it will be easier to trace too.

Jennifer Witham: It will be easier to trace but I do want to say that I believe in the area of IT contracting. That won't be as large in 11-13 because a lot of the funding that we are looking for 09-11 is for knowledge transfer, transition, and stabilization. Continued testimony.

Representative Ekstrom: In your overview testimony we have a $4.5 in million total funds. The general fund allocation is that $1.3. The rest is coming from the feds?

Jennifer Witham: Correct. Continued testimony.

Representative Metcalf: If you go to an auto dealer and they are going to charge you fees for a mechanic to work on the car. However they only get a portion of that. Is this the same kind of situation?

Jennifer Witham: It is but I do not believe that ITD is making a lot of money on this. There is the cost, the benefits, overhead charges that cover their administration. They can't be allowed more than 60 days of reserve. They are audited heavily. Even though it seems like it is a high hourly rate every piece is accountable for. Continued testimony.

Chairman Pollert: When you talk about the technology fee, did you say that is a one- time thing? Or is that a charge every biennium?

Jennifer Witham: The numbers that are going from $30-$45 is a monthly fee. We pay that for the number of FTE's that we are paying for, for 24 months.

Representative Nelson: That is two of them which are added on to the hosting fee?

Jennifer Witham: If you were familiar with ITD's budget that falls into major categories, this supports their networking.

Representative Nelson: In areas like this when they change from a port fee to an FTE and the number we see is the $320,000. How does that relate back to the 05-07. What was the net increase?

Jennifer Witham: The device count that we had in this biennium is 22,065 devices. At a cost of $30.75 each, it was a total amount of $1.6 million roughly. That moved to an employee count of 1,908. That's not the number of employees the department has. We were able to negotiate down by saying why should be pay for employees that work in the institution. At $43.5 each that comes to $1,992,296. With the net of those two being the $320,313.

Representative Nelson: what I'm looking for is the different between 05-07 and the 07-09. Is that something you could tell us?

Jennifer Witham: I don't think they increased their device fee between those years.

Representative Nelson: So this is a new increase?

Jennifer Witham: It's a new increase because of how they want to charge for this connectivity.

Representative Nelson: As the system is becoming operational and we are looking at the implementation cost but now all the support staff. Are states that are considering changes in MMIS that are suffering through recession areas, are they delaying that implementation? Do you know that in your conversations with surrounding states, this must be a deal breaker?

Jennifer Witham: First of all I wanted to clarify that this technology fee is for the entire department. The majority of the states, 40 of the 50, would consider themselves fiscal agents. They contract for the hosting and the maintenance of these MMIS to the vender as well. We have chosen to do a term key where we host it in the state and we are going to learn how to manage the system ourselves. We are going to reduce cost over time by doing it ourselves. For all the states that just contract it out are required by the feds. They can't go longer than 8 years without replacing or contracting their MMIS. They are obligated to refresh. The reason

for that is not always in that eight year time frame do they replace their MMIS. I think what it is that it gives them and their partner in the feds who pays for a portion of this to say that this contract shouldn't be locked in for 30 years. You need to be looking at whether or not this is still a good relationship and whether or not you still feel you are meeting their needs. They have to come back to the table and earn their business. For looking at what is going on in other states, the option to delay doesn't happen because of that reason. Minnesota is a big state run place, SD is also looking to run their own MMIS. They could choose to put it off but it's almost like pay now or pay later. There are some large changes that are coming down from the feds. Implementing those large changes into an older system is not only going to be difficult but you are going to run the risk of not being able to modify a legacy system to incorporate those changes. Once you have replaced your MMIS, the majority of those changes will have to be made to things that will affect our business rules that we will still be able to modify without having to go into the code. I do not believe states are pushing it back. I actually think they are being more aggressive. Continued testimony.

Representative Bellew: Southcentral Human Service Center, $26,000, do you have more than one person there? Do you have a whole staff there? Is that the state hospital?

Brenda Weisz: It's because we have more people there. I have 2 application support people who are in the Jamestown area. They are housed at the southeast human service center.

Chairman Pollert: So they charge you that lease space in that building by the Ann Carlsen center.

Brenda Weisz: I do have people at the state hospital but that is a different building. The people that are in the south central building are people that report to me on application support and one that is doing desktop support.

Chairman Pollert: That is a question we can ask the Southcentral people. Even though you are all part of one big happy family you are going to pay rent at the Southcentral human service center? Is it that building owned by someone else?

Brenda Weisz: When we have a rent payment for a human service center, we write the rent check. We have an accounting system where you can charge what funding stream should pay for it. They predominately are staffed and occupied by people who do the services out of Southcentral so that budget is directly charged. Jenny has three staff that are there and has a different funding stream. We can only charge the federal government of the appropriate expenditures tied for that program. Using the accounting system that all state agencies use, we just designate a part of the bill to be billed to Jenny's area. When Southcentral writes the check they just write one check. Behind the scenes the accounting system says to charge it to where it goes. We don't pay them it just gets charged to us.

Jennifer Witham: Continued testimony.

Chairman Pollert: What was the $6 million? Reduction? The reason why I ask is I just looked back to 05-07 and go to 09-11 and your talk about transmitting electronically will save you money over all. That is what you are kind of saying right?

Jennifer Witham: It is the contingency funds that we had put in to our MMIS budget. There was contingency and it wasn't contracted for you.

Representative Nelson: When MMIS is fully operational will this service be necessary?

Jennifer Witham: We put it in the budget because we weren't sure. It probably won't be in 11-13. Because we are going to be going up live with the MMIS partway through the biennium, there will be this whole transition for the providers to better understand what they can do with the new MMIS system and some transition involved. We felt that it was prudent to just leave it at the rate that we see today and hope that during those last 14 months of the biennium that

we can get those providers offices to use the Medicaid systems portal which they can submit their claims electronically. Even if they have that as an option, some may choose to still do it the way they do it today because they can. We will have to encourage them to move to our new portal. That is changing their operations. Right now we are thinking that for the time period of transition they may want to submit them as a batch where they can send their BCBS and their Medicare/Medicaid all in the same. The benefit to them for using the new MMIS is that portal doesn't do any specific Medicaid validations or edits. If they were to submit them through the new Medicaid portal, which we will have up, then it will validate them for them and they will be able to see if they need to make an adjustment. For their internal staff to get comfortable we just left that at the projected of what we are using today.

Representative Nelson: What I was getting at was in concept the MMIS will do this. I can understand the reason for having that in the budget. In your opinion from the provider standpoint, is it worth it for them to do that. Is it going to create a lot of heartburn? You can kind of get ownership in if you recognize the system you are working with. Is it a big transition to switch over to MMIS?

Jennifer Witham: I believe that the shares of these large electronic submissions are coming from our more sophisticated institutions. I believe that the providers are going to be more likely to transition to upgrading and having their Medicaid transmission go right to Medicaid. We still have providers that submit directly to us as well. I guess I would be reluctant. We are going to make a big emphasis to provide information and encourage them to have their claims submitted directly to us.

Representative Nelson: Does that include support staff and going to the facilities?

Jennifer Witham: We have a full transition and training within our current MMIS project.

Chairman Pollert: When you say contractual services you mean a breakdown of the IT data processing right?

Jennifer Witham: Correct, I will do that in both of those areas.

Representative Bellew: I see part of your funding sources are county funds, what does the county pay for and where does the authority come for you guys to charge them that?

Brenda Weisz: That is a result of swop legislation. That is different from swop funds. What happens is that they still incur the expenditures out there for the economic assistance programs. They still do the work and we can still draw those funds down. We just don't pay them back out. We keep them in our budget and use them to fund as retained funds. We don't have those types of expenditures in our area. Because of the legislation we trade it out. The counties operate and work on servers and systems from ITD as well. They do our eligibility so those system costs are tied to county work. We said that we won't pass those costs on to them until we hit a ceiling that is inflated by an inflationary factor each year. Once we cover all the technology costs, and the data processing costs of them using those eligibility systems, until it hits a ceiling that was laid out in Swop legislation. After it hits that we bill the counties for their share. It's the other way around. They pay until they hit a ceiling. Once they hit a ceiling of cost they are limited and held harmless. Swop was a balancing act.

Representative Bellew: That was way before my time.

Brenda Weisz: Basically, they were held harmless to that level. Once the costs for the operation of the systems hit that level then we pay the rest of that no matter what it costs.

Representative Bellew: Would it be hard to get a copy of all the county funds that are in your budget and where they are charged to?

Brenda Weisz: No that will be very easy.

Jennifer Witham: Continued testimony 2:11-5:21

Representative Wieland: Are we at the point yet with MMIS that we are saving money with IT yet that it doesn't cost us anymore?

Jennifer Witham: One of the things that is always hard with an IT budget is that it usually offsets someplace else to improve efficiencies of operations. I believe that my budget is continuing to reflect the increasing demands with more efficient operations. It looks like IT is growing. I can promise you that I believe the DHS does a good job with maintaining and working with IT with trying to keep costs down. I believe we are very aware of standards and replacement cycles. We do the best we can to manage it efficiently.

Representative Wieland: I don't want to be critical of IT here or anywhere else. It's just that over the years as I've watched IT evolve, every time we are told that it is going to save us money. The IT budget is something like $220 million total for the state. That's a lot of money. We haven't increased in population in the state. I'm just wondering with all of the things we are doing, when do we reach a plateau? When will it appear that we aren't spending money on one side and maybe not saving all that money? I'm not being critical of you or any department. We have all gotten caught up in this thing and we can't stop it. It is frustrating.

Chairman Pollert: We will continually see the $1.5 annual fee forever with inflationary increases. We will continually see the $3.5-$4 million of ITD fees for running their programs for the DHS. This is going to be an ongoing expense that we are always going to see. What I would be interested in seeing is if we were back to the old system with the amount of money we are going at, when we ask for all this information and you will give me a more detailed on contractual services. If we would ask for that information without this information, I'm sure we'd have it within five minutes. I can't imagine what it would be like with the amount of information that we are gathering from you if we were doing paper trails.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1012 – IT detail/ Economic Assistance Detail

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/15/09

Recorder Job Number: 7114

Committee Clerk Signature Morgan Pennell

Minutes:

Jennifer Witham: If you go back to the handout I gave you this morning the two front pages were detail by object code. The handout I just you're you right now is going to be information on two of those object codes. The top sheet is on the contractual services. In my detailed handout it is actually on page 2 is the very first object code on page 2. To walk you through this, the first number the $40,757,206 ties back to what is in the column of the current budget for 2007-2009. The Medicaid systems project reduction in that object code is $37,399,893. The additional or what is added back into some cases in a continued smaller reduction is that the largest number is the $9,256,512 in IT contracts that are in that. A piece of that is the $3 million licensing fee.

Chairman Pollert: The other part is the ITD charges you for?

Jennifer Witham: That would be correct. Brenda already knew that you needed additional information on that 9,000. She asked me at the bottom to take a break down of what is in that IT contracts. When we go through the second schedule I will talk the ITD piece. Part of that is the Thompson writer's contract which is our decision support system. The health information designs works with the Medicaid systems project. It does work with the pharmacy group. It's a contract that we have now so it is really a continuation of that contract. $8 million with ACS

health care which $3 million is the license fee in which we discussed this morning. The remainder is for that transitional services to help us do knowledge transfer and to bring ITD more up to speed with how to manage the system. Like you pointed out this morning that is unusually high. We will not see it at that level in subsequent bienniums. This is a transition biennium. Synergy software technology's is our aging systems providers. I don't need to necessarily go through the other ones unless you have questions.

Representative Wieland: Can you tell us where we are at with MMIS?

Jennifer Witham: This week we concluded the final design session. That was a big part of the project. We went through requirements and the gap analysis between the base product and what the ND requirements are. We detailed out how to design their system around our needs. We handed off to start coding or construction. Now we are in the construction phase of the project where they are actually building the code for us. That doesn't get all done in one big block. It happens the same way design did. We handed off the first segment of design. We just finished our first segment. They already started their technical design for the construction of the first iteration. They do this phased process of design. We are going to be going through construction and system testing operational readiness in training are the big components that we have left with the goal life date of May 2010. As they start completing the development then we start testing it and making sure there are no defects and it meets our requirements. Once we have signed off on that we start moving into training. What I mean by operational readiness is changing over the desktop processes to the new system and getting ready to manage the system once it goes live to medical services.

Representative Wieland: May of 2010 is the target date?

Jennifer Witham: Yes. That is true. We will have one small component come up earlier which is the provider re-enrollment. The providers that will be certified by Medicaid to submit bills and

claims which they are today. We are asking them to re-enroll into the new system because we are collecting different information. It allows us to refresh our enrollment. That is going to start in November of 2009 so six months earlier.

Representative Kreidt: When we go online for facilities, will the facilities be compatible? Are they already set up? Will it be continuous flow?

Jennifer Witham: For the facilities it is really to access our system. They will get a password to access our system.

Representative Kreidt: So whatever they are using right now will work?

Jennifer Witham: Yes. In 99% of the cases that will be true. I'm not sure if you have any more questions on this first schedule.

Chairman Pollert: What is Thompson Reuters? And what is the remaining of the $5 million of ACS for?

Jennifer Witham: Thompson Reuters is our decision support system. What that is, is our executive decision support system. It's a data warehouse which houses all the claims information. It is primarily focused on utilization review and trend analysis. It is an after the fact research component for the Medicaid system that allows them to do those more analytic studies on the data they are receiving.

Representative Nelson: The ACS health care, in addition to the $3 million that seem to rub a lot of people the wrong way, now there is an additional $5 million. Is that an ongoing expenditure with ACS as far as developing the system or can you explain that remainder?

Jennifer Witham: First of all it is not going to be an ongoing cost.

Representative Nelson: Has it been that way in the past? Or are we just seeing it in the next biennium?

Jennifer Witham: It has not been in the past. The reason for medical services or MMIS. It was first implemented in 1978. We have managed it 100% with ITD developers. This system is very complex. For the ITD development staff and the systems administration staff and actually the medical services staff to be ready to know how to modify the system. This has nothing to do with how it works on day 1. It has to do with when you guys are completed with the session. You will have changes to Medicaid. You may have changes in service limits. We have to know how to modify that system to meet the changing requirements of Medicaid. That is done in different ways and one is through configuration components which will be a combination of medical services staff doing that as well as ITD staff. The other piece of that is the software development staff. If we have to make enhancements to the system they have to know how the whole system hangs together. They will have to understand how the data construction is, how each of the functional areas are constructed. It's time spent with ACS. We are at a point where we aren't going to make too many changes because we have to be certified in the first months after go live. ACS comes in six months after operation to make sure things are going as supposed to and you get a certified MMIS system. As we start to make changes we want to make sure we are not doing that in a manner in which we aren't familiar with and how the product is composed. We've begun talking about how we transition that from ACS's responsibility to our responsibility.

Chairman Pollert: So you are saying that $5.1 million is needed for that transition? As well as other changes that we may make?

Jennifer Witham: Correct. The second schedule supports the budget line for $61,000 which is on the bottom of the first page of the detail for IT data processing. This is very similar to some respects to the one I have already handed out to you but you didn't have the plus and minuses like you had asked. This gives the full breakdown. The first number is $33,074,400. The

Medicaid services project has a reduction of $9.5 million. The next 5 items were items that we went through this morning. The total of those five items was the $4 million which was in my overview testimony. When you net that against the $9.5 million reduction you have a $5.496,920 reduction overall. When applied against the $33,074,400 which is at the top of the page, it nets to the $27,577,480 which is what our request is that is in the last column.

Representative Kerzman: Did you say what that TANF longitudinal study is?

Jennifer Witham: I will have to defer to someone else.

Carol Cartley: What the TANF is doing is a 10 year study of TANF clients. We want to attract some of the trends within the TANF clients to see about generational poverty or generational folks that are on TANF to see if we need to change some policies to make some adjustments that you could do something differently.

Representative Kerzman: How can you do a 10 year study when it is a 5 year program?

Carol Cartley: Certain aspects of TANF individuals can remain on TANF. If the unemployment rate is greater than 50%, that 60 month lifetime limit does not apply. For example, Rolette county , Benson county, and Sioux County, their unemployment rate is greater than 50%. Many of those have been on ever since TANF began. As long as they are living on Indian land they can remain on TANF. It would be including that generational study as well.

Brenda Weisz: Handout Testimony (Attachment A)

Representative Bellew: You said IT was capped? There budget shows a change of like $213,000.

Brenda Weisz: In other funds. It is indexed by CPI and swop legislation. The cap is always changed based on those two.

Tove Mandigo: Testimony Handout (Attachment B)

Representative Bellew: In your earlier testimony you state that there is $110,000 in a combination of increases/decreases. What does that mean?

Tove Mandigo: Basically it is how you manage the FTE's that you have. Some people have left the department, some people have been hired on. When new people are hired on you often have to increase the salary level because you don't come on at that level. There was also an equity issue in the food stamps FTE's so that was adjusted there. It is basically how you manage the staff that you have with people coming and going.

Chairman Pollert: When I look and notice travel. The current budget is about 200 and some thousand. Year 1 is $50,000. I see where you are going to reduce it by $46,000. If you double 50 it is 100. It seems you are projecting $98,969. It seems to be overstated a little but that's just my opinion.

Tove Mandigo: When we had the EBT procurement we thought there would be more travel involved. That is one of the reasons that the travel costs are less this time for this biennium. Does that answer the question?

Representative Wieland: It shows year one at $50,262. That means that out of the $203,000 budget the second year is going to be $150,000 or a bit more than that. There is a substantial difference.

Tove Mandigo: Part of the reason for that too is that part of the travel that has been planned during this budget didn't take place. Especially in our areas of the regional reps and the quality control. However, those expenditures and travel is expected to continue. It just didn't happen in the first year of the biennium. Some of it is just planning the travel and whether or not they are able to meet the obligations that they need to do. Continued testimony.

Representative Kerzman: The alternatives for abortion, 2 on 1 how many hits are you getting on that? Is it being utilized? Did you get the material out?

Tove Mandigo: I'm not sure whether we track the hits. We can get you that information though. Continued testimony.

Chairman Pollert: It seemed to me that we had a discussion on the payment system error last biennium as well. Is it mandated?

Tove Mandigo: It is a federally mandated program that covers childcare assistance, the childcare piece, the TANF piece, and Medicaid. It's on a three year cycle. You only hit it one of the years.

Representative Kerzman: In the past we have had TANF dollars that we haven't used. Is that the case now?

Tove Mandigo: We are bringing $11 million to this biennium. At the end of this we will only have about $1 million to carry over into the following biennium.

Chairman Pollert: During the interim of human services can we get a breakdown of where we are going to be at? Did we switch some TANF to general funds this biennium or not?

Brenda Weisz: We will bring a TANF schedule that you are familiar with forward. We can bring that during the interim committee. As we kind of guessed that during the interim we funded everything as it was funded before. We did not do any shifting from general funds. We continued to fund the foster care cost that we are previously funded with those. That leaves us with a balance coming in as Tove mentioned of over $11 million. At the end of this biennium we will only have carry forward of just over $1 million.

Chairman Pollert: Didn't we have some of the childcare bill?

Brenda Weisz: That was a transfer of $500,000. The majority of the expenditures are used in the foster care system.

Chairman Pollert: that is really when we got into that discussion. When it got to the Senate side we had a discussion as far as that. We are going to be deficit spending.

Brenda Weisz: I think we anticipated that we would have the trouble coming up the 09-11 biennium. Due to the changes with those on TANF and a reduction in our foster care with the smaller case loads, the problem did push itself out from the 2011-2013.

Tove Mandigo: Continued testimony.

Representative Wieland: Grants and other funds under childcare, are those county funds?

Tove Mandigo: No these are the swop dollars.

Chairman Pollert: And the jobs program is related to TANF?

Tove Mandigo: Yes. That is where we have contracts and options for Job Service.

Chairman Pollert: I think we had quite a bit of discussion on that.

Tove Mandigo: Continued testimony.

Chairman Pollert: When we look at food stamps, and I brought this up during the overview, there is no way in the current economic environment that they are ever going to back off on that. It is something that we don't have to worry about?

Tove Mandigo: They are a bit different on how they are done. One is a grant from the states. If we run out of money we would have to access other money. Food stamps is different. It is continuous. Continued testimony.

Chairman Pollert: You show a reduction in TANF's. Is the amount of clients on that dropping or where is that coming from?

Tove Mandigo: Our TANF clients did drop down in some areas. In other areas they came up. TANF is comprised of 3. As a population there is diversion, transitional, and the regular TANF clients. When we first built our budget last time we didn't know what would happen with transitional and we probably built it a little high.

Representative Bellew: TANF is a pretty large shift in your increase of general funds, can you explain? The total general fund increase is $1.2 million.

Brenda Weisz: Those are child support retained funds. When TANF clients down we don't collect as much money in child support. We have to fill that back up with general funds. I'm just going to take you back to my overview testimony on last Friday. I had talked about some funding changes with you. It was in my attachment A and it was one of my items on there, the very last one of the funding changes. What has happened during the course of the last biennium is that our child support collections in total are up. I talked about the fact that our child support collections and what Tove is referring to, the child support collections that we actually keep within the department to offset other costs are down. That is because our foster care case load is down. Our child support collection that we retain is down. We still have to meet our MOE. Child supports used to meet that MOE but if the child support collections aren't there then you need a general fund, another alternative source to meet your MOE. That was one of the funding changes and $1.1 million of the general funds added to that budget to offset the decrease in child support collections.

Chairman Pollert: The $1.1 million is the drop in what?

Brenda Weisz: Overall when we looked at what was needed to fund MOE, when we look at all areas that was the drop of $1.1 million which were the additional general funds that were added because of the child support reduction.

Chairman Pollert: Do we ever ask for a breakdown of TANF on this?

Brenda Weisz: This sheet shows you the breakdown. Tove has a sheet that she will go through with you.

Tove Mandigo: Continued Testimony.

Chairman Pollert: As an example on SNAP, you had a cost for 07-09 increased cost per case in 09-11. I understand food costs have come up. Is that a formula or is that just something?

Tove Mandigo: Some of the SNAP costs are involved in the farm bill. The farm bill removed the cap on deductions and also increased the minimum benefit from $10-$13 and increased the minimum standard reduction from $134-144 and indexed it from inflation.

Representative Wieland: What dose SNAP stand for?

Tove Mandigo: Supplemental Nutrition Assistance Program

Representative Wieland: I know what it is, just not what it meant. That is 100% federal?

Tove Mandigo: Yes.

Chairman Pollert: How much of yours is general funds? The big majority is all federal. There are few general funds in economic assistance I would believe. I would have to go back to the spend down to find that out?

Tove Mandigo: Correct.

Representative Kerzman: I seem to recall that power companies seem to pay the assessment for fuel assistance. Is that discontinued? Was that a different program all together?

Tove Mandigo: I'm not familiar with that but I can find out for you.

Chairman Pollert: On the $2 million increase in general funds, $1.1 is from the memorandum is from what is required under the TANF program.

Tove Mandigo: Yes.

Representative Bellew: Since I don't remember swop can you explain it to me?

Tove Mandigo: I understand it but not enough to explain it to anybody.

Deb McDermott: What that really was, was the counties would spend dollars. If they would spend $100 at a county level, they submit those bills to us and we would submit them to the

federal government. Most of the programs were a 50/50 match. We would then give them the 50 portion of federal money. On the other side with grant costs, we would bill the counties a share of the Medicaid cost, part of the DD grant costs, the childcare costs, part of the TANF and those programs. What swop did was the counties were no longer responsible for paying a portion of the grant costs that I listed. In turn, what they would do is still submit that $100 to us in admin costs. We would then in turn submit it to the feds. That $50 that we would get back, we would keep those costs or dollars as retained costs and use that to offset the grant costs that we were no longer billings the counties for.

Representative Kerzman: Are the TANF dollars still a block grant?

Tove Mandigo: Yes.

Representative Kerzman: Have those amounts been reduced? Utilization is up?

Tove Mandigo: We get a set amount. We get $52.8 million a biennium total. We get $26.4 million a year. It's up for reauthorization in 2010.

Representative Bellew: What is the statutory funding formula for Indian counties? If there is a $451,000.

Tove Mandigo: What I know is the test is 100% of the costs. Deb knows a lot about this as well.

Deb McDermott: The statutory law was changed basically at the same time that swop legislation was so the Indian counties weren't negatively impacted. What it is, is that you take all of the economic assistance costs for the counties. It's all the economic assistance counties. The counties that qualify for Indian county money have to have 20% of their case load living on a reservation. They have to be in excess of that average mills of those counties that do not qualify for the Indian money. You have to meet those three criteria. You have to take that excess of the average mills and basically that is how the Indian counties are calculated.

Chairman Pollert: What is the $274,000 increase in childcare?

Tove Mandigo: It increases the fees to the child care providers and the people who provide the childcare for systems. It increases the maximum for the ages of 0-2 to $20 and from 3-5 to $10.

Chairman Pollert: What are the fees for?

Tove Mandigo: To pay for the person who takes care of the children.

Chairman Pollert: Basically a subsidy?

Tove Mandigo: Correct. It is paid on a sliding fee schedule.

Representative Kerzman: On a TANF you have $9,700,000 federal funds in the block grant brings in about $26 a year. Yet we are losing money. We have to pull in about $10 million out of the roll up dollars? There must be something else included in there that I am missing.

Tove Mandigo: The reason for that is when Brenda brings down that TANF schedule it will become more clear. A lot of the funds are actually used in the child welfare area and not just the TANF benefit. They are also used in other areas of our budget such as admin, IT costs. The majority of them are basically used within the child welfare arena too and you will see that on the TANF schedule when you bring that down.

Chairman Pollert: Does anyone else need anything from Brenda today? If not we will be in adjournment until tomorrow at 8:30

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

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Hearing Date: 1/15/09

Recorder Job Number: 7567

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Minutes:

Larry Bernhardt: Handout Testimony (Attachment A) and (Attachment B)

Chairman Pollert: How many total employees or FTE's are in county social services statewide? Do you have a number?

Larry Bernhardt: I did but I'm drawing a blank. I will get that to you.

Representative Bellew: Do you have a breakdown of costs per county in total dollars? Would all these services be better served if the state took over them?

Larry Bernhardt: Each of the programs and services we offer through county social services has a different reimbursement process.

Representative Bellew: What does the cost per county of each?

Larry Bernhardt: The cost of food stamps itself is all federal money, there is no county or state money in the cost of the food stamps. The cost to administer the food stamp program is 100% paid by the county.

Representative Bellew: Do you have an amount? Your social service workers have to spend a certain amount of time on this. I would imagine it is salary and wages. If there is a specific amount and if it can be found I would like to see it.

Larry Bernhardt: We do a breakout by county and a state compilation of those costs. We can tell you what it costs for economic assistance programs and for social service programs. Within that we can breakdown what the costs are for child welfare or adult services. I don't' believe we have that information isolated so that I can tell you statewide the administrative costs for the food stamp program. All of our eligibility workers out there, I have 14 of them, they all do some food stamp cases, Medicaid cases, childcare assistance, fuel assistance and so forth. Our workers are generic. We could work up something to give you a rough idea. Secondly, I think your question is whether or not your programs would be better served and administered if they were state administered. The answer is no. I truly believe in a county delivered system. We are closer to the client, we have our presence in all 53 counties. We are a whole lot closer to the clients. We have a history of providing very good services in county social service agencies.

Chairman Pollert: That begs the argument of the dividing line between when should state take over costs of certain divisions of DHS and foster care. When do you do that and when do we say ok since social services aren't going to do these services then you don't need the job and you are done. Those are lines that we have to discuss.

Larry Bernhardt: You have to look at how the service is best delivered. At the same time the other half is that we all have a cost. We all have a share in this. We have to make sure that the share is done appropriately between a mix of federal, state, and county dollars. Sometimes that mix is not correct.

Representative Nelson: I agree with your answer on the job that you do. The people know the individuals. It's a center that people are familiar with. By raising the medically needy income level 83% that is obviously going to increase the workload. How does that compute in relationship to additional FTE's or employees?

Larry Bernhardt: I'm not sure that it will increase our workload. Those people that we have today are on medical assistance. The difference is that someone who has $750 a month today per monthly income, they get to keep $500 and pay $250 towards their medical costs before Medicaid will pay anything. When the medically needy income level changes they will get to keep $700 and pay the other amount to medical. We already have those people on medical assistance.

Representative Nelson: You don't think there will be any additional people that will qualify with that change?

Larry Bernhardt: There will be a few but it won't be remarkable simply because if people have that medical need they are on medical today. It's just that we are limiting the amount that they have to pay their other needs.

Representative Nelson: I'm becoming more and more sensitive to requests that have money in them that haven't gone through the department or the OAR system. There is no money left to spend. I don't know where we are going to start manufacturing these dollars from. There are legitimate and good requests but it is going to have to come out of someone else's budget.

Larry Bernhardt: I think the dilemma is that when the department of human services got their instructions for building a budget they were instructed to present a budget at 100% of what their budget was at a prior biennium. In order for them to live within that, even though they are wonderful ideas and make sense, they didn't have the capacity to add them in because of their budget. Somehow we need to get those needs before the legislator to see that these are definite needs that we have to try to address. I believe that if the department didn't have a limit of what they could present their budget, these things would have been in their budget. Just like there would have been money to build a new computer system. I think the OAR's would have

been funded but they have limits of what they can put in their budgets. We then as advocates for counties and clients we serve have an obligation to bring those needs before you.

Chairman Pollert: Why didn't we go to the SSI level instead of jumping 2 Tier and going to the 83% poverty for medically needy? The SSI level gets you within $9-10 for a family of 2.

Larry Bernhardt: I don't know the rational for why it went to 83%.

Chairman Pollert: Besides that it leaves more money in their pockets. That is an easy answer and I'm looking for the hard answer.

Larry Bernhardt: I think that people in the department that built that OAR would be able to tell you how they arrived at 83% of poverty level. I'm not sure.

Representative Wieland: I'm not very computer literate but when you talk about the new eligibility system computer program you mentioned that they have to enter data into four different computer systems. Is that for every client or just for some clients?

Larry Bernhardt: It depends on the client and the programs that they request. If we have a client that comes in and is looking for fuel assistance, child care assistance, food stamps, and Medicaid, they have to go into three different systems. As of may they have to go into 4. If they also have a child in foster care then we have to use the other system because that is all there. If they just want food stamps we can do that in one computer system.

Chairman Pollert: I was going to ask Legislative Council about where the ranking was for Cytec. I see it was written down as #5 on the ranking priority list. Then again I understand why they wouldn't when they are working and trying to get MMIS done. It was ranked #5 on the list.

Representative Kerzman: In regards to the Indian County Funds, I haven't seen the bill yet so I have to apologize. Could you expand on that a little bit? Now it's basically on Mills and property tax? Is it going to what they get for food stamps or do you know anything about it?

Larry Bernhardt: Currently the counties in the state that have Indian reservation land and Indian trust lands are over 20% of their current economic assistance case load is native American. They qualify to be considered to receive reimbursement for some of their economic assistance administrative costs .The way they do that is take the average of the mills that are spent in all of the counties for economic assistance and everything over the average of the mills then that county is eligible for reimbursement in county dollars. The problem is that the formula doesn't work very well because of the differences that we have in the makeup of the Indian counties across the state. I believe it is HB 1540 that is being introduced to change that so that we would then use the current food stamp program and whatever percentage of the food stamp program clients or any clients that are residing on reservation or trust land, that percentage would be the amount of the economic assistance costs for that county that they would be eligible to receive reimbursement at 100% of that percentage. It would make a considerable difference. It would be more fair for the distribution and would fix some of the disparities that are happening now with some of our Indian counties. I believe there is a fiscal note of about $1.5 million for that.

Chairman Pollert: Any other questions?

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1012 Child Support detail

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/16/09

Recorder Job Number: 7114, 7115

Committee Clerk Signature Morgan Peterson

Minutes:

Debra McDermott: Handout (Attachment A) 6:25

Chairman Pollert: So like Benson would be the 20.97 times $13,794?

Debra McDermott: Correct

Representative Nelson: The value of the $1.5 million has never been paid out has it?

Debra McDermott: Yes the $1.5 million has been paid out.

Representative Nelson: It doesn't add up as far as the appropriation in your testimony.

Debra McDermott: This is an excerpt of the testimony given in 2007.

Representative Nelson: The chart is in the same biennium. The testimony said to appropriate $440,000. The legislator added another $600,000. That is roughly a $1.1 million.

Debra McDermott: It was 1997 and 1998. That was way back in the SWAP legislation.

Representative Kerzman: The counties that are blank like Billings, Mclean, Mercer, Sheridan, Slope, do they not receive any economic assistance?

Debra McDermott: Those are actually counties that have been combine. Billings and Slope are combined. That is why on the bottom of column F it says number of counties 42. They are county entities.

Mike Schwindt: Testimony Handout (Attachment B)

Representative Bellew: When you have these people staffed, where do you rent space from?

Mike Schwindt: Our space situation is the same as it was when we started out when the counties were running the shops. We have made several changes in the interim. Fargo, for example, we now moved out of the region in Fargo. In Devils Lake the landlord wanted to put his building up for sale so we are in the process of moving out of there. A couple of months ago Williams County said they want us out of there so we are in the process of locating real estate. The central office is located in the WSI building on the first floor. Continued testimony.

Chairman Pollert: How many in Grand Forks?

Mike Schwindt: 16 plus 6.

Representative Bellew: When we get into the detail a little bit I have noticed on the organizational chart, there are an awful lot of attorneys. Can you explain that a bit better.

Mike Schwindt: That is part of the baggage that come with the program, we have to have attorneys. Continued testimony.

Representative Ekstrom: In terms of the attorneys I have been looking at the pay grades on the various folks. They are generally at a level 13. I think if you look at parody in terms of private sector and even county states attorneys they are probably making a bit more.

Mike Schwindt: Most of the attorneys that we brought in from counties, there were some that were over the pay grade and were frozen at that level. The Attorney I was grade 13. The Attorney II which are the lead attorney's are grade 14.

Representative Ekstrom: If you turn to parody and look towards private and public sector they aren't making anything like they would in a private sector.

Representative Nelson: Williston and Minot, what were the numbers for FTE's there?

Mike Schwindt: Williston was 8, Minot was 16, and Bismarck was 26.5 including the 4 for the high intensity enforcement unit.

Representative Nelson: You mentioned earlier that the Governor has a 7 FTE decrease in your office. In this chart you show 5 vacant positions. Can you explain how you are going to get to that or where the FTE's will come from or what the criteria was for that decrease?

Mike Schwindt: I can talk on how we intend to get to that if that is the final resolution of the legislator. Simply we have to get there. Part of what we have to do with this whole conversion is take a look at how we are doing business. Where the case loads are changing and what services are changing.

Representative Nelson: Are you going to take them from the regional offices or the tower?

Mike Schwindt: When it comes time to deduct we will take whatever is vacate and do the adjustments as we go along.

Representative Nelson: So there is no strategy?

Mike Schwindt: I have a lot of work to do before I know exactly where I want to make these changes yet. Some will come from the central office and some will come from the regional office. It depends on what the program changes need and require. The performance auditors recommended a trainer. Where do I put a trainer? I can put them in the regional or central office it doesn't make a difference I still need one.

Representative Wieland: Are all those positions going to be funded? Even though you are going to have a reduction?

Mike Schwindt: We are following the Governor's budget.

Chairman Pollert: So we will see that in the detail?

Mike Schwindt: It was in the overview that I presented the other day. We will cover that when I get to that in the next part as well in the budget overview.

Chairman Pollert: How many in Dickinson?

Mike Schwindt: A grand total of 7. That's the same level they had when they were transferred in. Continued testimony.

Chairman Pollert: So that total change is $142,623. That is the combination of everything from your bullets on the top of page 6 and 7.

Mike Schwindt: Yes. Continued testimony.

Chairman Pollert: On fringe benefits above, the reduction of health benefits, the $420,000, would come from the reduction of the people?

Mike Schwindt: It is the economic standard put in to the current accounting system. Part should have been up in the salary lines instead of the fringe benefit line. It's just a correction.

Chairman Pollert: What do you mean?

Mike Schwindt: When the budget was loaded up for the 07-09 biennium, instead of putting in the salary object code that 5,11,000 line some of it ended up in the 516 line. If you look on the third column of the very left side. You see salaries permanent and that 511 is to the left of that.

Chairman Pollert: Ok

Mike Schwindt: Down below you see the fringe benefits of the 516. For operating program it doesn't make any difference because it is in the salary line.

Brenda Weisz: When the bill was passed, 2205, we got the money in a lump sum. Then we had to put it to the correct budget object codes in the PeopleSoft system. Based on my fiscal staff, we put it in the wrong place. We should have put more up in salaries and less in fringe. Of course it didn't come to our attention. It just got put in the wrong place when we added 2205 to our appropriation.

Representative Ekstrom: On page 7 when you talk about a receivable study for $200,000. When is that going to start and what is the hope in terms of what you are going to achieve with that. Has the contract been let?

Mike Schwindt: It's itemized on the next item down.

Representative Bellew: I see you have other funds in here. Could you tell us where they come from?

Mike Schwindt: In prior bienniums other funds have consisted of county money or federal incentive money. Going into the future biennium there is $263,000 of fees. The rest is federal incentive money. There is no longer any county money included in this budget. This is the first biennium when we have fees included as revenue in this budget.

Representative Bellew: When we get to that point I would like an explanation on the fees.

Mike Schwindt: Continued testimony.

Chairman Pollert: When I look at travel and I see the current budget for 07-09 at 173. Year one you have went through $30,000. If you double that and take it times two, yes you did drop your budget but it still seems as if it's inflated to other years.

Mike Schwindt: We have pretty much grounded everyone because we have had work to do. No one has been doing any traveling. To get to the regional office seems impossible because I'm stuck at my desk. There is a $20,000 piece associated to nonemployee travel associated with a federal grant we had which is designed to figure out how we can provide better services to families when the kids are in foster care. We are paying for our travel associated with county people coming in to get advice. That is the big thing here. Without that 1115 grant we would drop that another $20,000. It's between those two things. Keeping people at their desk and that $20,000. Continued testimony.

Representative Wieland: I did want to talk about the rentals and the leases. Did we have some kind of a schedule. Do you pay for rent in the court houses?

Mike Schwindt: Yes the blue schedule will show you. Continued testimony.

Chairman Pollert: Where is that at? I caught the $13,000 on page two and then where did you go on this?

Mike Schwindt: Right below it to $200,000. That is the federal access and visitation money. If you go to the far left hand of that line you see $2,071,000. The biggest part back then is if you transferred incentive money out to the counties. Under state administration you can keep that. If you go to page three at the very top you will see the budget. Continued Testimony.

Representative Bellew: You charge people a fee to pay child support?

Mike Schwindt: No we don't charge a fee to pay child support. Go back to last session where there was a bill that talked about fees. We must put charge fees according to the federal rules. As soon as you get $500 collected and pass it on to the family. If we don't get $500 they still have to pay $25. That is part of the federal rules that were put in rule. Who do we charge the fee to? State general fund? The person who pays or the person who gets the money? When you charge it all through with administration. The fee is charged to the person who gets the money not to the person who pays the money. There are lots of nasty consequences. It is charged and generally it is to the mother because most of the people that receive the money are the mothers.

NEW JOB

Representative Bellew: So there is a $2 monthly fee taken out of the child support? IS there a subsequent raise to that fee?

Mike Schwindt: No there is not.

Chairman Pollert: The $578,000 of general funds on page 3 is the same as the salary general funds on page 1? I don't know if that is coincidence.

Mike Schwindt: It should be. That is all that is in the column. That is the overview of the child support budget. If you would like to go to the next handout which would be the blue one which deals with rent. Continued testimony.

Chairman Pollert: You are thinking the one in Williston will be about $12 a square foot?

Mike Schwindt: That is what we are budgeting. The numbers we are getting from the first year, it would essentially be the same price total dollar value as we are paying now.

Chairman Pollert: Lori I would like to know the square footage for P&A.

Mike Schwindt: Continued testimony.

Representative Wieland: Under the Century Center, the square foot costs $5 for storage. What do you use the storage space for?

Mike Schwindt: To keep case records. We have 130,000 or so case files we are trying to get rid of. As we work our way through those things and make sure everything is as it should be. We are trying to get those things out of there and shred them. It is literally shelve and shelves.

Representative Wieland: Is that a secured area?

Mike Schwindt: Yes. Continued testimony.

Representative Ekstrom: I'm business manager for a small business. We have had some turnover of people and brought some new hires in. Now we have those forms that go back out that say these are the new hires. It is supposed to cross match with child support. Where does that occur in your budget?

Mike Schwindt: That is part of the data processing match. We are trying to find people and assets. Continued testimony.

Representative Wieland: How would you perceive that study would be made. By a consultant or exactly how is It going to be done?

Mike Schwindt: Several years ago I talked to a couple of consulting firms that are more than willing to do it. Their price was considerably higher. We are going to be looking for somebody that has the skills. It could be a CPA in town that can help us or some sort of management consulting that can do that. We are going to be looking to get a much better grip on the front end between now and the end of the year and then doing a report on where we are going.

Representative Wieland: About how many people are involved? People that owe? Do you have any idea of the numbers?

Mike Schwindt: The last time we looked was a couple years ago and it was 23,000.

Representative Ekstrom: How does this $280 million give or take relate to states like SD or MT? The states to the west and south of us? In terms of another state that is similar to us in size and ethnic makeup.

Mike Schwindt: The last time we compared these numbers to SD we were running about 6-7 million ahead of them. We are unique that we have all child support payments coming through us. The thing you have to keep in mind when comparing us to other states is that half the states charge interest and half do not. We charge interest. Interest alone adds to about $275,000 in outstanding receivables each month. Continued testimony.

Representative Wieland: I was just going to ask about those two items. Do you do any billing back for those items or does the state pay all of it?

Mike Schwindt: The state pays all of it. You could bill it back. There is a fee associated with genetic testing. We pay the fee to the Sheriff's. Those are not billed back.

Representative Kerzman: A few sessions ago we did some work with establish paternity at the hospitals at the time of birth.

Mike Schwindt: That is one of the most useful tools we have for getting paternity in place. About 80% of our births out of wedlock are assessed because of that. You don't have to have a lot of fussing. People acknowledge their paternity. The hospitals have been most cooperative. That is a very effective tool.

Representative Kerzman: Another question I have is going back to receivables. Do they allow you to, like most business write off bad debt, can you do that?

Mike Schwindt: The court order is a court order. It does not go away unless someone does something with it. We can't do it. They are uncollectable.

Representative Kerzman: How about working with the courts to get some of the adjustments. Do you do any of that work? Do you make an assessment on how much an individual is able to pay? Every once in awhile I hear people say that child support has strapped them and they can't do anything.

Mike Schwindt: Again the amount a person owes for child support is set up in our rules, guidelines, calculation that comes into play. That is a big part of what those attorney's do. They take those calculations into court. The parents can't say that this is a fair amount. The court makes a decision on what is fair and puts it into court order. It is also included in the guidelines about 18 different deviations. If you look at the original chart for what a parent owes for a child under certain income, essentially that hasn't changed. We put a few more deviations in place and extended that out. Those reviews happen every 4 years. They involve the guidelines community. We hear the same thing from time to time but that is what the deviations are for.

Representative Metcalf: Suppose an employee or working would have an accident and two legs are cut off and they are unemployable. If he owes $1,000 in child support, is that continued on? Does he owe this? What do we do in cases like that?

Mike Schwindt: That is what is called circumstances. Until that court order is changed we are stuck with that. The best person to do that would be the person involved. If we know about it, we can accommodate that. If we don't know about that we go along in a happy little world thinking everything is fine then reality sets in.

Representative Metcalf: How long would this process take to get back to normal? This isn't his first concern considering he just got his legs chopped off. Will it take another 6 months or year to get him off child support?

Mike Schwindt: The judges have flexibility to that. They want to change that even before the stuff is worked out through the paperwork process. They can still make it effective at time of filing. Continued testimony.

Representative Metcalf: I see you have an attorney bar license. Do you pay the total license for the attorney involved?

Mike Schwindt: Yes they are working exclusively for us.

Representative Metcalf: How about an individual who has occasional work with you?

Mike Schwindt: No we wouldn't, only the ones who work exclusively for us. Continued testimony.

Representative Ekstrom: I didn't hear a lot of heartburn from the folks of Cass as they transitioned from county to state. I'd be curious to know if you experience a lot of loss of personnel to those who found the transition troublesome to the point of where they wanted to leave state service.

Mike Schwindt: Of all the people that have left, the best that I could concentrate on would be the regional administrators. Three of the 8 left. The gentleman in Minot and Devils Lake and Jamestown retired. They were ready for retirement. I told them if they had something they had to do to do it for the right reason. That was essentially it. Past that I know of no one else that

left outside of the normal course of people coming and going in the program. We have turnover but there is 172 people so you are going to have turnover.

Representative Bellew: Did you hire any of the retired people yourself? Are there some double dippers in there?

Mike Schwindt: Nope.

Representative Bellew: The case I'm thinking of is the states attorney in Minot who just retired from the county and got hired by the city of Minot full time. He is getting a pension from the county and a salary from the city of Minot. The other question I have is on the county foster care reimbursement to counties. That is the amount of money that child support used to pay counties. There were no federal dollars or any money like that.

Mike Schwindt: What it is, is the child support that has been there. When someone goes on foster care the amount that is due for child support is assigned to the state. As we go through the normal collection process we get the money and then figure out what has to happen to it. It was never used to send back to the counties. Instead it was used as a deduct on the revenue line. If you had $20 million for foster care and we are collecting $1 million of collections from child support that would be taken off the top of the money. That would be split between the state, county, and federal government.

Representative Ekstrom: The $25 fee per year for the obliges, that wasn't charged by the counties?

Mike Schwindt: We just started that. That $9.1 million is what we projected to the counties in terms of net savings. The green sheet is kind of a crib sheet for your use. Continued testimony.

Carol Olson: I would like to make a comment of the transition that occurred with moving the regional office into the state. As you well know those were county employees. When you make a transition like this it is a big deal. There was a lot of concern and nervousness amongst the

county staff about what is going to happen now. There always was some tension between county and state. With the help of Mike and his staff, we took a team out to each regional office that included Mike, Tove Mandigo, and myself. We met with all the regions and county staff. We took HR and immediately went out and met with all the staff to address their concern and answer their questions. We had follow up meetings with human resources because there is a transition that occurs with the annual leave, sick leave, and everything else that goes along with the HR. I just wanted to mention that. With the work of the whole department and fiscal as well, because of all the funding and book keeping that occur it was a transition that went very smooth because of the communication and outreach from the central office. Your question about whether there was a lot of people who resigned, one of the reasons we didn't lose employees was because of the way it was handled. A lot of these things don't get mentioned but I know it really helped in moving the county staff into being state employees. It took away the fear that they had with this kind of a change in their lives. Some of them had been there 10, 15, 20 years and now they are state employees. The whole department pitched in on that one.

Representative Bellew: Back to the fiscal note, your budget was $4 million less.

Mike Schwindt: We are trying to do the best we can with the taxpayers and take our best guess in fiscal notes. If I can add a bit to what Carol said. I was here when the department was created back in 1981. There was a lot of fussing going on. We didn't have it because of the leadership we got from the executive office. We had a couple people who didn't get the right paycheck for the first time but they all got the paycheck. One other thing I'd like to brag about is in 2000 we had 154 effective FTE's that means people actually working. We always have vacancies so we try to take out of the equation. We collected on average $287,398 for each one of those FTE's. In 2008 we had 155.6 FTE's and collected $530,387 per FTE. That is an

85% increase in that short of a period of time with essentially the same staff. There is a lot of good work being done there.

Representative Nelson: I'd like to commend the administration when there was an issue in the interim with the Devils Lake Region. I can personally tell you that it was handled very speedy and I was very impressed.

Representative Bellew: Any more questions? If not we will be in recess until Monday morning.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/19/09

Recorder Job Number: 7247

Committee Clerk Signature Meghan Pennell

Minutes:

Chairman Pollert: We will continue on our detailing. We will start with Medical Services today. Before we get started with Medical Service I know there have been some questions with the FMAP, 4.9 5% increase with the economic stimulus package. What does the 1% increase in the FMAP amount to general funds and what does the 4.5%. I know it hasn't been acted on but there have been a lot of people asking me that this morning. We will probably need that.

Deb McDermott: We were working on what that 1% would be as far as the Governor's budget. We will try to put together what that stimulus package too.

Maggie Anderson: Testimony handout (Attachment A). The first thing we have is the organizational chart. If you want to go way over to the left hand side we have three general areas within the division, long term care, services, budget and operations and program and policy. She went over the names and duties on the first page of attachment A. 2:40-25:50

Chairman Pollert: So the SCHIP rates don't matter if it's at $150 or $250 net because you are going to spend the same amount of money because you just keep advertising for it?

Maggie Anderson: We would not see that contract as contingent on a net dollar amount for the income eligibility guidelines that the effort would be the same. We would have the same type of requirements and criteria for the vendor to hit those target times a year where it is really

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important to reach parents about coverage for children. It is possible that we may ask them to tweak an activity or two if the eligibility goes to 200 and it is effective July 1. We may want them to do something specific to target that increase and get the new message out. We wouldn't see that dollar amount contingent on what level the SCHIP is at.

Chairman Pollert: You realize that you will probably going to the policy Human Services committee to explain the one stop call centers and the funeral set aside and SCHIP? Were you aware of that?

Maggie Anderson: I wasn't but I'm sure with the other areas that affect Medicaid and with the appropriate staff we will do that.

Chairman Pollert: Those motions were done in the full appropriations committee this morning. It wasn't only the DHS budget there were quite a few of them. We think that is quite a policy change and we think it should be heard in the policy committees as well as when it comes into here.

Maggie Anderson: Continued testimony.

Chairman Pollert: To refresh my memory do we have any say as far as what the Medicare claw back is?

Maggie Anderson: Correct.

Representative Bellew: I know you probably explained this before but why is this all general fund dollars?

Maggie Anderson: The reason it is all general fund dollars is because when the Federal Government took over providing prescription drug coverage to the dual eligible's this is really a portion of the dual eligibles. Those individuals who are Medicare and Medicaid only took that coverage over in January of 2006. Prior to that time those individuals would have been receiving their drug coverage through the Medicaid program because Medicare didn't cover

prescription drugs. At the time where they were covered through the Medicaid program a portion of that was paid by the federal government and a portion through FMAP. The federal government is now saying that we are covering that federal portion but we are still requiring the states to participate through this claw back or phase down contribution. It's supposed to reflect what the state's share would have been. They inflated this year with the health expenditures . They decrease it 1 2/3% each year to a point where we will be at 75% of what we should have been. It started at 90% of what we should have been but decreasing each year by 1 and 2/3. At the same time it is inflating by inflation. When we hit the 75% we will be exposed to the inflation and we will likely see it go up. That is why it is all general funds. They see it as our responsibility.

Representative Bellew: Do you have estimated numbers of the number of people that this covers?

Maggie Anderson: Yes. We are estimated 9.450 individuals a month and the monthly amount is $85.61.

Representative Bellew: That is the Medicaid and Medicare eligible clients?

Maggie Anderson: Yes that is the estimate of those dual eligibles.

Chairman Pollert: I made a copy of all the information that was provided to us last session.

Maggie Anderson: We do have the one for traditional Medicaid ready for you today if we get to that. We will have the long term care and DD one as well.

Representative Kreidt: The dual eligible's, now they qualify for part D now right, the prescription drugs?

Maggie Anderson: That is correct. This represents what they think our share of pay should be. Continued testimony.

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Representative Wieland: Do you have 1 person at Prairie Hills Plaza and one at South Central? One person for an office is not a lot. How many square feet do they have?

Maggie Anderson: At Prairie Hills Plaza, that person has the same size office as the other places. That is also where the staff for Aging Services, DD, and for VR are located. All of those areas are located. It just so happens that they have one person who is located there because it makes sense for them to be close to the DD staff.

Representative Wieland: So there are other people in the office that is just your share?

Maggie Anderson: Correct. Continued testimony 35:49-36:43

Chairman Pollert: Just to remind myself from last week. Fringe benefits were the health insurance increase, the salary increases, the 5&5, and the benefit increase is like FICA taxes?

Brenda Weisz: Your fringe benefits were the insurance. Your salary was the 5&5. The benefit increase was retirement and FICA.

Maggie Anderson: Continued testimony.

Chairman Pollert: You are saying that you need an increase in the FTE's if we go to 200% net? What would be the difference between the 150 and 200? I'm not talking the dollar amount. Is the workload that much different?

Maggie Anderson: Between 150-200 we estimated 1,158 children would come on the program. We further estimated that the majority of those applications would come to our office instead of the County office. Currently if families apply for benefits they may also apply for food stamps or the nutrition program. As you move up to 200% of poverty we believe that there are fewer families that would also be applying for those benefits. We estimated that a greater proportion of those applications would come to the central office. When we went to 150 we estimated an additional 800 children in the first year of the program. Our staff who were processing applications in our office are quite busy at the volume that they were at before. We

expected that we may need additional help for that. Rather than look at another FTE we decided to handle that with overtime and see what happened with the future. That's how we built the 09-11 budget because we had built some overtime in. When we built the budget going to 200% of poverty we knew that we would need additional staff for that, the dollars that were involved for that staffing were actually offset to what we had already built into that overtime line for 09-11.

Representative Bellew: You did ask the Department for a 160-175%.

Chairman Pollert: I did and I have a feeling that we will get those figures. I will ask for it here. The bill is going to come back to here anyways.

Maggie Anderson: We do have that prepared for you if we get to that point. Continued testimony.

Representative Bellew: Can you explain the Medicaid Autism Waiver? You are requesting an additional 1 FTE for that.

Maggie Anderson: The Medicaid autism waiver would serve children 0-5 who are diagnosed with autism spectrum disorder. It would provide an array of services. This came out of our stakeholder meetings where people identified this as a need for services. We did prepare a workgroup to look at this and develop services that would be offered for individuals who had an autism disorder. Then we would write a Medicaid waiver for that to allow those children to receive the necessary services. If you want a lot more detail in terms of the services we certainly can give you that.

JoeAnne Hoesel: This waiver is planned to be provided in the same process as the current self directed supports waiver is provider. The intent of a self directed supports waiver is to put the controls to identify what is needed for a family with a child that has a disorder on the autism spectrum because there is a wide variety that fall into that category. Of what we need to help

that child be as independent as possibly and participate in activities in school and community as would other children their age. We have designed this waiver to have three levels of service. This is also a unique waiver in that it would not require a child to have a developmental disability or as well, our current DD waiver requires that. The advantage of approaching that in this respect is because of the age it is not always known. Secondly, this will really reach the child population we are wanting to reach with this kind of waiver. There are three levels involved with the functioning of the child and the family would be identifying the continuum of services within each level. It can range from having supervision and someone coming to the home and providing on sight work and helping the child through cuing and the environment they are living in. It also ranges from speech therapists to physical therapists to a whole list of other professionals depending on the child. This waiver would look at serving 30 individuals. We made our best guesstimate based on our early intervention program and infant development program and the children that would most likely fall into that category.

Chairman Pollert: When you say a waiver, what do you mean by a waiver?

JoeAnne Hoesel: A Medicaid waiver is the permission that is granted from the centers from Medicare and Medicaid services to pay for things that they would not normally pay through the traditional Medicaid program. They are waiving the normal rules and allowing us to do something differently. Every time a state wants to move forward and pay for something that a CMS would not normally pay for through their state plan and state plan amendment we have to write a waiver.

Chairman Pollert: Could it be said that you would be giving away oversight or regulation for something like that. You are just trying to enhance the services for a group of people without having to go through federal government oversight.

JoeAnne Hoesel: It has actually come to the point where that happens. It is actually just a different set of rules that CMS uses. I would not want to give you the impression that there is less oversight because that is not the case. In the early days when waivers were available I'm told that it was a very short application and not a lot of oversight. I would have to tell you that since we have just written our waiver renewals for the DD program that were submitted January 1. That is what we consider our traditional waiver.

Chairman Pollert: Do waivers take a long time to get approved?

JoeAnne Hoesel: They have 90 days on the clock that they are supposed to provide us information. There are certain activities or if they have asked for a lot of information the clock stops. Generally 90 days to provide state information and a decision on that.

Chairman Pollert: Is the Medicaid Autism waiver going to be put in place? Has that been applied for now or will it be applied for July 1 of 2009 and the budgets, will it hopefully be in effect 3-6 months later.

JoeAnne Hoesel: If this would be approved through the legislative body we would anticipate that this would go into effect in 2010. It would take us a year to determine and talk with our stakeholders to determine the details and also apply for the waiver and receive comments from CMS and work through that process.

Chairman Pollert: You are guess is 30 individuals?

JoeAnne Hoesel: Yes. These are individuals that would not normally be served in our traditional DD waiver. That is really what we are attempting to achieve with this waiver to not only provide the services but also provide specialized services for this group of children that are very challenging, not only for families but for the systems that they touch. Minot State received a federal grant for school aged children that have autism spectrum disorders. We have been working with them and it will work nicely. It's Minot State and Ann Carlson Center

that are working on that one. This would be 0-5. They would also meet the criteria for the school aged one through that federal grant then they can continue to have services. Our plan is to work over the next two years to identify what we do with the transition age and also the adult population.

Chairman Pollert: So is every waiver an opportunity to enhance services to a special group of people. Is that an idea of any kind of waiver?

JoeAnne Hoesel: It tends to be. While there are exceptions, they do need to be cost neutral. You are really taking the same pot of money, unless it's a new service and you are doing it differently. You are receiving the ability and authority from CMS to use that same funding in a way that has been shown to be more effective than traditional services. CMS is very traditional medical model of what we would call that. They tend to be very comfortable paying for institutional care and hospital care. We are saying that we don't need to have those individuals receive services in an institution or in a hospital. We can serve them in our community. It is better for them. They often have better ability to transition because they are in the community with family and friends and their support systems. In order for us to use the money to do that we have to get permission to do that, and to get that permission we have to jump through the hoops and get that waiver approved through CMS.

Representative Nelson: What is the age spectrum in Medicaid Autism Waiver program?

JoeAnne Hoesel: It is 0-5 and they would be eligible for up to 3 years within that. A parent could choose when they would like that. It depends on the tests and how the child is doing. They may choose to do that at birth or shortly after. They may choose to do that at age 2, prior to the child going into the education system.

Representative Nelson: I'm interested in how they can diagnose autism at age 0?

JoeAnne Hoesel: Often times it connects with our early intervention program. What they look for is developmental delays. If you look at the normal developmental stages that a child goes through, what they do is assess the child. If there are delays in any of those areas then they can identify. What they are trying to do is remediate that soon versus letting it go until it becomes more pronounced and then it is more difficult to turn that around. There is a lot of different opinions about autism. Research continues and the department stays up to track on that. It is a continually changing field with the intent of really helping that child. It's an impact on the brain. What we are attempting to do is help when you can during a period of time that the brain is developing. We want to make an impact and intervene so that changes can happen in the brain and long term delays and developmental problems don't continue.

Representative Nelson: You aren't changing the spectrum of age in the waiver are you? How are you picking up the additional 30 people? Just in testing and developing criteria for the delays? There is no change in age requirements?

JoeAnne Hoesel: We don't have this waiver right now. If these children would show a delay they would have to be served through our traditional waiver or through infant development. Those services are not specific to Autism spectrum. This would take the children that meet that criteria and provide specific specialized services for that condition.

Representative Nelson: So there would be something that would trip a wire that there is a delay prior to this so these 30 individuals then in the autism waiver program should be offset through another program? Would you agree?

JoeAnne Hoesel: I think there is a likelihood that it might happen. I can give you an example. Even in our current mental health system and DD system and also we know we have young adults and adolescents that have autism spectrum disorder. They are served currently in our mental health system in our developmental disability system if they have an intellectual

disability. They are served in the school system. However, the school system only uses individuals who have an autism. It is only one diagnosis. It is very stringent. What we lack in the state overall across the age span is specific specialized services. That is what is frustrating for families and certainly those who work with these children as well. You need to know what you are doing with these individuals so that you have good outcomes. Because the research is new and changing on a daily basis, it's important to target your interventions. That is what this waiver does. It targets what we feel at a point in time when we can have the most impact. These are babies and infants that are developing. If we can get in there early research does say that there is a likelihood of turning it around.

Representative Kreidt: Are there other states that have already put in for these waivers and received them that we can look at and follow?

JoeAnne Hoesel: We did an analysis and we have copies of those waivers from other states. We used that in developing this waiver. There are a number of states that do have these waivers but not all at this age but some do. We have looked at those and certainly can make those available to you as well.

Chairman Pollert: So when you say revenue neutral are you saying that it is a way of providing services to an increased number of clients for the same amount of dollar that we would get from the federal government?

JoeAnne Hoesel: My understanding is that with a new service it would need to be at the average cost that is currently covered in the Medicaid waiver.

Maggie Anderson: Cost neutral waivers mean that in the aggregate the waiver needs to be cost neutral to what the institutional service would cost like our home and community based services waiver. We look at nursing facility costs and say that in the aggregate it is cost neutral to serve individuals in a nursing facility. Each waiver is compared to institutional services and

looked at in the aggregate to ensure that we have cost neutrality. That is an area that CMS requires significant reporting on.

Chairman Pollert: So the cost for the department could go up because of the added case load. The average cost of a nursing facility versus a less restrictive environment would be less. It is kind of a loaded statement.

JoeAnne Hoesel: One requirement for all waivers is that individuals have to be screened to an ICFMR level of care. One could make the case that whether we have this waiver or not, they are going to be functioning at that level that they need assistance. We prefer not to serve them at an institution. We are saying that we think that we can do it better and better for a family with this waiver. They do have to meet the functioning level of an ICFMR just like it has to be a nursing facility ICFMR in this case.

Chairman Pollert: Basically what you are hoping is to serve more clients. You could say that for the same amount of dollars you could serve more clients through a less restrictive setting than through an ICFMR.

JoeAnne Hoesel: Exactly. I would add that we feel more appropriately because that is what the research is saying. It is really bringing the research and the funding mechanism together.

Representative Bellew: If this is a Medicaid waiver why wouldn't this salary be under FMAP?

Maggie Anderson: None of our salaries under Medicaid are under FMAP. We are paid on what is called FFP, federal financial participation. Depending on the area of the administration of the Medicaid program we received different match rates for that. Most of those match rates are 50/50. For example, my salary is actually up against an allegation. For all purposes it is around 50/50. Our medical staff or any of the staff that have operations with MMIS receive 75/25 match. The majority of our staff are at 50/50.

Chairman Pollert: With that we should go on further. Where are we at now?

Maggie Anderson: We have finished salaries and are moving down towards the bottom of the second half of the first page that starts with travel, supplies and so forth. I will point out some of the change where you will see the biggest difference in that total changes column. One you will see where there is a significant increase in travel. This is for a couple of reasons. I spoke to you earlier about the program integrity position. In addition to a position that focuses on those areas CMS is also doing a lot of training in the area of program integrity. They are asking that all of our utilization review staff and our fraud and abuse staff be trained on the specific areas where we can look for and detect the integrity problems within the Medicaid program. In addition to that our money follows the person individual travels around the state significantly going to intermediate care facilities for the mentally retarded, going to nursing facilities, working with county case managers, and so forth. We have a significant increase from in state travel for that. We also have increases in the area of travel for the individual who runs our medically fragile waiver. We also have a responsibility to reach out to families and communities and people who are aware of the necessary referral networks to refer children for that medically fragile waiver. That individual would be traveling which wouldn't have been included in our previous budget. We also have the new MMIS coming up where we will have some commercial off the shelf products. Some of those will require initial and ongoing training in order to make sure that we get the most out of the reports and the data and information available. Finally, the centers for Medicare and Medicaid services are requiring some new federal reporting. Some of that is actually starting in February of this year where they are bringing people in to be trained and that will be ongoing where they are looking at modifying. They are kind of going more granular with some of their federal reports so we can provide some additional detail and we expect there to be additional training and the need to access that training so we can report correctly for them. That is the big picture of where the increases

are. We still have our existing travel in there for program staff to go meetings on Medicaid changes or updates. I go to the state Medicaid director conferences. We have our home and community based services staff who go out to the counties and not only provide training but review and audit the changes for the individuals who are approved for home and community based services. It is all of that type of travel for the FTE in the division.

Representative Wieland: Does the training take place elsewhere than Bismarck?

Maggie Anderson: Yes. Very little of the training that our staff will receive on to how best utilize MMIS will not occur in ND. This is training that our stall will receive to be better at their jobs and be better at mining the data and using the information in the MMIS system. The training that we will do to provide is not specifically included in that in the new MMIS. There will be some of that in our budget as we go out to train county staff and to train providers. That is not a significant share of the increase but it is a portion of the budget. That training won't necessarily be in Bismarck either. We plan to go around the state and do training on MMIS and try to get as close to the provider groups as we can to do that training. We are going to use technology as much as we can to do that. We know we will be going around the state to do that. Another area where we have increases is the supplies IT software. A significant portion of that increase is the ink cartridges that are needed for the printers. They are a necessary for the processing of claims and printing materials. Miscellaneous supplies, a significant portion is related to the 1.5 FTE with the health steps position and the supplies and the equipment that would be needed for that person. The original IT hookup and the computer, office equipment, and those kinds of things. It is located there right now in the miscellaneous supplies.

Chairman Pollert: When you look over the previous biennium and you look at year one where you are at and ask yourself that you need that many supplies for 1.5 FTE's.

Maggie Anderson: Where it is located, once those positions were filled those dollars would move to the appropriate area to locate that large sum of computers, the IT hookups, a desk, a chair, and all of those things that you need to purchase for an individual when you hire a new position. Those items aren't currently available. It is almost difficult to compare it to our current expenditures without that added amount for the new position. We probably would be very much in line with what our current budget is. The other major increase that you are seeing on here is for rent and that is the result of two things. The eligibility policy staff who are over at Northbrook. They were not budgeted at Northbrook in the 07-09 biennium. That increase needs to be included in here, and the individual who is at southcentral was not budgeted. That increase is reflected here as well.

Representative Bellew: Every other department has had a huge increase in printing because they said Office of Management and Budget has raised their rates by 9&9. Yours is $11,0000 less?

Maggie Anderson: We budget that based on what we are currently using. We are fortunate that our printing was lower in the first year. When we took a look at that we budgeted based on that. We are spending more on the cartridges than on the printing. There are other miscellaneous changes and I would be happy to explain those. Then you will see down at the bottom that little increase you talked about with the claw back and how all that ties together. Where I covered the $23.1 million in operating fees and services in that detail that I broke out. Otherwise we would have had a $327,000 shift in operating expenses and the operating budget adjustment of the $241,318 was specifically related to the claw back in the executive budget recommendation. That ties out the first page. Then we have the totals of the operating. We will get into the grant funds on the next page. We will be able to come back to this and tie out to the total grant funds on this chart. One of the things that we provided to you when we

were doing our long term care testimony was a chart that looked like this but was legal size. Now we provided to you the same chart for the traditional Medicaid services. I won't walk through all of these services with you but I will just walk through the nature of the table. The first column on the left is an actual service. We have those listed in the top ten order which is the same order we show on attachment G to your testimony. That is the color sheet.

Chairman Pollert: Are you getting to the point where you are going to start on this? I would like us to go into depth with how you come up with the rebasing figures for physicians, the inpatient hospital, and the out. We will spend quite a bit of time on that. I hope we ask questions.

Maggie Anderson: Yes. The first column is the services. The second column is the 2007-2009 appropriation. I should point out that three lines from the bottom you will always find healthy steps on a separate line outside of the Medicaid services. Again, that is because it's not a Medicaid services. It is its own program under a different title under the social security act so we break that out separately. The next column over are the cost changes that were considered as we built the budget. The next column is the case load or utilization changes. Then FMAP changes. The rebased services which is the amount for the rebasing. Then the inflation of 7&7 or for some of the rebased services. The amount needed for medically needy and the amount added for immunizations for children and healthy steps at 200. Finally the total changes for the 09-11 budget were added to the house. Very simply walking through for example, which physician services the third line down our current appropriation is $64.1 million. Our cost changes were $4.7 million. Our case load changes were $10.1.

Chairman Pollert: What are you saying then when I look at hospital, drugs, and physician services. You show the case load utilization dropping. Are the amounts of visits dropping?

Maggie Anderson: The data that we used as we prepared the budget was indicating that we were having fewer people receiving services for those area that we were seeing negative. Some of the physician services you might recall from my overview where we are clarifying some of those services that were previously reported under physician services. An example of that would be if you would go down to ND health tracks EPSDT screenings. You will see that we had a $2.8 million case load cost change. That is one area where we are clarifying that service and getting those codes that are used for EPSDT into the correct category. A portion of that case load cost change for physician services is really reflected at an increase down in health tracks. Another example of that would be psychological services which is about 5 down from health tracks. Overall, yes that is what those numbers are saying is that more people are receiving fewer services.

Representative Bellew: In the past we got how you actually build your budget or how you came up with a final dollar amount. The example that you projected would be 2,000 visits to a physician at an average cost of $22. Then you add in your rebasing.

Maggie Anderson: That is the chart we referenced earlier. We will use that.

Representative Nelson: Would you go through the Physicians services column? How did you arrive at that? Would you go across all those areas and give me your equation. Whether it is utilization or the next column over. Let's start with cost changes.

Chairman Pollert: The way you did the rebasing or the increases was different for physician services versus how you did it for hospitals. As far as the numbers you expected.

Maggie Anderson: Each of those services areas has a different way to go about establishing costs and looking at that so we can get through that. Handout B.

Chairman Pollert: Could you go through how you got to that number?

Maggie Anderson: When we built the appropriation for physician services it was built at $12.89 for 07-09. When we started building the budget. Our state fiscal year 08 average cost per unit was $14.96. That is where our average was at that time. We would look at where that trend was going. IN addition to that we applied a 5% increase. We had to take into account some of the shifting that was happening. That is how we got from the $12.89.

Chairman Pollert: So the $14.96 adds about 75 cents so it's like $15.75. That doesn't get us to $17.61. That little extra number comes from?

Maggie Anderson: That also includes the rebasing and 7& 7 of that number.

Representative Bellew: The sheet we received last year said the average case load was about $120,000. Is that a different sheet?

Maggie Anderson: Is it different from the sheet that we provided?

Chairman Pollert: When I look at what we had last session, you gave us different types of forms next biennium.

Maggie Anderson: We are going to provide those to you in the morning. We didn't think we would get to them this afternoon. I can wait with some of this for tomorrow morning. If I'm correct we use that . Handout testimony (Attachment C).

Representative Wieland: When they talk about the rebasing on the physician where does that 25% come from? Will that be explained in here?

Maggie Anderson: If you would pull out the sheet that Brenda provided to you last week it shows it. It was colored. If I could first go through the top sheet this was something that you requested in terms of what percentage each of the rebasing items reflect. If you look at the 07-09 appropriation total for hospitals its $156.7 million. The rebasing for year 1 only is a 14.05% increase.

Chairman Pollert: Is it easy to explain why chiropractors and ambulances would be drastically higher for the percent changes compared to hospitals, physicians, and dental?

Maggie Anderson: Each of the provider types has different reimbursement methodology. We certainly had to go about collecting cost information and preparing the information that the vendor needed to use to look at that information and make the assessments for what it would look at to pay at cost in very different ways. Cost reporting and collection of data is very standard for hospitals. They have a Medicare cost report that they have to file every year. It's used for data collection purposes and comparison purposes. It's not a very difficult thing for the hospitals to release that report from the vendor to use. From the other areas, the cost recording doesn't exist. Each of the vendors in these areas had to come up with a methodology to actually collect that. As they did that, for example with physicians we did not go out to every physician or every physician practice in ND to collect cost information. We worked with the medical association and some of the larger facility or physician group practices. They had some experience using some regional and national data that is collected from those entities. Using that data to estimate where ND stands in terms of how close we are to cost. We talked about the dental services where the instrument was very difficult for the dentists to complete. In return we had very low response rate to that. So we looked at the percent of bill charges approach.

Chairman Pollert: Aren't the dentists figured on 75% of bill charges?

Maggie Anderson: On setting the fee schedule at an average of 75% of bill charges.

Chairman Pollert: So would you have used that as a base?

Maggie Anderson: The OAR that we submitted was for 60%. It was funded at 75% in the Governor's budget. We were unable to complete the report because of the sample. That is yet another way of looking at how this information was collected. The ambulance service, the

vendor that we hired actually has extensive experience with the ambulance service and actually owns/runs an ambulance service in another state but dose consulting with this type of information on the side. We were very fortunate that they understood the record keeping and the business of ambulance services and they recognized that in small rural states you have a real discrepancy between your large metro type services and your small rural primarily volunteer in trying to establish costs of doing business with those is not always easy. They took this on as a challenge too. They would like to market the methodology to other states to look at. With the ambulance services, they developed an amount at cost. Then they also provided for the department as part of their reporting mechanism and what it would cost to go to Medicare. It wasn't something that was requested but it was part of their report. That information was requested of us during the budget process and we provided both of the costs.

Chairman Pollert: So for ambulances you came up with an average between what bill charges or costs would be and the Medicare rates?

Maggie Anderson: No we didn't do anything with the bill charges. We actually set out to establish the cost, what it would take to rebase ambulance services to cost, and that is the number that is on your OAR sheet. If you look under the category 4 it is the 8th item down. That total at cost would have been $5.4 million of which $2 million would have been general funds. The rebasing total was around $4 million instead of the $5.4. This is your one only.

Chairman Pollert: So the ambulance services off of the study or information that you have would have showed the costs to be at the $5.4 million?

Maggie Anderson: Yes. The rebasing amount for ambulance in the executive budget is $2 million. It is what you see there. Of that $743,710 are general funds. That is in comparison of the $5.4 million in the OAR which would have been at cost. What is in the executive budget

represents rebasing the ambulance fee schedule to the Medicare rates on July 1, 2009. In the second year of the biennium, inflating that forward by 7%.

Chairman Pollert: Ok.

Representative Nelson: To get to the $3.4 then that would include the 7%?

Maggie Anderson: The reason that the OAR is in the shading is that it was funded at a level different than what was at the OAR. It was submitted at the $5.4 total and funded at the $2 million total. In response to your question the 7% of ambulance for the second year is $187,814.

Chairman Pollert: So the total of the ambulances is roughly $2.2 million.

Maggie Anderson: That is correct. Not that you need to do it but in case you want to make notes on page 11 of my overview testimony is where I break out all the rebasing totals as well as what the inflation of what each of those will be. It is also on the detail sheet.

Chairman Pollert: Have we had these figures in another biennium or did we just decide that since we have a $1.2 billion surplus we are going to throw it out there?

Maggie Anderson: No. SB 2012 directed us specifically to collect the information as to what it would cost to rebase these five services. That is why the department went forward and provided this information and included it as an optional adjustment request on our budget.

Chairman Pollert: So then from the study would these have been the numbers or would the numbers have been drastically higher?

Maggie Anderson: The physician number on your OAR sheet you will see the total amount was $53 million. That is what the vendor reported back to the department that it would cost to rebase physician services to cost. As part of the information that Office of Management and Budget gathers from the department in the budget process we were also asked for what it would be at 25, 50, and 75%'s. Looking at all of the state's budget priorities, 25% was

selected. Our OAR was for the $53 million. That was the total that the vendor came back to us. I don't believe our numbers will change regardless of anything other than the vendor's reports to us. The vendor came back and said this is what it is going to cost to rebase ambulances and so forth.

Representative Nelson: Could you get us the number at 50 and 75%?

Maggie Anderson: Yes.

Chairman Pollert: If we wouldn't be doing these dollar figures would you say that our healthcare and everything is going broke?

Maggie Anderson: We certainly have heard from the Medicaid providers that the reimbursement rates are not keeping up with what it is costing them to deliver services . Aside from bill charges we are talking about the true cost of what it is costing them to deliver services. We have heard that in this committee from stakeholders during hearings that the Medicaid rates in many areas are not keeping up with what it is costing the providers to deliver those services. In the Medicaid program we do have a responsibility to assure access to services for our clients.

Chairman Pollert: Any other questions? We will pick up with the remainder of the documents in the morning.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1012 – Medical Service detail

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/20/09

Recorder Job Number: 7331

Committee Clerk Signature Morgan Pettit

Minutes:

Chairman Pollert: Called the meeting to order and took roll call. We will continue our discussion on medical services.

Maggie Anderson: If we could go to that packet of information from yesterday and walk through the ambulance and the dental pieces of that. Then I will let you decide on how you want to do the SCHIP. You had asked for the 165/175/185 scenarios. Now it has been assigned its own bill number so I'll let you decide how you want to proceed with that.

Chairman Pollert: I'm wondering because we are going to have to have the discussion later instead of now. I would say we wouldn't have the discussion now. I would say that we won't have the discussion but you will need the information for Chairman Weisz's committee. The one question I have is that the authorization of SCHIP doesn't happen and we go to 200% then general funds will have to cover it. Aren't they trying to fund that with a 61 cent cigarette tax?

Maggie Anderson: That is one of the versions of the SCHIP bill is to fund the reauthorization of the program with a tobacco tax.

Chairman Pollert: But that hasn't officially happened yet?

Maggie Anderson: No it has not. It passed the house and it passed the Senate finance committee. At this time yesterday I didn't know when the vote would happen.

Chairman Pollert: We will skip that part of the discussion until the bill comes in from the house human services policy.

Maggie Anderson: We also covered the increases as a result of the rebasing which was the first document of the packet I handed out yesterday. The next document in there was the ambulance code comparison that was requested. You asked for a comparison of the bill to pay and what that percentage is by ambulance code so we had provided that to you. This is using paid dates of calendar year of 2008. It is very up to date information. You can see by code we have ground mileage codes, ALS, we have BLS which is basic life support, and then to the rotary and fixed wing transport codes and then the mileage that corresponds to those rotary and wing codes, and finally the ambulance response and treatment where they respond to the scene and treat the individual there for what is needed but they don't end up transporting them back to a hospital. Those are the various codes that are based on the current fee schedule and calendar year 2008 dates of service. If you think about the fee schedule being increased for dates of service you will have a mixture of payments in here that some included the 5 and some included the additional money that was provided last year in SB 2012 plus the 4%. The footnote at the bottom provides the information on the additional money that was provided in the department's appropriation bill last year, specifically for ambulance services. That is the information that was requested on the comparison of ambulance rates.

Representative Metcalf: If we make that increase of payments for the ambulances are they going to increase the amount billed?

Maggie Anderson: We would have no reason to believe they would increase the amount billed. The amount billed is what they need in order to operate the business. It is their salaries and overhead, and the deprecation of their equipment. While salaries may increase for people, we wouldn't expect them to arbitrarily increase their amount billed. They are to bill Medicaid

their usual charge. If they would charge a non-insured individual $1,000 to transport from my residence to the hospital and they would need to charge Medicaid the same amount.

Chairman Pollert: So you are saying that ambulance services could not charge a higher rate because they have to have a nursing homes equalization of rates?

Maggie Anderson: We do not have equalization of rates. That is unique to nursing homes. What I'm talking about is usual and customary charges which is very different from the nursing home equalized rates. It means that you can't charge Medicaid more than they charge other payers. It is generally not an issue at all with your medical services. Sometimes it enters in with your home and community based services where we have to be more diligent with the usual and customary. What I'm saying is that they would have no reason to increase their billed charges because we aren't paying them a percentage of billed charges. What is funded in the Governor's budget is to pay to rebase their fee schedule to the Medicare rates. Let's say we would increase their bill charges to 10%. It is not going to affect what we pay them for the Medicaid program for reimbursement. We will still reimburse them off the new fee schedule that is rebased to Medicare then inflated by 7% in the second year of the biennium.

Chairman Pollert: So ambulances will be paid at the Medicare rate and the 7% inflationary for the second year?

Maggie Anderson: The fee schedule will be reimbursed to Medicare July 1, 2009 and will be inflated July 1, 2010. After July 1, 2009 it is not every year going to be rebased to Medicare.

Chairman Pollert: So two years from now unless we do something different, the 2009 rates will be in effect and we will look at inflationary unless something happens and we want to go to 2011 rates?

Maggie Anderson: When we inflate the rates by 7% on July 1, 2010 then those would be what the fee schedule would be for ambulance until additional changes are made by the legislator.

Chairman Pollert: I don't want to get into the funeral rate increases. There they can. I remember asking if they would be lowering the rates of a funeral to the private payers. Their answer was no. I know it's a different subject. We will get on that subject when we do get the bill from the policy committee.

Representative Kreidt: We are rebasing on the Medicare rate. Now ambulances are also for people on Medicaid assistance for the rate. Do you have a rate for ambulances that they are reimbursed on? If you do, why are we using Medicare rate for the rebasing?

Maggie Anderson: I'm not sure I understand the question but I'll try. The vendor who is hired to do the cost rebasing study did provide a number that was in our optional adjustment request that would have rebased the ambulance fee schedule to cost. As an alternative to that, the Governor funded an increase to go to the Medicare rates. Right now we have a Medicaid fee schedule in which this is based off of. We are going to take that fee schedule and increase it to the Medicare rates effective July 1, 2009. If you have an individual that is both Medicare and Medicaid, the chances of us paying on those claims would be very little. We usually process for coinsurance and deductible so we may pay up to the coinsurance. We wouldn't pay any additional. We currently have a Medicaid fee schedule and we are going to rebase it to Medicare July 1.

Representative Kreidt: There would be a difference between the two rates. Medicare is usually higher than the Medicaid rate. The ambulances are receiving the advantage I think. In nursing homes when we rebase we don't use the Medicare rate to rebase. We use the cost.

Maggie Anderson: Rebasing the ambulances to Medicare than to cost is a lower dollar figure. In the optional adjustment request, the amount for the ambulances to rebase to costs was $5.4 million in total funds and to rebase to Medicare was a little over $2 million. It is less expensive.

Chairman Pollert: Say we want to give them more money. Then we want to give them less money. Do you increase the inflator to 10% or do you decrease to 5%, or do you just whack money or add money to the top? It's easy to explain we are going to Medicare. As a committee and section we have a discussion to decide whether that is appropriate, if we should go higher or if we should go lower.

Maggie Anderson: When we wrote the request for proposal for all of the rebasing studies, we required the vendor to provide us excel spreadsheets that would allow us to do what if scenarios. What if someone wanted to fund this at 90%? What if someone wanted to fund the Medicare at 90%? We would go back and work with our vendors and our spreadsheets and be able to do that. If it was the committee's desire to look at the 100% of costs for the ambulance providers but you didn't want to quite go to 100% of costs and wanted to do 80% of costs, we would work with the vendor that we have for that project and prepare a what if scenario at 80%.

Chairman Pollert: So the current rate for ambulances is roughly at what percent of Medicare?

Maggie Anderson: I don't have that number on me but we could provide that.

Chairman Pollert: Could you get me that number?

Maggie Anderson: Yes.

Representative Nelson: In the ambulance division there is a number of codes in your handout. As I understand this, in your rebasing formula you are bringing every one of these codes up to Medicare rate?

Maggie Anderson: That is correct. A couple of those codes are technically over the Medicaid rate as of now. For example the fixed wing air mileage is over the Medicare rate. The rest of them would be brought up to Medicare that is correct.

Representative Nelson: From a practical standpoint are you dropping the fixed wing air mileage down to Medicare or leaving it where it is at? There are obviously some discrepancies. If I had a helicopter I would be happy about the way you rebased. If I had some other areas like ground mileage, they don't seem to be doing as well.

Maggie Anderson: Just for example, the ground mileage would see an increase going to the Medicare rates with the exception of the fixed wing. That mileage there is a bit higher than Medicare. The estimated difference was about $20,000 a year with mileage for the fixed wing only. The rest would be all increases. I don't think that the ambulance providers would be concerned about the ground mileage.

Representative Nelson: I just want a yes or no. Is it possible to rebase this and weight one area as more important than others? If this committee thought there were areas of ambulance services that needed more help than others we could change that rebasing formula?

Maggie Anderson: I hate to answer just yes because it will be misleading. You can rebase and do whatever you want with those numbers and allocate those numbers. You did that in SB 2012 last time. You gave us a certain amount of money and told us to work with the ambulance association and allocate that money where it was most needed. You can see from my footnote that we did that. They told us to put it to the ground mileage rates, put it to the BLS non-emergency transport and put it to the BLS non-emergency transport. That is where we put the extra allocation before the 4&5. Can you rebase and then reallocate? No. That is kind of mixing two concepts. Can you put a certain dollar amount towards increasing ambulance services and direct us how you would like us to allocate that? Yes you can.

Chairman Pollert: So we don't have to have this discussion is it the same with the Chiropractor's? Is it based on 100% of the Medicare?

Maggie Anderson: The chiropractor's amount is based on 100% of costs based on the rebasing study.

Chairman Pollert: So that would be similar to how we are looking at doing ambulances at 100% of the Medicare rate.

Maggie Anderson: It has nothing to do with Medicare.

Chairman Pollert: So the chiropractors are different than the ambulances?

Maggie Anderson: The chiropractors were funded in the executive budget at 100% of cost rebasing.

Chairman Pollert: So chiropractors were based on costs submitted by?

Maggie Anderson: The vendor who we hired which was a public consulting group. They worked with them to collect information and provided it to us based on the calculation is how we came up with the amount that was in the OAR. That was funded in the executive budget at 100% of costs.

Chairman Pollert: Dentists are at 75% of bill charges.

Maggie Anderson: Yes. That is your next handout. This is increasing the dental fee schedule on July 1, 2009 to the average of 75% of bill charges. Not every dentist will be reimbursed 75% of their own bill charges. We take the average; establish the fee schedule and that is what people would be paid. Then in addition to the executive budget there is a 7% inflation on dental services for each year of the biennium. The first line of the next spreadsheet that you have shows what is in the executive budget comparing the 07-09 appropriation to cost and case load changes that we had in preparing the budget? The rebasing of the dental fee schedule to the average of 75% bill charges which was $2.4 million to increase the schedule to 75%. The 7&7 inflation was $1.7 on top of that rebasing for a total of $18.1 million for dental. You asked us to compare that to what it would be without the rebasing to 75%. Again, you have the same

numbers in the first two columns, and no number in the third column. The inflation would just be on the base budget rather than on the budget of rebasing for dental to a total of $15.4 million. The difference in total dollars is $2.7 million should you want to look at the removing of the rebasing.

Chairman Pollert: So is it 75% of bill charges as of what day?

Maggie Anderson: I believe it was HB 1246. That bill started out at 85% and was reduced to 75%. Then it was averted from 75 to 85 for children and adults. In the end it was not a percentage but a dollar amount that was provided and we were to add on to the children's fee schedule which we did. We worked with Mr. Cichy and members to allocate those dollars. There was no funding at a certain percentage?

Chairman Pollert: There is no law in the books against 75% bill charges?

Maggie Anderson: Correct

Chairman Pollert: It is a base that we talk about for discussion purposes?

Maggie Anderson: There have been bills that have gone through the legislator in the past and that was what was funded in the Governor's budget was the 75%.

Chairman Pollert: 75% of charges as of what date?

Maggie Anderson: When we prepared the information for the optional adjustment request and then for the funding at the 75% we used dental services paid during state fiscal year 2008. All of the estimates we did were based on what the schedule was at that time and then what the difference would be at that time to rebasing them at 75% of the average.

Chairman Pollert: If I look at the OAR sheet for dental services for the 09-11 biennium, it shows general funds of $214,000. It shows a total of $580,000. Yet we see the requests from the governor's budget coming in at $2.7. That is going in the other opposite way where the OAR is considerably less than what the Governor proposed in his budget.

Maggie Anderson: That is an item that was highlighted at a grayish purple color. Which indicate it was funded at a different level than what was in the OAR. The OAR was based on an average of 60%. The Governor funded the executive budget at 75% of the average.

Representative Wieland: The problem that I have is when I'm reading what the columns stand for and see the numbers, I don't have any relationship as to where the numbers came from and where they were arrived at. I'm having trouble following where the numbers came from. If I understood that I wouldn't have any trouble following the bill charges versus the rebasing.

Chairman Pollert: Our 07-09 appropriation is $13 million. If we 2008. We had to have data that was already completed in order to build the fiscal note.

Chairman Pollert: So if you rebase at 75% of the bill charges that would add $2.4 million.

Representative Wieland: 75% up from what? What was it before?

Maggie Anderson: There is no set percentage right now. Every code is reimbursed based on a fee set by the department.

Chairman Pollert: Could you say you went to the dental association and they went out and got a report that showed what the average bill charges were and that is what you use for state fiscal year 2008?

Maggie Anderson: We have that information in that office. When dentists bill us they bill us their usual and customary bill charges. We were able to bring all that data in and establish an average and take 60% of that and look at what our current fee schedule is. I'm just going to walk you through a code. The first code is periodic oral evaluation. The total amount billed to the department for adults because most of our children's services are already above 75 or close to that. The largest impact is for adult services. The amount billed to the department in state fiscal year 2008 was $175,000 for that service for adults. When we take that number and

average it based on the number of observations which was $5,759. We take that times 75%. We come up with $22.72. When we set a fee schedule for that service at 75% of average bill charges we would be paying $22.70 for a periodic oral evaluation. Our current fee schedule for that service was $17.78 for that service. That increase for that one service per occurrence is $4.94. That one service we are expecting to cost us an additional $28,438 per year. That's how we looked at it. We went by code for everything we pay under dental services and prepared the spread sheets.

Representative Wieland: Give me the number of people involved.

Maggie Anderson: 5,759

Representative Wieland: So you divided the $175,000 by the 5,759?

Maggie Anderson: That would be my assumption

Representative Wieland: Are you using the same number of evaluations. To figure out the total, are you using the $5,759 evaluations or what number are you using there?

Maggie Anderson: We would believe utilization to be at the level that it currently is. We would take the 5,759 times the difference of 494 and that gets you $28,449. It is off a bit. We know we would expect a utilization for year 2 so we multiply it by 2.

Chairman Pollert: So when you do the 7&7 you are taking the 13.3 plus the $2.4 million and taking it times 107%? For the second year you would take that figure times another 107% and add those two.

Maggie Anderson: It is similar to that but of course we have to build in our utilization into the tables so it's not just a calculation.

Chairman Pollert: I understand that but for simply explaining trying to tell people how we come up with that, that is basically how it is done.

Maggie Anderson: We add 7% to the fee schedule. With this particular example at 75% of average bill charges, that 2272 we would add 7% to that on July 1, 2009. Then we would add another 7% on July 1, 2010. That is how we would do it.

Chairman Pollert: So when I go down to no rebasing with the 7&7, you are paying on the current schedule of how you pay.

Maggie Anderson: That is correct for the example that I walked through where I indicated that evaluation, our current fee schedule is 17.78. Rather than rebasing that to the $22.72 we would take the $17.78 times 7 and times 7 the second year. That is what the bottom numbers reflect.

Chairman Pollert: The question I asked about the ambulances currently being paid at what percentage of the Medicare rate. I know it's not similar to dentists. Where did you get that particular number to base off of?

Maggie Anderson: Where they currently are? I don't have that at my fingertips but we could get that to you. I do know from the data we pulled for doing the 60 and 75%, there aren't a lot of children's services that are below the 60 and 70%. We could get that percentage for you of how the fee schedule compares to that. I don't have that at my fingertips. Are they currently at 52% of bill charges? That is what you are looking for?

Chairman Pollert: Yes.

Representative Nelson: Let's move on to utilization. This is one area where there is a fairly significant increase. Going back, we have heard in the past that many dentists don't accept Medicaid patients because the reimbursement is so low. Was that one of the considerations in your formula for the increase in utilizations was the fact that rebasing and the inflator increase would allow more dentists to accept Medicaid patients.

Maggie Anderson: I know yours won't look like mine but you are looking at this sheet? S you are looking at the average case load increase of $1,919? That is not reflective of the rebasing. The rebasing is solely looking at cost rebasing. That case load is based on what we are seeing with our trend. When I hand out what you referred to as the spend down tables you will see that in there. We are providing more services to the Medicaid clients in the dental area. We had to build that utilization into the budget.

Representative Nelson: Is it a fair assumption that some increase number of utilization will take place if rebasing takes place?

Maggie Anderson: That is a fair assumption. I think some of what you are seeing here in our numbers compared to if you are looking at this sheet for the budget for 07-09 was based on a case load of $9,772. We weren't experiencing and we budgeted $11,691. I have seen some of that increase because of the increases that were provided last time in the appropriation.

Chairman Pollert: That was a discussion e had during the last session of whether the utilization in the dental arena would go up for low income. Did that happen?

Maggie Anderson: I think that is what our utilization numbers are showing us is that we are seeing more Medicaid clients receiving additional services included in that is the dental fluoride varnish that the legislator authorized for practitioners other than dentists to apply during last session. Those numbers, which are dental services and very important for children will be contained in the utilization increase.

Representative Bellew: Why did the dental services get a 7&7 when physicians and the rest only got a 0&7?

Maggie Anderson: That is how the inflation was funded in the Governor's office. We have heard from constituents, stakeholders, legislators, clients, and so forth when they are having

difficulty getting access to services. It was funded that way coming into the Governor's budget to help ensure that access to services.

Representative Bellew: That was not the department's recommendation but the Governor's?

Maggie Anderson: The department submitted the OAR for the 60%. We submitted OAR's for the 7&7 inflation for providers?

Chairman Pollert: So hospitals got rebasing of 0&7? Dentists got 7&7?

Maggie Anderson: Correct.

Representative Ekstrom: If you look at page 11 of the overview there is a chart there that shows exactly and it is all in one spot.

Brenda Weisz: In response to Representative Nelson's question can I add one more comment on utilization? As far as utilization you brought up a very good point about the fact that when we built the budget, how we built it is we took a look at utilization, looked at cost data, and put the rebasing on top of those numbers. If the new rebasing for any of the categories increases utilization in the Medicaid that increased utilization would not be reflected in the numbers. I thought we should clarify that too. The utilization built in this budget was what we were seeing all the way up to the rebased amount without any additional utilization added which might come in from rebasing.

Chairman Pollert: To be fair to everyone else, this sheet shows hospitals, physicians, chiropractors, ambulance, and dentists, is there anyone else rebased and the 7&7?

Maggie Anderson: Other than the nursing homes where the rebasing of the limits is in statute, then we rebased to costs every year as well as to other providers who are paid on costs such as the DD providers and PRTF's. The 5 provider types that the department was specifically asked to rebase in 2012. Those are the ones we did. We didn't single out any additional ones.

Chairman Pollert: You are saying that when we get to nursing homes we have to have this same discussion.

Maggie Anderson: It is different because that is in statute.

Maggie Anderson: Testimony Handout (Attachment A).

Chairman Pollert: This is the information that Representative Nelson asked for.

Representative Nelson: Quickly trying to work the numbers through. If you go to the chart on page 11, in that you have rebased at 25%. It looks to me that it corresponds with the physicians at 50% in the handout you just gave us.

Maggie Anderson: Those are if you go to one year in the biennium you have to go to the biennium number because you have to double it. You would have to carry the costs to the second year of the biennium. It's the 25% number that is in my testimony in the Governor's budget.

Representative Nelson: That is 25% for the biennium and these are one year numbers on your handout so we doubled them right?

Maggie Anderson: If you look at the handout we have doubled them for you. If you look at 100%, year 1 was 26.5 and the biennium was 53.

Chairman Pollert: On hospitals, inpatient and outpatient, that is based on the 100% of costs?

Maggie Anderson: That is based on the vendors report that told the department how much we would need to budget to rebase hospitals to 100% of costs.

Chairman Pollert: In the current biennium, what is the percent of costs?

Maggie Anderson: We could pull that information. I don't know if we can do it to costs, we can do it to billed charges which is not the same for costs. We don't collect cost reports from the providers on a regular basis. I will need to check with Barb and whether we will be able to do that.

Chairman Pollert: I'm going to have the same problem and I think we will as a section. Let's say we will be Santa Clause and give 110% of costs. Say we will be a Grinch but only give 90%. I would like to know how we get to that number. We can talk about that separately.

Maggie Anderson: The other thing I wanted to point out was specifically with hospital services, we have very specific federal regulations in that area that are tied to what is called an upper payment limit which means we can't pay more than Medicare in the aggregate for those services. We need to be very careful that we do that. If we provide more than Medicare we will have a difficult time implementing that with our federal partners.

Brenda Weisz: The other thing that I want to point out in the Medicaid is that it is easier when you are sitting in the audience to hear things that you should say. We don't pay costs. This whole cost rebasing thing that happened really took some provider groups and established costs where they never existed before. The only one that has cost data is the hospitals. When you ask for the requests is because we don't capture cost data for our providers. We can't get you cost data. It will take quite a long time. We could give you what we would have.

Chairman Pollert: I understand that. I'm just trying to get a base of what we can work off of.

Brenda Weisz: I'm just trying to remind the committee that as we go through everything that the rebasing we did is kind of a unique thing we did last biennium and it is nothing that has been done before except looking at hospitals. It's not that we don't want to bring your requests forward it is just that it is not available.

Chairman Pollert: On your OAR for Medical Services, the $36 million, the Governor funded that request?

Maggie Anderson: You are looking at the inflation OAR? The reason that is why it is in purple. Those were funded at a different level than what was in the OAR. It could have been higher or lower. This one was lower because we submitted the OAR at 7&7 for all providers. As you

know, we also submitted OAR's for the rebasing. When those OAR's were funded for the rebasing then some of those providers received only 7% in the second year.

Representative Wieland: This one is funded at a higher level?

Maggie Anderson: Lower level.

Representative Bellew: What was funded is on the handout from yesterday? You have inflation at 7&7, $21,035,670? Is that correct? You requested $36 million and $21 was funded.

Maggie Anderson: That is correct. The differences there would be the providers that didn't receive the 7% the first year because they were rebased.

Representative Wieland: Would you go through the other purple ones that are on here and tell us if they are higher or lower?

Maggie Anderson: Physician cost rebasing was funded lower, that was funded at 25% of that number. Ambulance service cost rebasing was funded lower rather than at cost. Dental services was funded higher. The OAR was for 60% and it was funded at 75.

Chairman Pollert: So anything in yellow was fully funded in the Governor's budget for this OAR?

Maggie Anderson: Of the OAR's listed those in yellow were fully funded in the Governor's budget.

Maggie Anderson: Those in yellow were fully funded in the Governor's budget.

Maggie Anderson: Testimony Handout (Attachment B)

Representative Bellew: Did you tell us what a unit was?

Maggie Anderson: Just a unit. For every service a unit is something different. A unit could be a stay in the hospital, it could be a diaper, or it could be a wheelchair.

Representative Wieland: In month 1, provider 1, there were no units involved. Why?

Maggie Anderson: They received a payout. We weren't able to process their claims. When we do that we don't know how many units are tied to that.

Representative Ekstrom: When we have the new MMIS system, are we going to continue to front load payments to providers. Are we going to get on a string where you submit the bill and the bill gets processed, and they get paid for what they are supposed to get paid for?

Maggie Anderson: Our sincere hope is that the payouts you receive in front of you won't be the last. I won't guarantee we don't do another payout again. One of the significant reasons we have to do payouts is that our current system does not tend to be real compatible with the significant federal changes that have to happen. That ends up resulting in the back log. Our primary responsibility is cash flow to providers.

Representative Ekstrom: One of the things I have seen in my own business is that not all physicians are not tied into electronic filing. That is for death certificates. Do you have a sense in terms of your providers how many would be running it through electronically.

Maggie Anderson: We are very fortunate that today we have a large number that file electronically and fortunately our large facilities do. The other thing we are doing with MMIS is to build in additional features like a web portal where a physical therapist or a dentist can go on the web portal. They can upload their information through that. We are doing all the things that we can to help them interface with their billing/software pieces. The paper claims do slow things down and bog down the process. There is a higher air rate with the paper claims that do come in. I hope we are making all the possible that we can. We will certainly be taking advantage of everything in the future as well. Continued testimony.

Representative Ekstrom: You have prepaid on the basis of claims that are in your office. Those claims have not been processed through. You get to the end of a biennium. You've got

a shift there that you may have prepaid more than perhaps so you won't see claims until the next biennium. How do you reconcile that?

Maggie Anderson: That is certainly a lesson we learned. This last end of the biennium when we had to do some of those payouts towards the end of the biennium. If we had to do it over again I can't honestly stand here and tell you what we would do because the primary driving force was cash flow to our providers. In the way we were caught between a rock and a hard place. We knew that the end of the biennium is not a very good time to do those types of payouts. We also knew our providers could not wait another 6-8 weeks for a cash flow. What I can tell you that we have done is based on how we know and how we processed claims out and how much we should be paying, all of the payouts that we have paid this biennium will be recouped before the end of the biennium. We have worked with the provider groups and within our time frames as to when the claims should have been paid to make sure we are accurately paying and taking back that money before the end of the biennium. Our intent is that it will all be reconciled by the end of the biennium.

Chairman Pollert: You are taking the utilization numbers, and it is the units we are using and not the actual people receiving. You are going through November of 2007 through September of 2008. Now are you doing that through all of these?

Maggie Anderson: I should at least go through dental because it is one we didn't do payouts for and I can walk you through how it makes sense. You can clearly see when you look at September, October and go way to the right we have major outliers. Those are the payouts. We threw those out right away because we knew they would just skew the data. We started in November and went through September for inpatient, outpatient physician services. It was just those three. The rest of them we tried to use the beginning of the biennium. There might be some specifically where you might want to walk through them and you can see about the

outlier and know we would exclude that. Often times we do exclude August because that beginning month tends to be close to the average of the biennium.

Chairman Pollert: So July 2008 and September 2008 are not used?

Maggie Anderson: Those are specific to inpatient hospital

Chairman Pollert: So if I'm correct, we take the actuarial services, average them through that time period and then do the average of the actual cost per unit. We take that and it should come up with over the 07-09 of $553,024. We take the numbers and add the rebasing and you are saying the net number is going to come up to roughly $887,070.

Maggie Anderson: That is not correct. I can't show you how we got to the $887 because of the rebasing. What I can walk you through is that November through September our average for that time period without July and September was $655.90 actual cost per unit.

Chairman Pollert: So if we took those numbers, took the actual cost per unit, divided by 9 I will come up with that figure?

Maggie Anderson: Yes you should. You also have to put the 5% on there which is the inflationary adjustment that the legislator authorized for all providers. Then you add the rebasing, and the 7&7.

Representative Ekstrom: With the dentists, since we aren't doing the payouts, what kind of time frame are they looking at when they are waiting for payout. Do you have a sense of how long?

Maggie Anderson: Very few dentists bill us electronically. They all tend to still bill on paper. It does take a bit longer for the claims to get in the system and for them to process. They are looking at a time when we got into the system about a 32 day turnaround time. I have not received any complaints about dental complaints in terms of timeliness and processing.

Representative Ekstrom: With the web portal idea we are talking about with the new system, do you have a sense that the dental association is going to start getting on board with more electronic file?

Maggie Anderson: I believe there is an interest there. I know that sometimes their percentage of their Medicaid isn't high enough to purchase the required software and some of those things. That is again why we think the web portal will be helpful to them. If they only see 5 clients, it is going to be quicker and more accurate and will see more timely payment by being able to use that portal. We will certainly be working with them to try to encourage them to use the required software that does have to be HIPA compliant. We haven't focused specifically on the electronic piece of dentists. Last session when the legislator did provide that additional increase for dentists, we worked with the dental association to apply those dollars across the fee schedule. We did a specific effort to go out to all dentists who were currently enrolled to tell them of the fee schedule increase and to encourage them to take more Medicaid clients. We went to all dentists who weren't enrolled and provided them a packet . For both sets of dentists we encouraged them to use electronic billing. We connected them up with our electronic billing staff person. I would see us doing something similar to that.

Representative Ekstrom: Do we have a sense of emergency room care that is taking place in this area? I remember last session we talked about folks utilizing emergency services. I would like a number of children who wind up in emergency need of dental work. If we could get a sense that would help.

Maggie Anderson: Antecedently the dental association has talked about that and shared specific stories. Our claims data is dependent on the diagnosis codes that are entered for the claims when they come in. It could be that the preventing condition is something secondary to

the dental. We won't have that information on the claims data. It could misrepresent that. We have tried to dig to that level before but we don't have good diagnosis or codes.

Representative Ekstrom: Let's do one more of your choice. On the utilization report obviously we have case loads in the negative. Could we do one in the positive?

Maggie Anderson: Yes. We will do one with the payout. (Continued testimony Attachment C)

Representative Wieland: Can you explain the two months you want to take out of there? It would be February and March?

Maggie Anderson: It's just September of 2008.

Chairman Pollert: But keep July of 2009?

Maggie Anderson: That will get you to $12.82

Representative Wieland: You said the inflation changed to 59. You said 59% do you mean cents?

Maggie Anderson: Yes.

Representative Ekstrom: Did you consider the ramifications of what would happen to your testimony when you did that?

Maggie Anderson: Absolutely not. We probably would have decided not to do it. The good news is that two years from now we will have that same process in place and we will hope to never do payouts again. We will be able to track all of this for you. We think they were very good changes. They are eligibility categories they weren't service categories. We weren't able to tell you a full picture of hospitalization or physician services. Timing is not always at our choice but it worked out in the end.

Chairman Pollert: In physicians you excluded September of 08 from the actual units of service and you excluded June and August of actual cost per unit? Is that correct?

Maggie Anderson: No the June and August was on the units.

Chairman Pollert: I'm getting something screwed up here. In the inpatient hospital you said take out July of 08 to September. Are both of them that way?

Maggie Anderson: That was actual cost. They aren't going to be the same for every service. Again, there are different outliers for different reasons in each service category. As you look through them you can see where that happens where it seems to be a little high or low. We try to get those numbers where they are falling within the appropriate average.

Chairman Pollert: In other words inpatient hospital could be a little different then outpatient hospital.

Maggie Anderson : Continued testimony.

Representative Ekstrom: On this particular category were some of these people being reported in another place?

Maggie Anderson: That is possible. Durable medical equipment could have been an item with any of those categories of eligibility. The other thing you will see in the case load change is that I reported in my overview testimony of some changes in the durable medical equipment. That will affect the cost per case that was in the executive budget. The trend that we were experiencing and seeing at the time when we built the budget was not in an area of where we did payouts and not an area of where we had big shifts or changes. My notes indicate to me that when you look at August of 07 coming down through June 08 that our average cost there was $1.69 per unit. If you look for the biennium we are still running at $1.70. That has been fairly consistent the whole biennium when we were running about $1.70 a unit. If you add the 5% of that you come up to $1.77.

Representative Ekstrom: When you redo the spend down sheets and show the percentages, could you put a footnote in that? In your testimony you have said a case of diapers was one unit and now it's per diaper. That is a significant number in how the units changed. The major

reasons why the utilization numbers is what I'd like. I see the step by step processes of how you built that number.

Representative Bellew: This is a request. You gave us a grant summary sheet. Would you put all the medical services on a sheet similar to that? The reason why I'm asking is that there is some pretty significant increases in these other services. In psychological services there is over a $3 million increase.

Maggie Anderson: We can do that and I'd like to address the three specific items that you mentioned. Those are three that I brought out in my overview testimony because of those clarifications we made in those. That is why you are seeing those increases in psychological and health tracks that you mentioned. With the medically needy income levels, those are not tied to a specific case. That is the optional adjustment request that the Governor funded in our budget. That is the total dollar amount. It's not going to be something that we have tied back to a specific case. It's the total dollar amount that was funded.

Representative Bellew: I'd still like it broken out to what are federal funds and what are general.

Chairman Pollert: I know we are going to have a discussion on recipient liability and the medically needy. I also want to have a discussion on personal care third tier that you have on the OAR just so I have a little clearer mind.

Maggie Anderson: I don't believe we ever walked through this document yesterday. We started talking about some of the rebasing items so we can do that now.

Maggie Anderson: Continued testimony on attachment F in overview testimony.

Chairman Pollert: So that is total federal, general, and other? Then you just breakdown the totals on the bottom of the page.

Maggie Anderson: It is total funds for all the changes excluding healthy steps. Continued testimony.

Representative Bellew: Shots for the kids, is that in the Health Department Budget or do you guys do some of that stuff too?

Maggie Anderson: I do know that they have an administered for vaccines children program. They actually receive a certain supply of vaccinations. The actual medicine part what this is an increase for is the staff time, what we pay those people to do the injection. That is not arrived by the health department. They provide the vaccine but they still need the health care professional to administer them.

Representative Bellew: So that is all health care providers that actually provide the shot? Not just the one that work at the health units?

Maggie Anderson: This amount of money that is provided here would be used to increase the Medicaid fee schedule for those specific codes. Whatever health care professional delivers that service within their scope of practice, when they administer a vaccine they will receive an increased rate of reimbursement for that.

Chairman Pollert: So federally qualified health centers, with an increase of $700,000. That is when you compare everything else. What is that?

Maggie Anderson: They are federal designations. They are a certain type of provider primarily your federally qualified health centers are in pockets of low income areas. They serve a Medicaid population and we have an encounter rate that we pay them for each service they provide.

Chairman Pollert: Did we need the federally qualified health centers for the immunizations?

Representative Nelson: If my memory serves me right, federally funded qualified health centers and rural health clinics were the ones that were chosen to administer the vaccines.

Maggie Anderson: Again they are federally designated and we have an established rate that we pay for them. With the federally qualified health centers you can actually see that it is more of a case load utilization change that we are just seeing more people participate and receive services through the federally qualified health centers. That may or may not be reflective of them receiving less care somewhere else. It's just for this biennium. Continued testimony.

Chairman Pollert: So the whole medical assistance section of DHS has an increase of general funds of $30.2 million and $147.285 total.

Maggie Anderson: Yes for traditional medical grants. You did want to go more in depth of the recipient liability. This is on the overview testimony on Attachment F. Continued testimony.

Representative Ekstrom: From last session I remember we had at least one group of medically fragile people or children with special diseases but have special conditions that were sort of above and beyond what you would normally see. Did we not exempt them from some recipient liability?

Maggie Anderson: I'm not recalling that. The legislator adopted the medical fragile waiver. The children in the waiver don't pay recipient liability.

Representative Ekstrom: What happens?

Maggie Anderson: The PKU and the Russell Silver syndrome are all in the health department's budget with the children's special health services. They probably would be best to answer that. Continued testimony on page 1 of attachment F Continued testimony 53:00-57:21

Chairman Pollert: You went from 83% of poverty. Is it a legitimate question to ask why you didn't go to the SSI at 637 dollars?

Maggie Anderson: It is a fair question. We tried to keep it comparable with a percentage of poverty that was comparable to SSI and you will see between SSI. Right now if you look at our

family size of 1 and family size of 2, our $500 and $516 there is very little change there. You go to SSI and there is a significant change there. We tried to make those comparable for that household size of 2 and tie it to a level of poverty that got us comparable to SSI and that was the percentage of poverty that did that. If a 2% household receives $16 more a month on a 1% household, that gap or difference isn't very large.

Chairman Pollert: Let's say we went to the SSI level, what would the percentage be? The 83% isn't 83% of 500.

Maggie Anderson: No it is 83% of the poverty.

Chairman Pollert: What does the 500 stand for?

Maggie Anderson: For a family of 1 it is 58%. For a family of 2 it is 44%.

Chairman Pollert: So DHS's position and the Governor's position as well, you looked at a family of 2 income levels when you based your decision on what you were going to fund.

Maggie Anderson: When we looked at that position of poverty that was comparable at that level we looked at a family of 2 comparable to a family of 2. Why that is, is more on page 3 that ties back to the SSI piece and trying to be at least where the SSI levels are?

Chairman Pollert: So the 83% of poverty or the 969 is where we come up with a general fund increase of $2 million to fund this and $3.5 million total funds?

Maggie Anderson: It is to fund them at the 83% of poverty level.

Representative Ekstrom: This is purely dealing with how much income we are talking about allowing. It does not change how someone qualifies for Medicaid. The total number of people who would qualify for this program would be in essence the same pool of people we are already serving.

Maggie Anderson: There could be additional people who currently their medical need surpasses what they have to pay in recipient liability because of where the level is. Let's just

say that their income is $1,200 a month for a family of 1 and they have medical needs of $400. At $1,200 a month with a $500 level your recipient liability is $700. If your medical need is only $400 a month then they may not choose or qualify because they won't have a medical need. So it's possible that if there are people that are right on that edge where they have a $695 medical need but not quite that as the level went up. You could see additional individuals. That was accounted for when we built our estimate.

Chairman Pollert: What would the SSI family increase be?

Maggie Anderson: Comparing SSI to the poverty level? I don't have that information. Are you asking what it would cost to increase from $500 to $637? We will have to calculate that.

Chairman Pollert: I'd like that number

Maggie Anderson: Keeping in mind that SSI only has one and two person households. It has that two person household. I would have to talk to our eligibility experts to determine how we would calculate that for larger household sizes because they do only have one or two person households.

Chairman Pollert: Then that will give me more information so it sinks in a little further.

Representative Bellew: Basically with the increase in your budget for this line item says is that the state is going to pick up the extra dollars for these people. It's not that we are going to earn the money but we are going to throw in $220 for a single person. Is that how we read it?

Maggie Anderson: What it means is that if you increase the income level, Medicaid would start to pay on medical claims sooner than we would have if we left the level where it was. Say we increased the level to $720 for a family of one. We will start to pay $220. If we increase the level to $720 we pay that bill because their recipient liability now becomes 0 and instead of the individual paying that bill then we will pay that bill and it will be at FMAP. Medicaid will pay those claims instead of the client paying those. Someone with a $350 recipient liability, they

are still going to have to pay the difference between the $720 and their income. About $130 is going to need to come out of their pocket. Then we will pay. It's not that they are giving them money or their income is changing. It's at what point does Medicaid start to pay and at this stage it is that Medicaid starts to pay sooner.

Chairman Pollert: Is it a legitimate question to ask if we would say we went to the SSI level of family 1. Would 65 or 70% of the people with recipient liability of that $137, would 55 or 75% of people be covered by that? As versus $720 of a family of 2 of $969? Is there a correlation?

Maggie Anderson: I'm sure there is a correlation or a percentage of clients who would be covered at that level, I do not have that information. If you want that as when we go back and prepare the estimate, we pull out how many clients would have 0 recipient liability when they get to SSI.

Chairman Pollert: I was complaining about all the audits we have to go through. Then we are here doing the same thing.

Representative Nelson: Is there a yearly inflator added to SSI?

Maggie Anderson: It's my understanding and I can confirm this that it is inflated based on Cost of living increase each year.

Representative Nelson: Have we changed this number like we are this biennium? Have we changed it at all? When was the last time we had it changed?

Maggie Anderson: I should have pointed it out on page 1. The last time that this level was changed is under history, was in 2003. Prior to that there were regular updates to the schedule and if you recall it was the biennium.

Chairman Pollert: So the last change was in 2003?

Maggie Anderson: Yes the income guidelines have been setting there for 6 years.

Representative Nelson: What criteria did you use as far as the inflator before? I remember 2003 was a tough session. Maybe we should go back and see how that income level related to previous sessions. We have been stagnant now for a number of sessions.

Maggie Anderson: So you want to know when the last time it was updated and when we did update it, what did we use as an inflator?

Representative Nelson: Yes maybe for the previous 3 bienniums because that would give us a fair look at how income levels were addressed.

Chairman Pollert: Does that kind of answer page 2 because it just breaks down what would happen.

Maggie Anderson: Page 2 gets into the charts. I'm talking about the backside of page 1. Continued testimony.

Representative Kreidt: The SSI recipients, their annual increases on their benefits is that based on the same for social security or is that a different percent?

Maggie Anderson: It is my understanding that it is an increase to SSI. We will double-check on that.

Representative Wieland: Do I understand that in the previous or current biennium that there was nothing appropriated for the medically needy?

Maggie Anderson: There is nothing specifically appropriated on the line item. The medically needy really is a reflection of all of the tables so to speak. It is accounted for in our actual cost of service. When we run reports on cost of service we take in account of what we paid which is net of any recipient liability. The reason why it is showing up on reports is that it is a separate line item because we submitted that as an optional adjustment request which was funded at that. We didn't go back and apply that to the tables. For example we have no idea whether that

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1012 – Long Term Care detail

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/20/09

Recorder Job Number: 7332

Committee Clerk Signature Morgan Rovell

Minutes:

Maggie Anderson: Testimony Handout (Attachment A) Committee had requested this information relating to nursing home and basic care services. The first chart just shows all of the nursing facilities, what city they are in, how many beds they are licensed for, and the committee was interested in knowing what their lowest rate was and what their highest rate was. This was for the rate year effective 1-1-09. You can tell by the chart that information.

Chairman Pollert: They aren't in any particular order? Is there a reason why Four Seasons is on top and Hillsboro is on the bottom?

Maggie Anderson: They are from highest to lowest. They have the highest low rate. The second chart in the nursing home information is for my overview I reported on the number of beds that were below the 90% occupancy as of 9/30.

Chairman Pollert: Is the veteran's home on here?

Maggie Anderson: Yes. The second chart with the block of yellow highlighting has to do with the occupancy question that came up from my detailed testimony where I indicated to you that as of 9/30, 23 facilities were below the 90% level. The committee asked for a 5 year trend of that so we actually went back to that to the cost report year which is the 6/30. You will see on 6/30/08 the ones that are highlighted are those that were below 90% on 6/30/08. Just so you

have those identified for the current period. Then the 5 year occupancy rate for each of those facilities. As you look at the middle of the page you will see the column on licensed capacity. The reason we provided that is the reflection that some of those occupancy shifts have more to do with reduction of license capacity than an increase in the number of individuals that are being served in a particular facility. For example let's just take 6/30/04 report for the Presentation Care Center in Rolette had 48 beds. They sold or no longer had two of those licenses. Their occupancy has gone from 87.9% back in 04 to 67.5% in 2008. That occupancy is always a combination of looking at if there have been changes in license capacity in addition to looking at the current utilization or the number of residents that they have.

Chairman Pollert: So those facilities with the negative have sold some beds? An example would be Bethel Lutheran Home in Williams County, they must have bought some beds then? Could you say that?

Maggie Anderson: They went from 168-175. They have had an increase in their license capacity. They either purchased beds or someone gave them to them but I'm guessing they were purchased. Barb suggested that I walk you through Dunseith. They are about 5 below the yellow line where you can see they have reduced their license capacity by 7 which has allowed them to get above the 90%. That is exactly what I wanted to show you. Sometimes facilities will de-license or sell those beds in order to get themselves above that 90% occupancy.

Chairman Pollert: Why is the 90% occupancy important?

Maggie Anderson: It is important for the rate setting and payment piece. If you want a lot of detail about that I'm going to need to have Barb come and explain that. It affects reimbursement. The last two charts are maps that we prepared in response to the request to demonstrate the bed movement that is occurring. We did it by county and so some of this may be easier to track that way. It was my understanding that the request was related to how many

beds are moving and are those beds moving from rural to urban areas and how that is all shifting out. We worked with the long term care association to help track those beds and prepare this chart for you. To understand this perspective, the ones that are in purple are current bed capacities. They are licensed bed capacities in those counties. Let's take Morton County for example. They have 276 licensed beds in Morton County today. Over the next three years in Morton County there will be an addition 107 beds. 50 of those are coming from Kidder County, 50 are coming from the Steele Facility, and the other 7 beds are going to New Salem and are coming from Bottineau County. You will see the other negative 7 in that county.

Chairman Pollert: If you added the green all up and took away the pink would you get 0?

Maggie Anderson: You may not get there exactly because of the Turtle Mountain and the Chippewa's who have those beds that they have had 4 years to get into service. They were unable to do that but they were able to sell some of them before they expired and so they may not necessarily show up. It might not work out that way depending on when that happened. Some of those have been sold and relicensed and are being moved to other areas. I can tell you it's this change and the impact of this change that we use to build our nursing facility budget for 09-11.

Representative Metcalf: As far as Barnes County is concerned, does that include this 154 and the psychiatric that they have there.

Maggie Anderson: No it doesn't. Just traditional nursing facility.

Representative Metcalf: So that will change. Basically it should be 16 more. 16 and 16 is quite a change.

Maggie Anderson: With what we are looking for in traditional nursing facilities it won't be represented on here. You are correct because there is actually 30 beds in that unit. There

were 14 previously and 16 now. There are 184 skilled nursing facility beds. Only 154 would be traditional beds.

Chairman Pollert: So the other 30 will show up somewhere else as far as when we get the details? You are going to hand us something like this again and they will show up somewhere else besides the traditional nursing home beds?

Maggie Anderson: The 14 original beds are in there. Because these were taken off of the 6/30/08 cost report these additional 16 weren't in there yet. They should be reflected in here.

Representative Nelson: What county is Lisbon in? Why don't the new beds in the Veteran's home show up in this?

Maggie Anderson: Ransom County. There is something special with the Veteran's home.

Representative Nelson: My memory is that the additional beds don't count against the moratorium but they certainly should count in this equation shouldn't they as far as increased bed count?

Maggie Anderson: I have to be honest. I haven't followed the Vet's home bill. Is that an expansion or just a new facility?

Office of Management and Budget : The 150 beds is not an expansion. That is how many they are licensed for now. Because of the size of the rooms there are many beds that were licensed for two beds being in them. They can't put two people in those beds. They are licensed for that many but have not filled that many.

Representative Kreidt: There are 150 beds but now with the new facility, 52 of those will be skill beds. There would have been a 27 bed increase if I remember right.

Chairman Pollert: You will have to get us a breakdown on what is at the Veteran's Home for enlightenment purposes.

Maggie Anderson: I know that when we worked with the long term care association we were kind of focusing on those beds moving in from rural to urban. We did not specifically look at the Vet's Home and the expansion piece and all of that. We will work with the Long Term Care Association and our staff. I do want to point out one of the increases in Cass County that is also not going to allow you to take the reds and the greens and get 0 which is the plus 33. The reason that you have two different greens in Cass County is the 109 are actually skilled nursing facility beds that are moving from other areas into Cass County to various facilities. The other 33 are sub acute beds that are currently at Meritcare. They are licensed nursing home beds. They are currently Medicare only. They are in the sub acute at Meritcare which is in the process of moving out of that area of business. Those 33 sub-acute beds are staying in the Fargo area. We wanted to show you that those are 33 additional beds that will also be available for Medicaid clients to use as skilled nursing facility beds.

Representative Metcalf: What is the definition of sub-acute?

Shelly Peterson: Sub-acute is a term that we use in ND. Meritcare is a skilled nursing facility just like the other 3 skilled facilities in ND. We have 3 that turn themselves sub-acute. The reason they term themselves sub-acute is that they are located within a hospital. They get Medicare only funding. They provide generally the same types of services as a skilled nursing facility, however they are located in the hospital and have closer access to physician care and other types of services. It is a skilled nursing facility. As Maggie indicated, those 33 beds used to be Medicare only meaning Medicaid residents didn't go into those. Now with them being transferred to Bethany and Eventide they will impact Medicaid budgets.

Representative Metcalf: How does this affect our moratorium?

Shelly Peterson: It does not. Those 33 beds were in the system and in a licensed facility. As long as they are a licensed bed in the State of ND they can be transferred to anybody so it doesn't impact the moratorium.

Barb Fisher: I have just a little bit more on the history of the sub-acutes. Those actually came into the system in 1995. They went before the state health council. At that point in time it was a funding mechanism for Medicare to pay for skilled nursing facility in larger hospitals that could not qualify for swing bed status. At that point in time Medicare allowed sub-acute unites to come into existence as long as they set up a distinct unit within the hospital. In that point in time they chose not to participate in Medicaid. The state health counsel said they would approve the licensure because the moratorium was going into effect if they did not purchase the Medicaid. Throughout the years they have chosen not to participate in Medicaid after that. They were strictly Medicare only. It was services provided at a lesser level than acute.

Maggie Anderson: Of the 219 that are coming into the Bismarck/Burleigh area, 8 of those are the origin of where those are going to come from are unknown. Those are some of your entities that have beds around the state and haven't decided where they may be pulling those from. Again, that is why the plus and minuses won't add up. Finally, it does not include any expected changes with the transition of Richardton Memorial Hospital to a skilled nursing facility which we understand is expected to have 20 licensed beds. This movement won't reflect all of that change. Finally, we did do a map with basic care. This has fewer changes. They are primarily in your large areas. It is a combination of beds moving as well as in the basic care area if the provider has a proven need to the department of health and human services we will approve expansions of beds and basic care. It is a reflection of beds and both of those ways that beds can be moved and added into the system for basic care. Those were the requests you made relating to the nursing home and basic care. We don't have an

organizational chart for long term care. The one I reviewed yesterday with you was all of our staff.

Chairman Pollert: Any questions?

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1012 – Aging Services detail

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/20/09

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Committee Clerk Signature Marilyn Pollert

Minutes:

Chairman Pollert: I have made a chairman's decision. I have delayed long term care for the day and am going to start tomorrow morning. with that Linda are you ready to start?

Linda Wright: Testimony handout (Attachment A)

Chairman Pollert: Why would you have the one in Fargo?

Linda Wright: Brian is one of our long term care people. He has mostly Fargo and Jamestown regions of the state where there are a lot of facilities located. He is located closest to where there are a number of facilities that he serves. Continued testimony.

Chairman Pollert: So you stay state fund to provide what, who do you mean?

Linda Wright: This money goes directly out to our Older Americans Act contract entities and along with the federal Old Americans Act dollars.

Chairman Pollert: Who would the providers be?

Linda Wright: Folks like elder care in Dickinson, South Central Senior Services in Jamestown, Burleigh County Senior Adults Program. The non-profits and the units of local government that provide the Older American Acts services. It goes directly out to them. Continued testimony.

Representative Kerzman: Going back up to the community support services, that is all federal the way it looks. Does that end at $1.1 so you are talking about $3.4 that goes out to

communities?

Linda Wright: Actually the $1.1 million would be divided between those community support services and the nutrition services. It also helps provide for the home delivered meals and the congregate meals. Preventive health is federal money.

Chairman Pollert: Could you tell me if one of these is meals on wheels or something like that. If you could just start at State Funds for providers as an example. You told us who that goes to, Community Support services what that would be. Is it in Jamestown or Bismarck, or is it state wide. Could you just give us a little education on it?

Linda Wright: The state funds to providers actually as I said is divided up among all of our Old Americans Act contract entities. It goes out with the federal money. We also are able to use that in showing that we are matching the federal money because we are required to have a maintenance of effort and matching requirement. The community support services would be outreach services, health maintenance services. We fund legal services and information and referral which we are required to fund. It is those kinds of access services that help people know about the programs and services that they might be eligible for.

Chairman Pollert: Where do they get that information from? Do you go to your local county social services or where would you go?

Linda Wright: Probably your local senior center in your community. Continued testimony

Representative Wieland: That is for both of those delivered meals?

Linda Wright: That is correct.

Chairman Pollert: You don't have to meet any requirement except the age of 60?

Linda Wright: That is correct. The Older American's act prohibits you from using a sliding fee scale or setting a rate that people must pay for the service. It is a contribution basis. A little later I have a fact sheet that will show you how much of the money that is expended in the

state comes from contributions from the participants. We are one of the highest rates in the nation.

Representative Kreidt: On the Congregate and the Meals on Wheels, is it a suggested donation or do you specify an amount to use or what you can pay. Is that still that way?

Linda Wright: You can set a suggested donation. Some of the sights do that. Anyone under age 60 have to pay the full cost of what that meal is worth. Continued testimony.

Chairman Pollert: Didn't we do something with QSP's and increasing the amount of dollars last biennium. Was that through this section of the DHS budget?

Linda Wright: That was part of the long term care budget which is in Maggie's. Continued testimony.

Chairman Pollert: What does OAA stand for?

Linda Wright: Old American's Act

Representative Bellew: Was this an OAR or just part of your requested budget?

Linda Wright: This was a nice surprise from the Governor as it was not an OAR. We did not request it. It was requested by the providers was my understanding. They had other miscellaneous fees and services which is like advertising and background checks and that sort of thing.

Chairman Pollert: Give me an example of a service provider, someone from my district that I can relate to.

Linda Wright: One of the providers would be the Minot Commission on aging. Another example would be Southcentral senior services which operates out of Valley City or Elder Care in Dickinson.

Chairman Pollert: What services do they provide?

Linda Wright: They provide Congregate meals, home delivered meals, and some have health

maintenance services. We also fund some public health districts to provide those. Things like foot care, blood pressure checks, those kinds of things that folks can't afford to access.

Chairman Pollert: Do they do that at the senior citizens center then?

Linda Wright: Correct.

Representative Nelson: In this area, the increase is sent back to the service providers in grants? Is there an increase in reimbursement?

Linda Wright: This is money that would go directly back to the service providers. We have to put our contracts out as bids and request a proposal. As the proposals come in they are funded through grants or purchase agreements. The money would go directly to those entities.

Representative Nelson: How many service providers are there in the state?

Linda Wright: We have about 27 contracts in place right now.

Representative Nelson: Would that distribution of the $900,000 would that be by people served or is it taking the $900,000 divided by 27 or how is that distributed then?

Linda Wright: We provide a cost allocation method to distribute funds. It is based on population over age 60, poverty level, persons with disabilities, minorities and such. It is a rather complex schedule. We use that to determine how money is divided out among the regions and among the tribal entities. We use that formula to distribute that money.

Representative Nelson: Are you aware of any cases with the added money if there is going to be increased services or is this a maintenance of the current effort to keep the same services.

Linda Wright: Some of the money definitely would be used to pay for the existing cost of providing the services. What we are able to reimburse is certainly not meeting the need. We reimburse currently $3.00 per meal. Plus there is the 62 cents of that nutrition program money. So it's about $3.62 for each meal. We did increase that now for 2009 to $3.50 because the cost of food has risen dramatically. The average actual cost around the state for a Congregate

meal is $6.18. That is what it costs to produce the meal. For home delivered meals the actual cost is $6.21 per meal. That probably accounts for the kinds of containers you have to use to keep the food hot when you deliver them.

Chairman Pollert: So let's say you have a home delivered meal. Who is paying for the time to deliver the meal?

Linda Wright: In most cases it is volunteers.

Representative Ekstrom: With regard to the $900,000 to increase to the providers, that money has been coming from counties pretty much. If we looked at this as one more offset against property tax would that be a fair assessment.

Linda Wright: The additional local money that you have had to put in I believe is mostly coming from things like fundraisers, other grants, because they also have to provide a match in addition to these local moneys that they are keeping up with to keep operating. Most of that is used for the match.

Chairman Pollert: Speaking of that, I got a copy of that but does the committee want a copy of the senior citizen meal levy. It is a figure that is $2.667 million.

Linda Wright: I have not seen that exact chart but the state treasurer's office usually does inform us of what they have allocated out in dollars.

Chairman Pollert: Ok. Of the $900,000 increase, it sounds like it is an increase of the higher costs of meals. How much of that is going for that?

Linda Wright: For the purposes of the budget it was put into the congregate meals for a place to put it. Once we determine which of the services has the most need for the dollars and then using that funding allocation formula will determine where it will be divided.

Chairman Pollert: Is that on the green sheet somewhere?

Representative Bellew: Yes on page 6 #22.

Linda Wright: Since there were so many questions about the Older American's Act we should flip to the fact sheet called the Older American's act fiscal year 2007. Continued with testimony

Representative Bellew: Where in the budget would state funds with older American funds be located?

Linda Wright: Are you meaning in the cost centers or in this chart? There is a separate cost category called state funds to providers. It's in the operating fees and services category. Continued testimony.

Chairman Pollert: We have been asking this question of everyone when it comes to travel. When you look at this it seems like everyone's traveling is going up when gas is going down. Your department is doing that much more traveling?

Linda Wright: It includes a variety of things. It includes 55 volunteers who serve as volunteers in the long term care facilities. We allow them to ask for reimbursement for mileage. That is included in here. The Governor's committee on aging has a small budget of $20,000 of the biennium. Their travel is reimbursed. We are required to attend conferences and training sessions for some of our programs. One example being the senior community services employment program. They require us to attend two conferences a year which is included in here. In addition, any travel that is done by our long term care is included in here. Also if we are doing on sight assessments of the providers that would be included.

Representative Nelson: When do you go through your budget and start preparing that?

Linda Wright: We had to have our part submitted by early July.

Representative Nelson: We look at gas prices today. You don't have to go back very long. We were still paying $3 plus for gas. For much of this biennium, it has been there as well. I noticed your travel budget is up over your total budget. It's a minimal increase. You will be $5-6,000 over. You are asking for a $30,000 increase. My question is if there is increased travel

from the current biennium or is this just the inflationary increase of what travel you are currently using.

Linda Wright: It would be based on a little of both. Some increased travel as well as what the state fleet reimburses.

Chairman Pollert: I want to go back and go forward at the same time. If you go forward further down the line to rent a little leases with an increase of $35,500. If we go back to the piece of material that you just talked about, we talked about the rent and leases. So now I've got to go back further to the 05-07 and you have a rental lease of $926 and 07-09 is $20,850 and you want an increase of $35,500. It almost looks like your whole staff has moved out of the DHS and moved somewhere else.

Linda Wright: We were located in the capitol. In November of 2007 our whole staff was moved out of the capitol and into Prairie Hills Plaza.

Chairman Pollert: Where you just running out of space in that building?

Linda Wright: Yes. There was room at Prairie Hills Plaza because of some moves of other divisions.

Representative Bellew: Who owns Prairie Hills Plaza? Is it a private person?

Linda Wright: It used to be a bowling alley.

Representative Kreidt: This intrigues me on building and grounds with a budget of $30. Are we planning some flowers or something?

Linda Wright: Because we have had one staff person at Southeast human service center there has been some unusual cost categories that explains what our share has been of having one staff person at the human service center in Fargo. Continued testimony.

Representative Bellew: Instead of going to one place to find out if they are eligible for services can you just go to that place to find out where the services are?

Linda Wright: Yes. They certainly could. Aging and disability resource centers are meant to serve any person that has long term care needs so they don't have to be on public assistance. They could also be a private pay person that needs information. Continued testimony.

Representative Ekstrom: My question is in regards to the ADRC's. It is certainly a national trend that is done everywhere else. From a public policy stand point could we get an assessment in terms of how much pressure we are going to start to get from the federal government in terms of cost containment.

Linda Wright: I certainly have received pressure from our regional office of the administration of aging regarding an aging and disability resource center. As I stated in my overview we have submitted a couple of print applications that have not been successful to date. Now with the change of administration I don't know about the source of funding or the kind of pressure that might be put on us. However, the Old American's Act in the 2006 amendments requires aging and disabilities resource centers to be established in every state.

Representative Nelson: Of all the states that currently have aging resource centers, was there federal money that helped them establish them?

Linda Wright: Yes there was federal grant money that helped them establish those centers. At the end of 3 years they had to be able to be self sufficient. During those three years they had to develop private pay income, other grants income through cost efficiencies. It's a variety of funding sources that have been used to support them. Plus the grant money has helped them establish those.

Representative Nelson: The states that are left , are we all in the same box that if the grants have been written and not funded or is there no desire in some of the states to go to the level of establishing these ADRC's.

Linda Wright: I'm not aware of whether or not those other states have applied for the grants before.

Representative Bellew: Can we possibly get a break down of how you came up with the figure for travel? And maybe for the entire department? I would just like a little more detail of the travel.

Linda Wright: Yes.

Brenda Weisz: Yes I know what you are asking for. It's just a whole lot of detail. When I walk through mine what it was made up. A lot of the divisions have walked through it. We could do it.

Representative Bellew: I guess why I am asking for it is because travel has gone up throughout the whole department.

Brenda Weisz: Yes.

Representative Kerzman: We talked about single point of entry. How are we coming with the uniform assessments. Are we getting that yet?

Linda Wright: We do currently have a uniform assessment . It has some drop down boxes for different programs. It is being used by all of the County Social Service offices to assess for home and community based programs. It is used by the Old American's Act providers to assess for those services. We are working on having a common assessment and data base .There is certainly many others that we would like to include at some point in the future which would be one of the things that an ADRC would accomplish.

Representative Kerzman: Going back to the $40,000 for guardianship, in the last biennium didn't we talk about shortfall there? How are you handling that with just $40,000.

Linda Wright: When the law was passed to provide guardianship services for other vulnerable adults that are not DD there were many sections of the law which we were not able to

implement because of the resources. There was $40,000 that was provided in the budget. I believe the original request with the funding and the bill which came from the guardianship association group was $740,000, somewhere in there. At this point since we administer the $40,000 the only thing we have been able to use it for is emergency guardianship requests. It pays for the legal fees to actually execute the guardianship or take care of getting rid of the guardian who may have been abusing and neglecting the client.

Representative Kerzman: Why didn't the department request more?

Linda Wright: The way that we are administering the program by only approving emergency guardianships, we have been able to stay within the $40,000. Every request comes through one of my staff people who goes over what each request could do. Could the power of attorney do the job? Could a conservatorship do the job? She makes sure that every avenue is explored before she approves the emergency guardianship. We set a limit of $2,500 per case. Most of them are less than that but it is the legal fees.

Representative Ekstrom: We heard from Carol Olson in regards to a grant writer being needed within the department. It may not be a question for you but I would like to know what the priority is for going after the grant for the ADRC for the resource center. In other words, in terms of the department's criteria as far as what they consider most important in terms of grants, is this one high on the list?

Linda Wright: It's been very high on the department's list of things that we would like to move forward with. We see it as a real priority and as I said. For over 20 years it has been recommended that it is something we need to do. We feel it is time to do that.

Representative Bellew: Any more questions? We will recess until tomorrow morning.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012- Children and Family Services detail

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

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Committee Clerk Signature

Minutes:

Tara Lea Muhlhauser: Testimony Handout (Attachment A)

Brenda Weisz: Legislative Council is going to put the vacancy report together for you but what I would like to do and I didn't get time is give you DHS's piece that we turned into Legislative Council. What will happen is you will have people coming up now that you could actually ask them specifically about the vacancy. I think it would be more beneficial for you to have it right away. I'll get you some copies. Tara did have two vacancies at this time but they are both filled now.

Tara Lea Muhlhauser: Continued testimony

Chairman Pollert: Out of the $391,364, aren't the background checks like $600,000?

Tara Lea Muhlhauser: You may have seen that somewhere. My guess is that it probably wasn't all staff costs. It was on page 8.

Brenda Weisz: I think the $600,000 is on the overview testimony I gave on January 9. The $600,000 was the total and $308,000 is the background checks and another $300,000 was an increase to the child care providers a rate increase. Together those were put in one bullet to talk about increases for child care, background checks, and the fees paid.

Chairman Pollert: So the $300,000 is for the salary position for how many FTE's?

Tara Lea Muhlhauser: Again it's on page 8 of the budget overview testimony on the second bullet.

Chairman Pollert: Its 4 temp staff and basically one FTE. Are you taking an FTE and adding more responsibility to that one that is a .5?

Tara Lea Muhlhauser: These are new positions for us. One will be an administrative assistant. As the background checks come in they come in with a fair bit of paperwork and application. BCI requires that we keep that and we file that and maintain that. The program administrator position is a professional position to work with the work that is created when we get hits on background checks to determine whether those providers have sufficient rehabilitation, whether the history of the hit that is coming back to us is enough to foreclose them from a licensed category and stepping into the category that they are applying to be part of.

Chairman Pollert: The other $300,000 was for rate increase for the child care providers?

Tara Lea Muhlhauser: Yes.

Chairman Pollert: You are including the 4 temp staff. Are the temp staff on hand right now or do we have to include the 4 temp staff?

Tara Lea Muhlhauser: No they aren't on hand now. We won't actually have need for the temp staff until the provisions go into effect on August 1. That will bring in the new group of background checks.

Chairman Pollert: So you are saying that your major case load will be when you start to implement the background checks. Two years from now are you saying that you are going to need the 4 temps?

Tara Lea Muhlhauser: We are anticipating that we won't need 4 temps two years from now. We figured at about a 25% attrition turnover. Our first 2 years we have anticipated about

$9,000 checks a year. Thereafter I think we go down to about 3,600 checks a year. By our own experience in our last two years we are able to handle 1 FTE about 24 checks a year. The 4 temp staff we have anticipated that we will move down to 1.5 positions in the next biennium.

Chairman Pollert: So one FTE can handle 2,400 checks? You figure you are initially going to have 9,000 checks. Then it will drop to how many?

Tara Lea Muhlhauser: We will have 9,000 for the next two years. That will bring on the entire group of child care providers plus attrition that is factored in particularly in that second year. There after we are anticipating the attrition rate for those child care providers will be about 25% or about 3,600 checks a year. Continued testimony.

Chairman Pollert: What do you mean by the $50 increase? You are saying that these are in department employees so besides the regular pay you want to increase it $50 or what are you saying?

Tara Lea Muhlhauser: We are very careful about that. We do have paperwork so that if they are state or department employees they do take annual leave for that day if they claim the perdium from us. They have the option in asking their supervisor if they can just participate as throw in time or if they want to be paid for their time we require them to have to show us the paperwork that their supervisor signs off on to indicate that they have taken the day off. This would be an increase in that actual daily perdium fee from $150-$200. The rational for the increases were substantially behind the federal rates that the federal reviewers pay for that daily perdium. We have lots of people complaining to us saying why they wouldn't go to Hawaii and do the review when you want to send me to Fargo or Dickinson and want to pay us a whole lot less.

Chairman Pollert: Do you know what the federal rate is?

Tara Lea Muhlhauser: I don't know but I can find out for you. We've had some discussion and

we were unable to put our fingers on it. I believe it is $350 or $400. I will find that out and get it to you.

Chairman Pollert: Basically what you are doing is if the employee has to take the day off we better make sure that their compensated for their time.

Tara Lea Muhlauser: Yes.

Chairman Pollert: Are these state or federal requirements for you to do these?

Tara Lea Muhlhauser: The child and family service reviews that we have around the state are not federal requirements but they are built in to our plans that the federal government requires us to have in terms of the quality assurance component in our child welfare programs.

Continued testimony

Chairman Pollert: That would be an increase or decrease or stable as far as 990 children?

Tara Lea Muhlhauser: An increase. Continued testimony.

Chairman Pollert: When I look back at your 05-07 biennium and you were at $878,000 and of course last year and biennium we went to just a little under $5 million. I see a reduction of $120,000. I know you weren't in this position last year. Can someone remind me why we had the huge increase last biennium? Is that increase then consistent with what the operating fees are. What I'm wondering is like on your budget detail I know you reduced it by $120,000. I'm just wondering if some of these are big increase or stable with last year. I still want to know why we increased it roughly $4 million.

Brenda Weisz: It's actual a change of where we recorded our contracts with the Village and Lutheran Social Services. Previously with the layout of the contract they were under the grants area. They were under operating fees and services. They were reported in the wrong line item.

Chairman Pollert: So like the adoption contracts that you have in operating fees that is Lutheran Social Services their program is through there. Who else was?

Tara Lea Muhlhauser: It's actually a contract with Catholic Charities. They run the program that is called ASK. It's an RFP contract.

Representative Bellew: Do you request RFP's every year or two years? How is that done?

Tara Lea Muhlhauser: We reissue the RFP's every two years.

Brenda Weisz: With the procurement rules that you passed back in 05, some renewal options like this one in particular is for a 2 year which means two contracts for 2 years each. Some renew for 2 consecutive terms of 2 years. What we outlined in our RFP is to have one renewal period. That will be up for RFP again this spring for the new biennium.

Chairman Pollert: You said subsidized adoption has 992? I know that is an increase but where were you at the previous biennium. Am I going to have a chart that shows that later? Is it going to show up here when I get looking?

Brenda Weisz: That is part of the grants cost. We will have a chart for you that is in your handout. It actually shows the increase.

Chairman Pollert: It will show the increases for whatever programs you are offering. Do you do foster care too? We will see the increases or decreases in the case load.

Representative Wieland: The $395,000 for travel, that just seems to be high for anybody. Can you break that down again for me as to how it is spent?

Tara Lea Muhlhauser: Do you want me to go to the level of breaking it down program by program?

Representative Wieland: That might help.

Tara Lea Muhlhauser: We have got family preservation training which is at $5,391. That is a decrease. We have got travel for our foster care information systems administrator who is out stationed at the human service center in Williston. That is $12,480. Our foster care administrator and that is travel not only for them but for services under that program. That is

$97,000. Refuge assistance is about $13,000. Early childhood services is about $22,000. Family preservation administration is about $6,000. Independent living is about $43,000. A portion of that not only goes to fund youth activity and coordinator activity in the field but our own program person in our office. Adoption administration is about $23,000. Community based child abuse prevention is about $4,000. Child abuse and neglect is about $68,000. Personally from building that budget it not only includes my travel as a program administrator, but a larger share of that is our ability to select county people and regional people to go to a national child abuse and neglect conference and other kinds of national professional development conferences. It also supports their travel to do that. Early childhood services training is $25,000. Head start is $39,000. Again that supports activity outside our office as well. The director of CFS has an administrator travel budget of $31,000. An example of how we use some of that administration money last year is that in my budget overview I told you about the data system we have been working on. We actually provide the travel support for a number of county people and regional people to come in and work with us at the table to develop that system. That would be an example of how to use the travel dollars. Continued testimony.

Representative Bellew: I would like to go back to foster care and grants county funds. You show an increase of $850,000. Could you tell me how you got those figures? The total cost is $9.1 million. I know it has something to do with the statute that says ND Century Code that says 25% of some federal fund match has to be charged to the counties.

Brenda Weisz: You are right. What that is, is that anytime there is an increase in foster care grants in total where they did increase? When you look at the various areas what you have to do is it says that the statute says that the counties are responsible for 25% of the non federal share. The reason you can't mathematically do it is because what is happening with our foster care population is that fewer and fewer of the children are determined to be 4E eligible. That

federal match we get is lessening which means that our non federal share is increasing which means that 25% of the non federal share is also increasing and it passes to the counties. That is why theirs went up proportionally higher than the foster care costs themselves.

Chairman Pollert: I take it the provider increase is the 7&7?

Tara Lea Muhlhauser: It is actually more than 7&7. There was a 7&7 put on the actual mark rates. This was an increase in the base rates for our family foster care. I can give you greater detail on the actual amount of those rates if you care to know that. Continued testimony.

Chairman Pollert: Why do the rates increase? You are saying the private industries or whoever are doing this are charging you more money?

Tara Lea Muhlhauser: My understanding is that it is a process that you go through to determine what their rates will be given their costs.

Chairman Pollert: The costs are determined by who?

Brenda Weisz: In the ND administrative code, we have cost reports that are required from our foster care provider facilities. Just like we have administrative rules and rule settings for nursing homes and DD providers. The foster care facilities are also required to follow the rate setting rules for them. They turn in cost report as well. Whatever costs are allowable according to NDCC is reflected in their next rate.

Representative Kreidt: Are these annual audits then?

Tara Lea Muhlhauser; Yes. Continued testimony.

Chairman Pollert: What is foster care therapeutic in a statement?

Tara Lea Muhlhauser: It is an intensive therapeutic based care. It is higher therapies. Generally the children have more extreme behaviors, psychiatric involvement, greater need, and so on. Parents are better trained. Continued testimony.

Chairman Pollert: I'm also looking on the next page of your handouts. That doesn't have subsidized adoption. Can we go back to where that was?

Tara Lea Muhlhauser: We talked about subsidized adoption in a bullet point on page 9 in the general overview testimony that details the 922 children per month for a total program increase of $4,210,886 of which about $1.5 million is general fund.

Chairman Pollert: Going to 992 children what was it the last biennium? What is it based off of?

Brenda Weisz: In 07-09 we had budgeted 911. This next biennium, because of the movement of moving children through foster care into subsidized adoption the budget is prepared at 992. That is an increase of $81 a month. We are going from $911 to $992.

Chairman Pollert: Do you have a rate on that?

Brenda Weisz: Average monthly cost per case in 07-09 was $635.36. Our budgeted average monthly cost per case for the 09-11 biennium is $760.46. That is an increase of $125.10.

Chairman Pollert: That is an increase of about 25%. Why the big increase?

Brenda Weisz: The subsidized adoption, the subsidy that is negotiated is often replicated to what is paid to the foster family. Often times the adoptions take place in the foster home itself. The rate is negotiated. That rate nears as to what they are essentially receiving in foster care. Our cost for foster care as you noted are going up as well even though our case load is down. The costs are going up. When we do the negotiation for the adoption you negotiate at a cost that is similar to what you are being paid in foster care. What we aren't paying any longer is the case management cost that go along with foster care. Those costs then are no longer paid. It is a cost savings if you will from that regard. That is no longer provided. Just the subsidy payment.

Chairman Pollert: The increase of the 82 kids, what can that be attributed to? Is there any particular 1, 2, or 3 areas?

Tara Lea Muhlhauser: I think that is attributed to our permanency work to get children a permanent placement. When we look at the group of children we are working with in foster care, there are a number of children who have been in care for 2 years or longer. Those are children that we look at with greater planning intensity to try to move them to a permanent placement via guardianship or adoption. That is attributable to good permanency work in the field and getting those children in a settled placement.

Chairman Pollert: Maybe you had this in your testimony but for your foster care is there an increase or decrease? Is it attributable to meth, drugs, or that? Are those case loads dropping or increasing?

Tara Lea Muhlhauser: I think a couple of years ago we did see a meth bubble. I think our attribution to meth is down a little bit. It certainly has not changed in the general drug and alcohol spectrum. Drug and alcohol is a great contributor to child placement.

Chairman Pollert: There was a bubble from meth but now that is gone?

Tara Lea Muhlhauser: As the testimony you heard last week from JoeAnne Hoesel when she talked about the changes in the drugs of choice, I think we are experiencing the same kind of recognition of greater use of marijuana and continued high rates of drug and alcohol. Then we certainly still do have meth but to a lesser degree then we had a number of years ago. Continued testimony.

Chairman Pollert: The last biennium didn't we have an increase for Bismarck and Minot when they bring these kids in for testimony. Didn't we have like $300,000 for that?

Tara Lea Muhlhauser: Yes you did have a budget line item that was specifically attributed to

the children's advocacy centers located in Bismarck, Fargo, and Minot. They do forensic work and medical examination work with sexual abuse cases.

Chairman Pollert: Is that in this section? Did we oversee it and I missed it?

Tara Lea Muhlhauser: Yes. Children's Advocacy Centers is $500,000.

Chairman Pollert: Where is that at?

Tara Lea Muhlhauser: That is in the child abuse and neglect section. I believe that it is general fund dollars.

Chairman Pollert: So it's going from $300-$500,000 this biennium. Did I hear that correctly?

Tara Lea Muhlhauser: No it was $500,000. Continued testimony.

Chairman Pollert: Collaboration grants?

Tara Lea Muhlhauser: They are dollars that we use to provide support for trouble foster care cases. We call it our 4E claims process where we provide support for them and 4E dollars for the division of juvenile services. We named it collaboration because it requires agreements on both of our parts.

Chairman Pollert: There is general increases in general and federal funds. Is there an increase in rates/clients? Where is that from?

Tara Lea Muhlhauser: It is in the collaboration column.

Chairman Pollert: Contract program changes? It shows an increase of $828,000 general funds and $2.167 of federal funds.

Tara Lea Muhlhauser: If you look above the yellow banner that says collaboration grants. It is right above that.

Chairman Pollert: What do you mean by county reimbursements? Is it as simple as it says?

Brenda Weisz: The counties have indirect costs out there that contribute to the programs they operate. What is in place is county wide cost allocation plans so they can capture additional

federal revenue for some of the services that are provided for the counties like the check writing. We have the county wide class allocation plans in place. Predominately what we do is we draw down the federal funds for them for the foster care areas, not the EA. This is a pass through that a portion of this is drawn out from the federal government. The other part is the DHS receives a social service block grant each biennium. Historically it is an agreement with the counties that 40% of the block grant that comes to the state of ND will go to the counties. 60% of that will remain with the department and it funds services at the human service center because we both have legitimate expenditures that can be covered by the social service block grant. During this biennium and the budget section on September 25 I presented a budget adjustment to you to tell you that instead of giving the counties the 40% of the actual federal fund we would give them the general fund equivalent of that. The reason for that I stated was because there was reporting requirements that are due in December of every year to the social service block grant where we have to state how many were served, what they were provided and so on. In tracking and pulling that data from 52 counties and get the information timely is rather a challenge. It is easier to get it from 4 human service center directors. So what we said to the counties is we will give you the equivalent. We have the funds that are human service center and legitimate expenditures. We will give you those general funds and then we will replace that with the entire block grant. That is the other part of the area. That is the County wide allocation cost we are passing through and their share of the social service block grant.

Chairman Pollert: At the end you said it is 40% of the social services block grant goes to counties. What was your statement before that?

Brenda Weisz: We give them a general fund equivalent of the 40%. Because of the federal reporting requirements it is easier to keep 100% but we still want to abide by that agreement that we had with them. We said we will take 40% of our money we went to the human service

centers with. We will give that to you instead and replace it with the block grant. That way the reporting is much easier for us, you get what you feel you are entitled to.

Chairman Pollert: During your overview I wrote some numbers down. I show foster care at 523 clients Is that for the 09-11 biennium? If it is, what is the client base for the 07-09 budget? I have the same question or the RCC F's and also therapeutic foster I show at $242,000, foster care services at $196,000, subsidized guardianship at $40,000. Are those 09-11? What were the 07-09's?

Tara Lea Muhlhauser: You have a schedule that answers all of those questions.

Chairman Pollert: Could I ask for whatever numbers aren't here for the client case loads, can I get those?

Tara Lea Muhlhauser: Yes.

Brenda Weisz: I think what we need to do is give you a schedule that has the subsidized guardianship on here for you and the subsidized adoption in the same format. Then you will have a complete picture.

Chairman Pollert: Ok. With that we are in recess until 15 minutes after floor session.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1012 – Long Term Care detail

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/21/09

Recorder Job Number: 7447

Committee Clerk Signature

Minutes:

Chairman Pollert: Called the meeting to order and took roll call. Every member was present.

Maggie Anderson: Testimony handout (Attachment A)

Representative Ekstrom: How often are they reevaluated in terms of where they are in this continuum.

Maggie Anderson: A lot of that is dependent on the situation of the client if they are receiving home and community based services. The case manager reviews them every six months to see if their care needs have changed. If the manager is aware of a change in their needs of functional criteria or functional abilities they can reassess them and access services at any time. The nursing facility doesn't necessarily do level of care screening on a regular basis. They do their MDS screening that they do every three months or within 14 days of returning to the hospital .Continued testimony.

Representative Bellew: Would you define assets. Does that include a home?

Maggie Anderson: I don't believe it does for SPED. Continued testimony.

Representative Ekstrom: We got a map yesterday with regard to the basic care beds and the nursing facility beds . I would like the rest of the committee to kind of look at that as well as we

are looking at the shift that is happening down the road. These folks are going to have to go someplace. I am referred to the old and that is the folks over 85.

Representative Kreidt: In regards to Representative Ekstrom we are living healthier so we aren't going to need a nursing home so let's look at it that way.

Chairman Pollert: That's a good thought.

Maggie Anderson: Handout (Attachment B).

Representative Ekstrom: On page 9 of your overview you talked about that personal care third tier. The executive budget adds money in to expand that out to 10 hours a day. Your contingency sheet here says in terms of the computer system you need the system up and running before you can implement that.

Maggie Anderson: We have two different columns here for computer system changes. That is to the current system. The new MMIS affects the hospice waiver on this sheet. We don't need the new MMIS. We just need changes to the current system. We need CMS approval for that one. That one we are estimating a January 1, 2010 effective date.

Chairman Pollert: What does AFFC stand for?

Maggie Anderson: Adult Family Foster Care point split. With regard to where you would find these in my testimony, we started covering the program changes on page 3 of my testimony. The first few changes were those items that occurred in the current biennium and those that we expected to occur. Continued testimony.

Chairman Pollert: What do you mean 8 hours?

Maggie Anderson: 8 hours of care a day. That includes the personal care service assisting with bathing, toileting, homemaker services, and those kinds of activities needed to allow people to remain in their home.

Chairman Pollert: You are saying that personal level care B is capped at 8 hours?

Maggie Anderson: If you look at the program cap at the bottom of that level it says 960 units per month. The units are 15 minute units. That comes out to about 8 hours a day. You have the months with 28,30,31 days. It's a little iffy. It's about 8 hours. Continued testimony.

Representative Wieland: Going from the 8 to 10 hour, was there a study done that would indicate at what point the SPED program would no longer be best for someone and they should move into a nursing home. Is there a long range program where 12 hours would work? What is the maximum of going into a nursing home.

Maggie Anderson: With the SPED program specifically we have a program cap of a certain number of dollars per month. They have to receive services within those dollars. With this personal care, outside of the SPED program, this is a Medicaid state plan service. The way we came up with the 10 is we heard about this at stakeholder meetings. People told us that they needed a little more care. We looked at all of our clients who are at the maximum and worked with the case managers to determine what it would take in some of those situations to make sure that those individuals can remain at home. The maximum would be the balance of looking at cost effectiveness and client choice of remaining in the home. In terms of dollars, personal care services has built in the Governor's budget the average cost per case of $1,481.71 a month. That is the combination of getting level a and b today plus adding in the dollars for this third tier. That is still significantly below nursing home costs per month.

Chairman Pollert: Well a nursing home could be $200 a day. Is that what you are trying to point out?

Maggie Anderson: The average daily rate for nursing homes is $170.78. Our goal with doing this isn't to necessarily to make those comparable. It is to give people choices about where they would like to receive care.

Representative Wieland: How many days a week are we talking about? I'm trying to get a handle of how many hours a month that this would apply to.

Maggie Anderson: It's 7 days a week. They meet nursing home level of care. They have care needs and without that they wouldn't be able to remain in their home. It generally is 7 days a week that they need the care.

Chairman Pollert: All the personal care level a and b are 7 days a week? It's offered 7 days a week. You could say SPED is too right? Every one of these are 7 days?

Maggie Anderson: That is correct. With expanded SPED, personal care level A it is possible that those individuals may not need services that many days a week. When you move into the services that meet nursing home level of care and these individuals would otherwise qualify if you go into a nursing home, the expectation is that they do need some level of care each day.

Chairman Pollert: If you give us all your spread sheet you are going to have those daily numbers on there anyways? With expanding to personal care level 3, could it tell me that you are going to have people not going into the nursing homes at $170 a day that this is allowing them to stay home? How many clients do you see shifting to personal care instead of going to nursing homes?

Maggie Anderson: Yes. We would expect this to allow people who the 8 hours doesn't allow them. For example there could be 10 people right now that are at the maximum of 8 hours. It's just right on that edge. Once they need 8.5 hours or 9 hours and we aren't able to provide that with our current limit, their choice may only be to seek institutional care. Those are the individuals that we considered. In addition to that I mentioned that the money follows the persons stakeholders identified this as a service need in order to help people transition out to the community. The combination of the current clients that we currently see as needing this service to prevent them from going into an institutional setting as well as the clients that we

see moving out of the nursing home and back into the community, the growth that we expected from this was 27. When you see the averages on that sheet you are going to see it is going to be 20 and that was because of the 18 months. We have to do that average. We really expect about 27 people to be able to use this between January 1, 2010 and the end of the biennium. That was how our estimate was made.

Chairman Pollert: It is going to be hard for us to see this directly because the nursing home expenditures are going to be going up anyway.

Maggie Anderson: With the shifting of the nursing home beds from the rural into the urban areas and knowing that in the urban areas there is a demand and a waiting list for nursing home and Medicaid has a certain penetration rate. What we will still see is Medicaid clients going to nursing homes. To be able to offset this and say we prevented this, we won't be able to say that. The money follows the person clients we will be able to identify the people who transitioned out of the nursing home and those that are taking advantage of this level of service we will be able to show you that.

Chairman Pollert: But it is a savings. Those clients would be going to the nursing homes. That would be an additional cost to the state if we don't do level 3.

Maggie Anderson: Those individuals that I indicated that we could track, one of the criteria for money follows the person is that they be Medicaid eligible and be in an institution for 6 months or more. We know we are already paying for those individuals in those institutional settings.

Representative Metcalf: You mentioned something a little while ago when you said there are people on the waiting list to get into these nursing homes. If they meet all the criteria, do we have any ways of providing additional hours for those people who are on waiting lists to take care of their needs at their home when it appears very likely that they need to be in the home.

Maggie Anderson: What generally happens with the waiting list, is those individuals need that level of care. They sought that level of care perhaps in a nursing home in an outlying community. They may be in Glen Ullin and Garrison and just waiting for a slot to open up. They are receiving services and they have generally selected a facility. They want to be in Bismarck/Mandan and have chosen a facility outside of that area until a bed opens up.

Representative Metcalf: There aren't people who are on the waiting list that are still at home?

Maggie: To my knowledge that is not the case. I do know that the PACE program is one area that they are doing outreach to those who are on the waiting list and seeking that level of care. That is also the level of care that they provide services too. They have also been able to offer services to those individuals and allow them to remain at home.

Representative Metcalf: I'm just concerned so nobody is slipping through the cracks.

Maggie Anderson: We are working on that. Home and community based services are really a wrap around process. Our administrative staff, our staff, and the county staff members and family members really try to work the puzzle pieces together and find out what's right for that client. I believe that the county case managers would make sure that nobody was falling through the cracks and if they needed services to remain at home in that time that we would step in and provide those.

Representative Wieland: I like the program because I like the idea of keeping people out of nursing homes as long as possible. You said the maximum cost is $1,500 a month.

Maggie Anderson: That is for SPED. There is no maximum dollar cost for personal care. If you look at the purple sheet, way down at the bottom is the program caps. We limit that based on units for personal care. For SPED which is not part of the tier 3 we limit that to dollars. Personal care level B which is the next, we limit it to 960 units. This service is not limited by dollars but by units of service.

Representative Wieland: Walk us through and individual who would be eligible for the 10 hour program. I want to make sure that there is enough money in there for someone to be able to do that.

Maggie Anderson: It could be an individual who is frail, elderly, they need that. Someone is at the maximum of 960 units. The maximum now would be 1200 units. The 1200 minus the 960 gives you an additional 240 units. The way we built the optional adjustment request was at the agency level of QSP rate. You might recall we have agency QSP's and we have individual QSP's and we have rates for those. We use the higher rate to make sure that we account for that correctly. Also, when people need this level of care, often times it is agencies that provide that. That rate was $4.91 per unit. That comes out to $1,178 of an increase per month per individual who would need this maximum level of service.

Representative Wieland: Then would you add it to the 960 units? That is at what rate?

Maggie Anderson: That is going to be at a blended rate of the specific rate. In our executive budget the personal care community is at that blended rate of individuals and agencies because they both provide the services. We do it by the month per client rather than the unit. Per month what we are expecting to pay in the Governor's budget is $1,481.71 per client per month. That is the average for the biennium.

Chairman Pollert: That is for personal care level 3?

Maggie Anderson: This has nothing to do with SPED.

Chairman Pollert: So $1,481.30 is for level 3?

Maggie Anderson: No for all personal care. When we build the budget we don't build from level A, B, or C. We build personal care services. It's an average of all those services weighted within that. Because the Governor's budget reflects the increase including level 3, this $1,481.71 includes the average cost of level A, B, and C.

Chairman Pollert: Now on the green sheet it shows on page 5 $1 million to general funds, $1.7 of federal, and $2.7 total. That is for 18 months?

Maggie Anderson: That is correct.

Chairman Pollert: That is where you are trying to get the waiver?

Maggie Anderson: We don't need a waiver we need a state plan approved by CMS.

Representative Wieland: If you add the 2 together you are talking about roughly $2,660 for the 10 hour days, 30 days a month. Is there something else?

Maggie Anderson: That $1,481 already includes the weighted average of the level 3 personal care. Your number is going to be overstated. It is already in that average. If you want that per unit amount we can calculate that for you. Using this number will overstate this average.

Representative Wieland: I'd like to see that. We have to make sure that there is enough in there. Are there people willing to work for that. It's not very much per hour if you are going to compute it out per day.

Chairman Pollert: $1,481.70 is per month times 12 months times 1.5 times 27 clients.

Maggie Anderson: I don't believe that it is the right way to do the calculation. You are taking an average that already includes that. Let us do a spreadsheet for you on this because you are taking that average and you will end up overstating it. The 491 is the current rate that we had at the time we built that request. The Governor's budget would include the 7&7 inflationary increase for that rate. That 491 would be 525 in year 1 and 562 in year 2. That would of course be accounted for in the inflation side.

Chairman Pollert: Personal care is actual care needs. Are you saying that for the extra two hours it's like the ADL's on this list is what you are talking about, that is the services that will be offered?

Maggie Anderson: That is correct.

Chairman Pollert: It would not be transportation or outside mobility? It's the ADL's not the IDL's.

Maggie Anderson: It would be the ADL's. It could include meal preparation for one of those items. We would not be authorizing additional services for the laundry, the housekeeping, and the shopping. It would be focused on the care needs.

Chairman Pollert: Can you give me the example you used for the spreadsheets.

Maggie Anderson: A client has $925.33 of income. They have assets of less than $25,000 so we are using the first white sheet. They have been approved for 40 hours of service through the SPED program. The current rate was the $1,380. When you take the 40 hours times $1,380 you get to $552 per month. The current SPED fee schedule if you look at that $925.33 and go across the first line you end up at the second column as you are going to the right that says 90% discount or the client is paying a 10% fee. They are paying 10% of all the care that they receive.

Chairman Pollert: That care is the $552?

Maggie Anderson: What they would be paying today is $55 a month towards their care out of pocket. With the proposed revision to the fee schedule and now you have to flip to the first yellow page, that individual is still earning the same amount of income. You will see that it now falls into that first column 100% discount or no fee. Instead of paying $55 a month they will now pay 0 assuming their income doesn't change.

Maggie Anderson: Testimony Handouts (Attachments C&D)

Chairman Pollert: Could it be said that you want to go to a personal care 3 level. Could it be said you are saving the hospital portion of DHS money or not really? I can see where we are with the nursing homes.

Maggie Anderson: I suspect in isolated situations there may be cases where an individual doesn't have those extra couple hours of care something could happen to their aids. Something can happen where it would lead to hospitalization. I don't know if there is a direct 1-1 correlation where you can see by increasing this we can take a reduction in hospitals. I don't believe we can do that. I just don't think you can draw that type of correlation again. If someone is only receiving 8 hours today and if we weren't there for 10 hours, they would end up in the hospital. Would that have happened outside the 10 hours? It's possible. I just think it would be a very hard statistical connection to make. Continued testimony.

Representative Kerzman: Our state is unique compared to other states. Is there any kind of a move on country wide. Isn't our state kind of molded the DD providers so they look like long term care. It just seems so confusing. We are doing basically the same services but doing it a different way on account of the lawsuit. We are almost treating our providers like public employees yet they aren't public employees. We have kind of a hybrid out there. I don't know if other states offer it that way or not. It just seems so different to me.

Chairman Pollert: That is something I would have to do some research on. I am not aware of that. I couldn't give you a good answer on that. I have only been to one out of state meeting and that subject hadn't came up.

Maggie Anderson: I believe that it is probably the best question for JoeAnne Hoesel but she had to go to another hearing. Maybe when she returns she can address that.

Karen Larson: Medical Services Division. Testimony Handouts (Attachment E)

Chairman Pollert: If I can ask you to work through that number and the day supports, in order to get your net growth of 09-11 for the budget you show an increase of 61 which would be the 22, the 9 and the 8. Then you are taking that 61and splitting it by 2 because they are coming in 1 each year. Am I reading that right?

Karen Larson: Yes. It's 31 the first year and 30 the second year.

Chairman Pollert: Is that the same for the ISLA's? When you say the Grafton Development Center, can you state that again?

Karen Larson: What we have is budgeted transitions from Grafton Developmental Center.

Chairman Pollert: That is the ISLA's. You go from the developmental center to the ISLA. You are projecting that you are going to drop 30 people from the biennium. What you are saying is that if we have clientele of about 150 at the developmental center you are hoping that it is going to drop to 85.

Karen Larson: Of that 30 growth of the biennium's, 22 are high school grads. We aren't quite that high. It's 9 and 8 transitioning from the Grafton Developmental Center.

Chairman Pollert: Oh so it's 9 and 8. Not the 22 & 23. I'm just trying to remember off hand. Was it 115 clients or people at the developmental center that is in the budget? This is saying that we are going to drop 17. Are we going to drop 17 people in the Developmental center to put them in ISLA's. Is that what this is saying?

Maggie Anderson: The 115 is correct. We built the transitions knowing they would go into the community care.

Chairman Pollert: Yeah so you are putting them into the budget.

Karen Larson: Continued testimony.

Representative Wieland: I don't have a question. I would like to go back to the infant development and growth for a second. 96 are state birth rates which is down. That is quite an increase. Where is that coming from?

Karen Larson: The numbers came from child count. It's information that DD gathers and has access to. It shows an average of 5 per month currently. You will notice if you look back to the

07-09 information we had projected a higher ending number for the 07-09 budget. It was budgeted at 8 clients per month. That number has gone down. Continued testimony.

Maggie Anderson: Testimony Handout (Attachment F)

Chairman Pollert: We were at 105.35 and then you said the 115 is from where?

Maggie Anderson: It would include the 5% of the second year as well as the increase that was in the base budget. The $2.4 million in total dollars for the ISLA admin change.

Chairman Pollert: We will get into that increase in more detail? What was the $2.4 for?

Maggie Anderson: The ISLA administrative reimbursement increase. In my overview testimony on the top of page 10 we provided the information on that administrative reimbursement so the current rate structure doesn't provide inadequate level of reimbursement for the DD providers who care for clients with high levels of need. So we worked with the DD providers over the interim to come up with a solution for that in terms of looking at this progressive assessment review as a means to establish the administrative funding for that. The $2.4 million was in the base budget. The value of adding that on is included in the number we started with. It will not match to the spend down reports because they are current biennium actual expenditures. We have to start with the plus 5 and any other additions.

Chairman Pollert: Legislative Council isn't here. I'm just wondering which one of these bullets that this is part of.

Maggie Anderson: It was in the department's base budgets. I'm not sure how they laid that out as we submitted it to Office of Management and Budget prior to any changes the Governor has.

Chairman Pollert: It was in the changes of the first request of the Governor before he put the changes in. We had the two column thing and we put them together.

Maggie Anderson: When the department submits the to Office of Management and Budget we call it our base budget. Then the governor makes his changes and it becomes the Executive Budget. It was in the base budget.

Chairman Pollert: So the 115 is the 5% which comes out to about 110. Then the base budget adds roughly another $5 for $115.

Maggie Anderson: That is correct. When you take the $115.50 and you add the inflation of the $818 which is the 7&7 inflation, you get to $123.68. This is not going to match dollar for dollar. That is a reflection of audit settlements and the DD rates being prospective in that.

Chairman Pollert: So it's the plus 5 plus the budget plus the 7&7? That is how we get to the $124.94. Are you using all the months to do your averages for the month? When we were on medical services you had November through September and took out certain months.

Maggie Anderson: It is the highlighted columns. Typically we start building the budget in April/May of the even numbered years prior to session. That is generally the expenditures we are able to use. We did go a little longer with traditional medical. We knew we were having those system payout and other issues and we wanted to normalize that as much as possible.

Chairman Pollert: So in the case of the DD's you did the front months. In Medical Services you used different months? You picked and chose between the months.

Maggie Anderson: That is correct. If you go to the far column from medical expenditures you will see that there is not much of an anomaly there for DD. Where when you look at those for medical services there is big fluctuations because of those payouts we did. Specifically for hospital services and physician services we need to fill the outliers out. If you would go to the level of dental services, we didn't throw out those early months. We would be using the same time frame for those. It depends on that whole system issue we had. If you want to go to MSLA's which is the next item down on your grant summary sheet, and in the chart.

Chairman Pollert: Are we going to be talking about ISLA's or not? Can we talk about that a little bit and as fares you come up with that proposed increase.

Maggie Anderson: If you would like to talk about them we can. We haven't planned any specific information other than answering any questions you had.

Chairman Pollert: The ISLA funding for the $2.4 million increase, can we talk about that a little bit as far as how you come up with that proposed increase.

Brenda Weisz: You want to know how we did the administrative change?

Chairman Pollert: Yes and when I read more into the paragraph it looks like these are individuals coming out of the developmental center that are requiring more levels of care.

Brenda Weisz: Over the last couple biennium's ISLA is set at 2 reimbursement levels. With more and more people wanting to live in those individualized supported living arrangements rather than group homes, when we do have transitions that often is the choice where they want to be. With Olmstead we can't restrict where they go. With that being more of the location what is happening for the DD providers is that they are struggling with the reimbursement. Currently there is only 2 levels of reimbursement. You have varying levels of need for people who are in ISLA and they are measured in par levels. To measure the complexity of the amount of services or level of ability is to a par level which is used throughout the DD system. What we did was worked closely with the DD providers and the interim to talk about what would be helpful to them to be able to retain individuals in the ISLA environment with that administrative structure. We went from a two level payment to a 5 level payment. It's based on their level of ability then of the client and how much direct service time they would need. That is where the change happened.

Chairman Pollert: So in future biennium when we do DD's and ISLA's are we going to get a purple sheet with the columns to show the levels of care?

Brenda Weisz: That wasn't what I was anticipating.

Maggie Anderson: That sheet shows levels of care. Brenda is getting more to a level of need rather than care. All of the clients in the waiver services will need ICFMR level of care. It's a level of need.

Chairman Pollert: Now we are getting into policy between care and need. The $2.4 million you are going from 2 levels of care to 5 levels of care and there will be different reimbursement rates for that?

Brenda Weisz: We actually have two levels of reimbursement for administrative costs. We changed that to 5 levels based on the degree. It varied by just saying 2 blanket levels we said we are going to have 5 levels of reimbursement because we recognize the different levels of need. Some of the clients don't need much direct time at all. Some need a lot of direct time. Instead of just going with 2 levels of reimbursement we move it to 5. It's stepped differently than just two.

Chairman Pollert: So the average cost structures are going to change? So wherever the proposal is at is going to be a combination of all 5 rates?

Brenda Weisz: Yes for the administrative piece of that. There is services in administrative. That is what we worked on to change from 2 levels of reimbursement to 5 levels of reimbursement.

Chairman Pollert: Yeah it's just that the average of $125 is actually an average of a bunch of rates.

Brenda Weisz: Do you want the sheet that shows the five levels?

Chairman Pollert: I'm just trying to segregate out where the enhanced services or the others are. That is where I'm getting down. I need a clear understanding of how you come up with these.

Brenda Weisz: We talked yesterday about our hold even and cost to continue budget. Because of the issues and the problems that DD providers are having with the reimbursement and being able to keep people in the community and with us being faced with the Olmstead decision, the actual cost to continue and the ability for the DD providers to continue with that ISLA service is actually in our cost to continue. That is important for our DD providers to move forward. That piece in general funds is $911,000 of your change.

Chairman Pollert: Would the cost of providing the extra higher levels of care to the DD be more money than the average daily cost of running the developmental center.

Brenda Weisz: It would be close.

Chairman Pollert: When we are looking at the detail of selected services the ISLA's are done because you rose the amount of the administrative to go from 2 levels to 5. Will we see that on the other sections of this utilization?

Maggie Anderson: It would be on the other area. From my overview testimony that wasn't as large of an increase for that area because of utilization is different. That area family care option 3, it was $96,000 total increase and of that $35,000 were general funds. It won't be as significant but we will see an increase because of that.

Chairman Pollert: That is on what?

Maggie Anderson: The next one I was going to go through was the MSLA's which is the minimally supervised living arrangements. It's the next one down on your grant summary sheet. Continued testimony. (Attachment F).

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/21/09

Recorder Job Number: 7470,7471

Committee Clerk Signature

Minutes:

Chairman Pollert: We will call the committee back to order. I think Brenda has some information that we wanted.

Brenda Weisz: Testimony Handout (Attachment A). This is a vacancy report. I will walk you through some of the areas that we have been through already. I won't touch the ones you will be talking to coming up. Walked through handout.

Representative Metcalf: Where this says currently recruiting, some of them have several months that it has been open. What is the likelihood that these will be filled within the reasonable time?

Brenda Weisz: I think most of them that are currently recruiting are at the institutions is what we are predominately seeing. I would feel more comfortable with Alex addressing that.

Chairman Pollert: Out of the 74 unfilled vacant FTE's we know for sure 1.357 million has been accounted for. Of the 74 unfilled for the developmental center and the state hospital has taken back 1.35 million.

Brenda Weisz: That is accurate. Instead of fully funding his pay plan for the full amount he reduced it by the exact amount he said. It is from both secure and the state hospital. (Attachment B)

Tara Lea Muhlhauser: This is a replacement schedule to the schedule this morning with the addition of subsidized adoption and subsidized guardianship.

JoeAnne Hoesel: Handout Testimony (Attachment C)

Chairman Pollert: You don't have any vacant FTE's in your division?

JoeAnne Hoesel: We have none. Continued testimony.

Chairman Pollert: What is the $54,000 from again?

JoeAnne Hoesel: The $54,874 is a combination of things. First is the cost to continue the 4% salary increase for the last year of this biennium which is $37,474. The remaining $17,400 is a combination of increases and decreases with some of the changes that we have made in the division. With that we will go to the operating section of the budget if you are ready to do that. Continued testimony.

Chairman Pollert: Why do you only show funding for the first half of the biennium?

JoeAnne Hoesel: The funds will be expended. They are aware of that and have been planning for that. Then we will go to operating fees and services. Continued testimony 22:13-27:02.

Chairman Pollert: Where does that show up on the grant lines? It's on the grant lines but not the operating fees?

JoeAnne Hoesel: The $80,000 is in the operating line that we are talking about. When we get to grants I'll let you know where that other piece comes up. That is the history. $100,000 was in the Governor's office and they chose to move it over to the division since we manage contracts and have that experience in history.

Chairman Pollert: So you are on operating fees and services?

JoeAnne Hoesel: Yes.

Chairman Pollert: As we are going down this item because you have a $2.5 million increase can you tell me where the increases are at and what the amount of dollars would be.

JoeAnne Hoesel: Yes. The first one is $80,000 for the Governor's prevention and advisory council support.

Chairman Pollert: So that is new?

JoeAnne Hoesel: Yes. The next is $300,000 which is an increase in the compulsive gambling treatment program which is all general funds. We originally had $400,000 and an additional $300,000 was added so we have a total of $700,000 for compulsive gambling treatment in the upcoming biennium.

Chairman Pollert: I think that should be in the Attorney General's budget.

JoeAnne Hoesel: If you would want information as to why it's in that spot I would be happy to tell you that for your information.

Started new job:

Representative Bellew: She answered my question. I was going to ask her why the switch but she just answered that.

Chairman Pollert: Did you say that was from the Grants line? From the tribal?

JoeAnne Hoesel: No we have 12 prevention coordinators around the state. Four of them are tribal

Chairman Pollert: So 1.634410 is regional and tribal?

JoeAnne Hoesel: Yes and we need to be more prescriptive. I mentioned earlier that as the federal government requires more accountability and reporting and oversight, that requires us to be more prescriptive in our contracts as well. That is the main difference between the contracts and the grants and purchase of service. Continued testimony. We could go back to the prevention coordinators which are about half of the way down. That is $1.6 million. Then

you want to know where the safe and drug free schools and communities are. The Roughrider conference which is $16,242 which is halfway down is our prevention conference in the state. From the bottom is $82,990 that is grants that we have a contract with UND which will end in 2010. Then we have an increase due to the transfer of their enforcing underage drinking laws grant from the grant line up to the operating of $220,922. That is just a shift again from the grant line which will be found halfway in there .Keeping in mind that I'm identifying where the increases are. This sheet is identifying the total. We had some already in the operating fees and services as well and now it is halfway in that list, enforcing underage drinking laws and contracts. Then we have $145,810 and that reflects the 7% inflationary. You are going to find that on that list of operating fees and services right under the AOD summit and it is called the share house meth treatment contract which is $1.5 million.

Chairman Pollert: The only increase is the 7% for share house and they aren't getting anything extra?

JoeAnne Hoesel: Correct. From this division and this department, no. I should say that from this division the human service centers might have a contract but for this meth treatment residential no.

Chairman Pollert: How much money does share house get from us now? What did we do last session? $1.2 million?

JoeAnne Hoesel: It would be this amount minus $145,810 for the contract that this division has for them for the Robinson Recovery Center.

Chairman Pollert: I know we are doing a treatment program through the TRCC at the state hospital through Carry Wicks. Do we have any comparison between the outcomes of share house and the outcomes of the TRCC to see which programs are working?

JoeAnne Hoesel: We have not done a comparison study. We do have a report from Robinson

Recovery Center share house that I could share with you.

Chairman Pollert: I would like to know as an example of what the success ratio of what the TRCC program has done. Let's say the TRCC program has a 50% success ratio and share house has a 25%. I'm just using that as an example. Then we need to take a look as a committee as where our dollars are going for the best bang for our buck. Are we going to be able to see if there is correlation. We have been doing that for about three years .Maybe we have to have an amendment to this budget that says I want to see a study between the two which shows which program is working instead of just throwing general fund dollars at share house or the TRCC program. I want to see which is working.

JoeAnne Hoesel: Here is my initial reaction to that. You are talking about two very different programs. One is a prison based program where they are in a locked facility for at least 100 days, it could be more or less. The Robinson Recovery is a residential, unlocked facility where they are required to work at least 20 hours a week. Not all of them have criminal charges. Certainly we have a fair amount of individuals that are under probation or parole. The intent of the Robinson Recovery Program is to be an alternative to prison to get people early in the process. One could make the case that you are talking about two very different groups of individuals and two very different settings. We certainly can do outcomes. We have outcomes but it would be important for the division to work with you and the state hospital to identify what you consider a success. It could be very different in those three. You have locked and unlocked.

Chairman Pollert: Do you have anywhere else in the state of ND that is doing a program similar to share house where we could see if there is different programs. I don't think share house is the only one that does meth treatment in the state. I'm trying to find out if we are getting our bang for our buck in share house versus somebody else.

JoeAnne Hoesel: I can tell you that there are certainly other residential treatment centers in the state. Robinson Recovery is the only one that is meth specific. It is important for you to know that it makes a huge difference. The drug has unique effects. The rest are mixed so you are going to have a variety of drugs.

Chairman Pollert: I'm not picking on share house but I want to know whether our general funds are going for the right programs. Doesn't share house also pick and choose who they want for clients which could affect the results as well?

JoeAnne Hoesel: I would say that they are taking everybody that meets the criteria for that level of care that gets to that facility. They are very clear on why they can't admit certain people. They are real clear on what the barriers are and what the challenges are or what they consider a success.

Chairman Pollert: I wouldn't mind seeing those results. I think as a committee we should see them. Is there any other sources offering meth addiction services that we can make a comparison to that isn't in a locked facility?

JoeAnne Hoesel: The residential treatment centers in the state do provide treatment to individuals that are addicted to meth. Robinson recovery reports the same outcomes that the human service centers do. I'd have to work with Nancy to see the extent of what we would have to give you. They certainly haven't been asked to do the reporting that Robinson is required to do through our contract.

Chairman Pollert: Are you saying that we could actually see some results that are working through kind of an outreach program? The human service centers wouldn't be a 100 day or a 6 month program. It would be an outpatient sort of a program.

JoeAnne Hoesel: Human Service centers have a variety of levels of care. They do have the same level of care that Robinson Recovery has. Which is considered a clinically managed residential. It is a specific level of addiction treatment.

Chairman Pollert: Is it possible that we could see how their results are too?

JoeAnne Hoesel: They would probably come back to me on this. I will work with Nancy and the addiction supervisors at the centers. We do have an individual that works in my division that works with the date for the human service centers because we are required to report federally on the outcomes as well. Let me see what we can provide you.

Chairman Pollert: I'm just trying to see if we are getting a bang for our buck.

JoeAnne Hoesel: It would be important for me to know what you consider a success as well.

Chairman Pollert: I have no idea. If one says they have a success ratio of 25% and the other says 10-15% then we should take a look at that. I'm just trying to see if we are getting what we asked for at share house.

JoeAnne Hoesel: We will pull some data together with you and see if that is helpful. Then we have an increase for mental health evidence based treatment training. Since the department has and is making a consorted effort to implement evidence based treatment which has been shown to be effective this is the division's work force training initiative. What you will see, keeping in mind that it is $146,191 increase on the operating fees and services. The items that fall into that category are the matrix which is 6 down for $62,000. Recovery support contracts for $109,958, contingency management of $20,000, evidence based program development of $15,000, mental health training contracts of $179,542, supported employment of $15,000, mental health recovery of $25,000, IDDT of $25,0000, and under writing conferences of $5,000 would be the major ones in that area. We also have an increase of $225,500 for the state epidemiology outcome work group. In the middle of the page you will see the acronym of

SEOW contracts of $225,500. That is that contract. That is all federal funds. Then we have an increase of $40,098 for substance abuse programs which is general fund and that would be inclusive of the matrix and summit as well on that sheet. $24,093 increase is all federal funds and that would be the trauma network. That is included in that $179,542 of the training contracts. If you look at the first two you will see the sex offender advocate contract and the sex offender treatment contract. Those two reflect a decrease of $911,507 from the current biennium. $894,507 is general fund. What we have done is worked with the ND state hospital in our secure unit and also the department of corrections and rehabilitation and they have identified the number of offenders that would meet the criteria for this community high risk sex offender treatment program and would be coming into the community over the next biennium. So we were able to decrease that appropriation in that line.

Chairman Pollert: By $894,000?

JoeAnne Hoesel: By $911,507 actually. Again, it is total over here. If you would add the total of this is how much is in this division's budget right now for that program. We are taking that much out because there have been some changes in the criminal justice laws for sex offenders that have affected the number of them coming out into the community. The DOCR has identified some other reasons as well. Then we have a decrease of $12,245 for postage and prevention resource center. We have gone electronic with our catalog and then we have a decrease of $37,807 in professional development. That is because in the substance abuse area we just continued a stipend program. Also, back on the Bars report, there is a decrease in $12,916 in other operating costs. That is a combination of changes in printing, communications, and office equipment. We have a decrease in grants as well of $2,657,638 and you can see that on the second page of the BARS report. It's about 1/3 of the way up from the bottom. I will detail out what has created the situation for those that decreased. The first

one is the safe and drug free schools and community. Two things happened. The first one is that the federal government of the department of education they decreased our funds and grants. That dropped it by $268,834. Then the remaining $546,340 we shifted from the operating line to the grant line. We also transferred out $272,000 to the enforcing underage drinking program which is all federal funds. We transferred up to the operating line and fee services $125,000 which is a mental health contract. The increase in this of $200,000 and that is where the Governor's prevention and advisory council grant money is located and that is new. The rest of the decreases were identified as increases in the operating line.

Chairman Pollert: That is on that page 2 of that BARS report on the grants?

Representative Bellew: Can you explain to me again why you shifted from the grant line item to the operating? Does it just make it easier for you guys?

JoeAnne Hoesel: It reflects the amount of directives that we are able to put into a contract. A grant is saying here is the money. This is the type of program that we want you as a contractor can tell us the best way to do it. A contract that is up in the operating line we say we have this much money and we need you to do this prevention program. It needs to be provided to ages 0-7, you need to use evidence based practices from this list, and you have to do this reporting and it gets very prescriptive. As the federal government requires us to report on those things then we have to make sure that we have and are informing the contractors that they have to provide us that information so that it can be reported.

Chairman Pollert: So does the $200,000 awarded to the Governor's prevention, what is that $200,000 being used for?

JoeAnne Hoesel: That committee hasn't met on this yet. However, I can tell you that this document in green shows you the 6 grants that were funded in our current biennium and based on the data it showed that the youth in ND are starting to drink at younger ages. So the

committee used that data and decided to fund 6 grants that targeted 1st – 4th grade. What the group will do when they meet in April and when we have a finalized budget, then that group will decide based on the data where they want to place the money out. It does need to go out to communities. It will be prevention dollars.

Chairman Pollert: When I look at your grants item breakdown, there is not that much general funds. It is almost all federal dollars.

JoeAnne Hoesel: This is actually the major general source of funds for grants that is coming from the Governor's council.

Chairman Pollert: I was looking at the $2.6 reduction and then looked at the line down and it said $2.8 reduction. I thought it was all federal funds.

Representative Wieland: So I can follow this, JoeAnne let's pretend we are moving ahead at the biennium. In your budget for the next time, instead of under operating fees and services shown for that where you have $26,059,484 for the 07-09 budget we would actually add $2,657,638 to that so we would have about $5,317,122. Then you add to that the changes which are $22,534,487. Then we would have the total of the operating fees and services.

JoeAnne Hoesel: You are asking for two years down the road what would be in that total column of operating fees and services? That would be the $7,899,000.

Representative Wieland: I understand that but what I'm getting at is because you are changing and going away from the grants, is that correct. You are taking the $2,657,638 of grants and adding that to the operating? That is why I'm saying that. Then you would add the change to that which is $2,534,847. That is what you indicated here as an increase in operating fees and services.

JoeAnne Hoesel: That is how we got to that number.

Representative Wieland: It doesn't quite come out. I'm just trying to follow all this shifting. I understand why you might want to do this but I would like to know that it is where the numbers are coming from.

JoeAnne Hoesel: That is where they are coming from and that is where when we come before you in the next session that will be our starting point.

Representative Wieland: You will start at $7,899,893 plus any changes at that time? But because we aren't doing it that way this time I just wanted to know that I'm taking the numbers from the right place to put them into what would be actually the 07-09 budget because you are combining two different sources of funding.

JoeAnne Hoesel: Yes.

Chairman Pollert: Yes so you will see the $7.89 million in operating fees and then the next biennium you will see the $1.6 million in grants instead of all the increases and decrease being fluctuated around.

JoeAnne Hoesel: That is all I have for the division of mental health and substance abuse.

Chairman Pollert: Any questions for JoeAnne? Any other questions?

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/21/09

Recorder Job Number: 7472

Committee Clerk Signature

Minutes:

JoeAnne Hoesel: Testimony Handout (Attachment A)

Representative Nelson: Explain that, 33 additional trips around the entire state. Is that from Bismarck to where?

JoeAnne Hoesel: That is the 19 regional visits keeping in mind that there are 3 staff doing that. That is inclusive of the human service center licensing. There are 14 specific waiver DD program management trainings that will be added because of the waiver and the need to train them.

Representative Nelson: This isn't necessarily meant for you but the travel budgets have really flagged this committee. It would be helpful to know how much new, additional travel as compared to increased costs is. I assume there is training going on every biennium with staff. I know it's hard to get a method where you aren't always comparing apples to apples. It seems to be that so many divisions are doing this. We are seeing double with the travel budgets. I'm assuming that some of that is anticipating a higher motor pool cost or gasoline increases. That may be somewhat mitigated in the next biennium. It would be nice to be able to compare that data.

JoeAnne Hoesel: In other divisions it would be a little less obvious as to what's driving the increase. In this division I can clearly tell you that those 19 and 14 are directly tied to the waiver renewal. Those are in addition to what we would normally do. Keep in mind that the waivers are renewed every five years. It's been five years since we've had to renew our waivers. This waiver renewal includes all of the CMS regulatory changes which impact incident reporting which impact abuse and neglect and exploitation and how we review that. It impacts how regional staff do their jobs and how they report them. They will need to report much more than they do now and use the electronic system differently. All of those things are directly related to that. I don't think I would be able to be that clear outside of some of the licensure types of things. This is clearly regulatory due to our renewal and DD waivers.

Chairman Pollert: Representative Bellew asked yesterday for a report from Brenda regarding the travel expense by section. It's not going to be as detailed as Representative Bellew asked. You are going to bring what you can because you are going to computer generate it. Otherwise what you are really asking for would be manual which would take a lot more time.

Representative Nelson: I forgot that from yesterday.

Brenda Weisz: What we will start with is going into the data base so the travel line you see from Joeanne's right here will pull all of that in one report for you so you can see each area that actually increased. We actually had decreases too believe it or not. You will see that. What you will do is look at that. For the areas that there are significant travel that we can dive in to, you tell us what divisions to go do that manual work for. If it ends up being all of them it ends up being all of them. If it's just selected ones then it is selected ones. That is what we are going to start with and go from there. One thing that occurred to us as we were doing this was during the legislative session the perdium was increased. The hotel was also increased as well as the motor pool mileage. Our budgets weren't changed to reflect that although we are

required to pay that. Part of this increase is a catch up because of the perdium increases. We have people out traveling. We have to pay the higher rate. When that legislation was passed we didn't go to each agencies budget and add the additional $5 a night plus tax. The additional perdium amounts. Part of the catch up you are seeing is that we are doing the same travel we are catching up with the NDCC to pay at those levels. We have to pay it now. We are budgeting for it at that higher level as well.

Chairman Pollert: So you will be able to show us because it might be a certain percentage due. We will be able to see that I suspect.

Brenda Weisz: I would hope so.

Representative Wieland: Instead of traveling do you ever use interactive TV?

Brenda Weisz: We sure do. We actually have what we call polycom systems in our human service centers where we have many meetings that we schedule with our staff across the state. The travel we do, a lot of it is required for our federal grants that we receive in the department. We have multiple sources. We are required to take often more than one trip a year to go to the meetings that the federal grant requires. Often times then you have mileage, airplane flights which have increased substantially as well. We use polycom for our internal state and staffing meetings. We do also have the out of state travel that we are required for grant requirements. We also have the other travel that JoeAnne is talking about for licensure because we can't do that through polycom. We actually have to visit the sights. A lot of your divisions have that kind of travel and your advisory boards around the state. I just want to remind you that motor pool is only in my budget of admin and support. All of the other central office divisions do not have motor pool but they might end up having to pay parents and that sort with the new mileage increase with the new mileage increase that was passed last

session. When you start in with the human service centers tomorrow, the human service centers themselves have motor pool in each of their budgets.

JoeAnne Hoesel: Continued testimony

Chairman Pollert: You said 414 individuals?

JoeAnne Hoesel: Yes and it is $5.24 a day. This is a contract that has and will receive the increase of 7% so that it will go to $5.61 and $6.

Chairman Pollert: So what was the number of individuals a biennium ago? For the 07-09 it must be an increase I take it?

JoeAnne Hoesel: 35 people. The court determines an area where the individual is unable to make decisions in. That is the level of guardianship that is applied.

Chairman Pollert: I'm looking further down on your operating fees and you have corporate guardianship contract. That wouldn't be covered under the other contract? The $1.784 million?

JoeAnne Hoesel: That is the one I was talking about.

Chairman Pollert: What is the Acumen contract?

JoeAnne Hoesel: That is our fiscal agent for the self directed support waivers. The corporate guardianship and then the right rack which is the $1.7 as well and that is our infant screenings. Then we have a variety of part C contracts that have to do with our early intervention programming. Then we have parents as trainers and we have a technical assistance. This is the area in this budget that currently works with individuals and screens for autism spectrum disorders that we talked about earlier. Continued testimony.

Chairman Pollert: Did you address the $46,000 increase in professional development?

JoeAnne Hoesel: I'm not sure. The $46,179 is to support the early intervention services contract or program. It is such a rapidly changing program that we supply them ongoing

information and training in terms of what they need to know to appropriately screen infants for potential delays. Continued testimony.

Chairman Pollert: Are there any more questions for JoeAnne on the DD policy? If not we are going to adjourn today.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012 – Human Service Centers detail

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/22/09

Recorder Job Number: 7566, 7568.

Committee Clerk Signature

Minutes:

Chairman Pollert: Called meeting to order. Clerk took roll and every member present. We are going to start this morning on global health initiative.

Nancy McKenzie: Handout Testimony (Attachment A)

Representative Kerzman: Is there any restrictions on how far you can move those people out of the communities to provide the services. Say that Dickinson wouldn't get anything up and running could you move them to Bismarck? You would still be 100 miles away.

Nancy McKenzie: There is not any kind of rule for a restriction. We always aim to be serving people as close to home as we can. It's better for them if they can maintain closet o family. Sometimes if we can serve on an outpatient service they can maintain at least part time on a job. We do, in terms of capacity, have times where we may have a transitional living bed that was available. The person was in the state hospital. If they were ok with it, they would go to another community. We work individually with people on that. We know we can't provide anything, everywhere. There is going to have to be some specialized services. Certainly we try to have those base services everywhere so people can be treated close to home.

Representative Kreidt: The badlands is a 16 bed residential facility. Are you looking at someone building a new facility? Is this an existing one?

Nancy McKenzie: They do have a developer that is interested in putting that together. I believe that it will be a new building structure.

Representative Nelson: I'm assuming that these are new facilities. You look at $1 million here and there, the question I get is that we have communities outlying the regional centers where there may be a school where is closed. They ask why we can't find something to utilize a good facility. The situation that may have a use. The staffing in a rural setting too cumbersome? Why don't we use some of these facilities for housing and other use?

Nancy McKenzie: We would certainly be open to talking about that. If we are able to have a cost savings that is a great thing. The challenges are staffing. Even in our larger communities they are struggling with keeping staff. Those type have 24/7 staff. Obtaining and keeping staff is a tough issue in the small communities. Also, there is the issue of just the other services. When those clients are in either a crisis bed or a transitional living facility they aren't only residing there but probably seeing a psychiatrist for the Center for meds. They might have a nurse coming out to follow up with that. They have a case manager. Some of it is economies of scale and giving people access. We do try to do whatever kind of outreach things away from those major cities. The residential piece is harder for those reasons.

Representative Nelson: I'm sure in some of those cases they would actually give you the building just to get it back to use.

Nancy McKenzie: That is something that we wouldn't be opposed to talking about at all.

Chairman Pollert: Would this be a correct statement in saying that this global health initiative is actually a program that has been going on in conjunction with the hospitals and this is just a way of transferring it to the human service centers and to the hospital.

Nancy McKenzie: It is accurate to say that these services have been going on. This is not a whole brand new initiative. I'm not sure that I fully understand what you are asking.

Chairman Pollert: What I'm hearing is the Global Behavioral Health Initiative is a mental health and substance abuse. We seem to have a fair amount of programs on mental health and substance abuse. So I'm wondering is this brand new? Is this something that has been going on? This will be reimbursed on the new Medicaid rates. Because of what we have been hearing as a section if I'm correct is that the Medicaid rates don't pay worth a darn. Are you going to come back the next session and want a raise?

Nancy McKenzie: The local hospitals know that the rebasing is being looked at and that we are looking at trying to strengthen our contract in that way. They are very pleased. I don't necessarily anticipate that we are going to have to redo our contracts over and over beyond inflation. I imagine that there will be a point where we will need rebasing.

Chairman Pollert: Could it be said that the hospitals don't want to furnish the service anymore and that is why you guys are taking this over.

Nancy McKenzie: We aren't looking for the hospitals to take over what the hospitals have done. We have always done this.

Chairman Pollert: Can the hospitals not afford to do it so they are discontinuing the programs?

Nancy McKenzie: Yes . We have had one discontinue and we have had others talk to us that say they can't continue to contract with us if we do this. There is another piece of that issue. If our clients present that in the emergency room, I don't think a hospital has a right to say they aren't going to serve them. That's not going to happen. We want them to be connected with us. Our staff goes up to Meritcare and up to St. Alexius and sees clients. It usually means a shorter stay for the client. The other alternative is that we go to the state hospital. If everyone under our contracts went there we would be in trouble. Certainly there is a big financial press there. I wonder if it would help if I say that all of the services and what the human service

centers do with some of their step down facilities and so forth are in place. These particular things that you see are additions to better fill out that continuum. Just as in the last biennium you supported some funding for some additional beds in certain places so we could to that. The name is something that we tagged on it to try to convey that it is a packaged deal.

Chairman Pollert: So it's not a nationwide initiative but something that ND is doing?

Nancy McKenzie: Yes.

Brenda Weisz: It really came about with the fact that we had to prioritize our OAR's. All of these belong together in one grouping. We prioritize by category on our OAR's. We came up with the name for our category to prioritize in an OAR so that we could pull these together and prioritize them as our number one priority of services. We arrived at that name. That is a name we had to pick to use to track so Office of Management and Budget and the Governor's office knew what our number one priority was. That is where it derived.

Chairman Pollert: So with medical services we are going to increase the rebasing, do a 7&7. You can clarify that we are going to increase this mental health and substance abuse through the global initiative. It sounds like you are doing the program because the hospitals don't want to fund it anymore but yet we are going to increase the funding to the hospitals then take this service away from them?

Brenda Weisz: In the medical services division we did that rebasing report that included all hospitals which was inpatient and psychiatric. We contract for those two in the regions. What we said is that we have indigent clients that go there as well. Let's build the budget so when they take the indigent client and they get paid the same reimbursement it will be through a contract but the same rate will be paid. It was to make a consistent payment methodology between those clients. Now that hospital is going to get the same rate of reimbursement.

Nancy McKenzie: The human service contracts do have an amount in their budget. There is in essence a cap. There will be a higher daily rate. The total has increased from what it was in the current budget. There still may be some cost sharing with these hospitals because if we would have a real high amount of hospitalization or longer lengths of stay, we may again run out of money before the biennium. It's a capped amount.

Representative Nelson: What is the bed count that generally goes through the human resource centers in a biennium?

Nancy McKenzie: Are you talking about number of people that go to inpatient treatment. We built the budget on about 1,500 bed days which is based on what we have been using which is statewide.

Tim Sauter; Testimony handout (Attachment B)

Representative Ekstrom: The young transitional group that you are working with, is it true to say that they are similar in terms of their problems to the adults that you are serving who have already had a run in with the justice system. Have they already been through the juvenile system process. I know your adult clients have been through the justice system.

Tim Sauter: That is true for some but not necessarily all. A lot of these children have not experience legal difficulties as a child. When they go out on their own they find bad decisions and they come encounter the legal system. It is our hope that we can better prepare them for their transition to adulthood that we can help them avoid those situations. Continued testimony.

Chairman Pollert: Do we know what the average turnover rate in ND is?

Representative Metcalf: Is this rate going up considerably because the department of corrections is viewing their needs in a larger consent. Or because there is more people that have a problem?

Tim Sauter: I don't know if I have an answer for that as far as the cause and effect. Certainly I think there are challenges for hiring people to work in the corrections system. I think they have to often times pay people a higher salary in order to make that job more attractive.

Nancy McKenzie: Were you asking about the referrals in clients or staff?

Representative Metcalf: The people referred over to your facility.

Nancy McKenzie: I do think we have seen quite an increase in referrals there has been a lot of joint work done to look at how people get referred to us if they have mental health or substance abuse problems. That is happening sooner now. We have people on joint work groups. That is a big factor.

Representative Nelson: I'd like to know if the increase in referrals, does it have anything with the quality of the Tompkins program in your opinion? We keep being told that this is one of the most successful drug treatment programs. The success ratio has been very good. This would indicate something other than that. Is it increased numbers?

Tim Sauter: I will say that it does an outstanding job. The people we treat at central speak highly of the program. The people we serve out of that system are people who are in an aftercare program and wanting to maintain their sobriety and keep myself productive in the community. I don't think it's a negative reflection at all. We also have an increase in the Dickinson region. Being in Bismarck, a lot of the people that come out of the penitentiary stay in Bismarck. They go from the pen to the Bismarck transition center. We are just part of that community and helping those people transition into the community.

Representative Nelson: I know that although meth convictions have leveled off through the system there were a high number of people that are probably going through transition at this stage of the treatment. There may be a bump in numbers. Are you seeing that. Every region is probably different.

Tim Sauter: Not everybody who is at the pen with addiction problems go through treatment. I think they are just putting more effort into making sure people transmission into the community and are getting the services they need so they don't reoffend and end up back in the pen. That is probably where the effort is coming from and why we are seeing an increase in the numbers.

Nancy McKenzie: I agree with what Tim said. Not everyone who is referred to the human service centers are coming out of the prison or Tompkins. A number are referred by probation officers or parole officers. They are individuals who have never been in the pen but are being followed on probation status in the community in the hopes that they don't have to go to prison. Treatment is an important part of that. Some people might come to us from aftercare from Tompkins but that isn't the majority of our folks.

Roxanne Woeste: If you will remember back to one of the first couple days of session you did have a joint hearing. They reported that 2008 the average state turnover for all agencies was 9.1%.

Brenda Weisz: The turnover for DHS is 11.37%.

Chairman Pollert: That is including the DD and state hospital?

Brenda Weisz: Yes.

Chairman Pollert: Do you find any segments of the DHS budget are worse than others. I would suspect like the Northwest human service center rate would be higher right now because of oil.

Brenda Weisz: You are right. It is 22.92% turnover there.

Chairman Pollert: I would like to know the turnover rate of each human service center when they come up.

Brenda Weisz: I will leave the sheet here for everyone.

Chairman Pollert: Do you have any clients coming from Robinson?

Tim Sauter: I believe that all the regions of the state do have clients who are at Robinson recovery. If they do return to the community from Fargo then certainly they would be eligible for services. It might be a choice thing unless they are under a court order for treatment. We would have some of them return to the regions.

Chairman Pollert: I know that when we were setting up meth programs at Robinson and TRCC they said we were going to get what success ratios were and I do want to see some of them. We should be asking that question. If there is anything like that, I would like to know if there is a correlation between that.

Tim Sauter: Continued testimony.

Chairman Pollert: So you see a difference between rehabilitation with teen challenge and other programs? Is the success rate better at one of those places? Have there been any studies done on that?

Tim Sauter: I haven't seen any studies relative to the success of teen challenge . I think every program has its place. It's been beneficial to people.

Chairman Pollert: I probably should have asked JoeAnne. I'd like to have that discussion.

Representative Metcalf: This is probably something that you can or cannot answer. I noticed that you said you started two new businesses and assisted six farmers to stay in business. Is this a process that is happening state wide at all the centers or in your particular location?

Tim Sauter: I believe most of the centers vocational rehabilitation programs do have rural services. I would say that it is happening. I believe it is a state wide effort. As far as working with indigent medication programs I can't answer that. I would just assume they do. Continued testimony.

Representative Bellew: What are your other funds?

Tim Sauter: Other funds relate to direct payment from clients and third party. Continued testimony.

Representative Ekstrom: In this salary package, is the Governor's equity package in there already too?

Chairman Pollert: I would suspect that there would be more equity payments for the Northwest areas or not.

Brenda Weisz: It actually will depend on where those employees sit. We can formulate a plan for them that would cover some of those areas. Also we would have to be cognizant of our staff that are there that might be sitting at a pay grade. They may have been there for many years but are still sitting low. We have to balance both of the situations.

Chairman Pollert: Is Office of Management and Budget going to come up with an equity for every department or are you expecting every department to come up with equity?

Lori Laschkewitsch: The department's each come up with their own equity plan. This is not a formula that is done with the class agencies. We are taking a look at each individual agency to see where their issues were and what kinds of needs they had.

Chairman Pollert: But Office of Management and Budget decided the total amounts of equity that go to every agency.

Lori Laschkewitsch: Yes. Based on what the needs for that particular agency were. Where they had their shortages and all of that.

Chairman Pollert: Based on compression, longevity of service, all of that?

Lori Laschkewitsch: All of that was an element that played into that. We felt the agencies would best be able to take a look at where their individual employees were. They knew the specific situations that they had to deal with.

Chairman Pollert :Do you know if government ops are taking a look at equity since the budget is in their section? I think it's on the house side this time. Are they taking a look at how that was done? Any idea? I think their budget was just heard the other day.

Roxanne Woeste: The equity dollars are in each agency. I believe for those agency budgets that you are hearing that you would be responsible for looking at those equity dollars.

Chairman Pollert: At the same time we had heard there was a discussion through Office of Management and Budget.

Representative Metcalf: Along that same line, are the Office of Management and Budget and whoever else involved taking any effort to approve those plans that the agency come forward with as far as the distribution of those funds? I'm concerned if we don't have somebody that is pulling this together and trying to keep them on a level basis, it could become rapid.

Lori Laschkewitsch: The provisions written into Office of Management and Budget's bill are that they have to present a plan that we will approve. We do ask that they present us with what it is they are planning to do but it's not based on our approval. Again, we just feel very strongly that there are so many different situations in each agency.

Chairman Pollert: If I'm correct the total equity was around $3 million?

Roxanne Woeste: The DHS equity was approximately $5 million total funds, $3.5 was general funds.

Representative Metcalf: The reason I asked that question is we had an emergency services department that went wild giving equity payments here not too long ago. I don't feel that should happen. Somehow we have to have oversight.

Tim Sauter: Continued testimony.

Representative Bellew: the 7&7 for provider increases, where did those figures come from, was it the Governor's recommendation or your request? It's in your OAR's too?

Brenda Weisz: You answered your own question.

Tim Sauter: Continued testimony.

Representative Wieland: When you talked about case load on page 1, are those individuals unduplicated?

Tim Sauter: Unduplicated for that population in the grouping of mental health, substance abuse, and developmental disabilities.

Representative Wieland: The second question regarding your FTE, the majority of that is federal funds. Am I correct?

Tim Sauter: If you look at the numbers it is a total of $100,626. $50,313 is general funds. The rest would be federal funds.

Representative Wieland: Was the position because you had federal funds available for that or was it something you wanted to fund regardless?

Tim Sauter: The reason that we are asking for this position is looking at the additional requirements that are coming from the center of Medicaid and Medicare services that relates to the DD wavier. We are looking at an increase in the order of responsibilities.

Representative Wieland: When you have a federal funded FTE, when you hire someone to fill that position do you do it on the basis that if the federal funded goes away, that the job may go away as well? Do you have a policy regarding that type of an issue?

Brenda Weisz: That would come into play in some regard when it would come to some close end funding. With Medicaid, if the expenditures are allowable, we continue to draw it on federal funds. With this FTE we wouldn't run into the circumstance you are talking about. However, if you look at some of our block grants and if there is positions that are funded with block grants or specific close end grants we would have to take a look at if we were running out of dollars

and if the services are still needed we would have to balance services provided versus staffing. It would come into play on some sources.

Tim Sauter: Handout testimony (Attachment C)

Representative Kerzman: Going back to child welfare services, I show 3.5 not 30.

Tim Sauter: Its 3.5. If I said that it was an error.

Chairman Pollert: I'm looking at the vacant FTE's for Westcentral. I see you have 3 of them filled. It showed 5 of them. One says unclassified.

Tim Sauter: That would be the psychiatry position which we are in the process of recruiting that. There were other positions that were being filled. We are still recruiting and have more interviews.

Chairman Pollert: Is the human service center outside contracting psychologists or psychiatrists? Are you able to do it in store?

Tim Sauter: At Westcentral we have two psychiatrists that are on staff. To fill the void while we recruit the third one, we are contracting with psychiatry networks out of Fargo for some additional psychiatry time to help us meet the demand.

Chairman Pollert: Let's just proceed down the line.

Tim Sauter: Continued testimony.

Chairman Pollert: Can you go over the rental again?

Tim Sauter: Our primary office for human service center is 35,521 square feet. The rate will be $14.05. That is a 54 cent per square foot increase from the current budget. Then we added those $5,210 for VR services and that is being rented at $16 a square foot.

Chairman Pollert: That was added the last biennium?

Tim Sauter: We are just in the process of moving into that space.

Representative Kreidt: Fringe benefits seem to be looking at the $11 million in salaries.

Tim Sauter: If you look at the first line item under the executive salary recommendation that is $534,932. That is to cover the health insurance costs for the staff. Then going down the list looking at the benefit increase there of $142,143 that is our other benefits like social security, retirement, and those kinds of things.

Representative Kreidt: Would that also include the vacation , sick leave, benefits?

Brenda Weisz: We don't factor in for the allowance or an amount we set aside for vacation or sick leave. The number you are seeing for the fringe benefits, the three numbers that are singled out is due to the Governors salary package. We don't ever put reserves away. Just like with the other testimony the fringe benefit is the health insurance coverage of the Governor's salary. It just looks different because they have a lump sum budget instead of seeing them all in one group.

Chairman Pollert: On the rental with the increase of $200,000. The rehabilitation services are a new rental or expansion?

Tim Sauter: That would be an expansion that is occurring currently.

Chairman Pollert: Was that improved in the last biennium and then this is just a continuation of the rent going into the next biennium with the $5,200 extra?

Tim Sauter: It would be a new addition to that.

Chairman Pollert: This is proposed. It sounds like you are doing it right now.

Brenda Weisz: Because in his testimony he talked about the issues we are having with staffing over at Prairie Hills Plaza. It's a space issue. Some space opened up in that building structure. In the lower level there used to be a private operation. The space opened up and because of the staffing and the crunch for the west central service center and the doubling up of staff and offices, and the need for more group rooms. We said we would be interested in

that space down below on that first level. That is where our VR part of the human service center is relocating and moving in soon.

Chairman Pollert: So you are in there now. You found the money in your budget to do the extra rent?

Brenda Weisz: That's right. It is VR which is predominately federal funds which helps with that whole decision in order to do that.

Chairman Pollert: Did I ask in the overview for a breakdown of your turn back?

Brenda Weisz: Yes we did talk about that. I talked to you collectively of the human service centers and collectively that is $2 million. I could put that on a schedule for you.

Chairman Pollert: I know there are 2 different breakouts there.

Brenda Weisz: Between human service center and different parts of the department?

Chairman Pollert: No I'm talking about the Medicaid dollars.

Brenda Weisz: Did you want a breakdown for the whole department or do you want it for just the human service centers?

Chairman Pollert: Whole department.

Brenda Weisz: I can bring that later.

Representative Bellew: Under your rent, you have residential apartment rent for CDMIDD. Would that be more appropriate under the grants line item?

Brenda Weisz: What we do when we build a budget is we look at the budget structure that is laid out for us from Office of Management and Budget. All state agencies budget for rent in one spot so we follow that same specific outline. Since there is a rent category that is why we put it in the rent category. We follow the rules.

Representative Metcalf: I have a couple questions concerning the fees for professional services and the amount that it is costing you. You have here fees for professional services. Dose that include the fees you are paying your psychologists who are not on contract?

Tim Sauter: Those would be under our grants line item. This category will be for services like our interpreter fees and some of the support that we purchase from the Beulah Hazen clinic where we have our outreach office.

Representative Metcalf: What is the situation as far as the rent a doc. How much more do they cost us than when we get our contracted services? The psychiatrists you get out of the Fargo facilities.

Tim Sauter: We pay $210 an hour for that service. We are paying our contracted psychiatrists $175.

Representative Metcalf: Are these doctors from Fargo? Are they local?

Tim Sauter: The person who is delivering the service for us currently is from Fargo.

Representative Metcalf: Then you pay them the $210 while they are in travel status?

Tim Sauter: There is no travel we do that through tele-medicine. He is actually located in his Fargo office and we have the clients seen at the badlands office. They are hooked by a network. Continued testimony.

Chairman Pollert: I see you have a $15,000 increase in operating fees. Can you show me where the increases are showing up at? Then maybe explain to me wrap-around services.

Tim Sauter: Right. It is partly federal dollars. When we look at the flexible funds for services to the homeless I think one of the situations there was that it is an item that we are required to do by the federal government as part of our grant. I don't think we had a line item for that in the past. It shows up as new. It was in the budget before but it was just somewhere else. The wrap around services, I don't have the figure there.

Chairman Pollert: Can you tell me what wrap around services is?

Tim Sauter: They are used to help preserve families and preserve safety for children. It can be used for a variety of things from helping with daycare so parents can go through treatment to helping with mileage. It could be providing some kind of a service. It could be helping them with the risk of being evicted from their home. We might take that on as a onetime expense to help them stay together.

Chairman Pollert: I was just looking at years of service awards. If you take $6,500 divided by $135 people if you gave them all a plaque that is $48.

Tim Sauter: The state also has a system depending on the years of service in addition to a certificate or plaque you may receive a gift certificate or a bank savings bond as part of the award for that. It varies by the years of service.

Brenda Weisz: It's not all that much money. If you look at how many FTE's they have and now that they changed it to that. You get service awards for three years. It used to be at 5. It is outlined in administrative code. That is what gets it.

Representative Kreidt: Again in the salary lines, looking down I see you plug in a million dollars down further in the line items under $59,910 and $160 salary and benefits. What is that?

Tim Sauter: That is specifically the Governor's salary package.

Chairman Pollert: That is FICA, retirement.

Representative Kreidt: But that is anther million that is added on top.

Chairman Pollert: Every budget we are seeing, the salary increase is the 5 and 5. The fringe benefits and health insurance premiums increased. The benefit increase is like your FICA taxes and such as that. Is that correct? If there is an extra FTE that would be included there also?

Brenda Weisz: For the FTE that was added to Tim's budget that would be in the total changes column. The bottom category is used specifically for the Governor's salary package and things tied to the Governor's salary package. That is why we left that executive salary recommendation column separate so you could separate out what is done outside of that 5&5 and health insurance. You will see some doubling up on the fringe benefit because they hit both of those for the FTE and changes in the fringe benefits.

Chairman Pollert: I think why Representative Kreidt is asking is that normally the benefit increase and salary increase was up with the fringe benefits.

Brenda Weisz: Yes that is why I said you are going to see it different on the Westcentral human service center and all of the other human service centers and in the institutions it will be different and broken out. They have a lump sum fund budget. At the central office we have salaries, operating, and grants. This ties with salaries in the central office and they will show up together. Because everything is all in one line item the account codes on the left are in numerical order. Because we are held to line items in the central office it will go up with the line item and be in numerical order by line item because this is purely by line item.

Representative Kreidt: That has got the 5&5 on top of the salary? That shows a 5&5 increase in there on the top line.

Brenda Weisz: The increase there would be changes that Tim pointed out in his testimony outside of the Governor's salary package.

Representative Kreidt: Yes but that would be a 5&5 in there then?

Brenda Weisz: The 5&5 is in a separate column. These are changes before the 5&5.

Chairman Pollert: I think what Representative Kreidt is asking is that you have total changes in salary of almost $800,000. Then you show the 5&5 under the salary increase. Why is the $800,000 increase under salaries permanent versus the other.

Tim Sauter: If you go back to page 3, we talk about additional changes in the salary area is the result of adding the one FTE for development disabilities case management. It shows that amount. The realignment of staff to meet client needs made up the bulk of that. Those are the things that are contributing to the larger number up on top.

Representative Bellew: When you realign staff that means you take this amount of money from somewhere else and put it in your budget?

Tim Sauter: In this case we had the physicians but we didn't have the funding. That is why we are asking for the funding. I have enough roll up to cover it during this current biennium. We don't have the money for next biennium.

Chairman Pollert: The 1.552 would be the $534,932 plus the $875,143 plus the $142,143. Is that correct? Then I would think that Representative Kreidt is asking if you have the salary increase of the $1,552,000 if it's in the three columns then why does $797,000 increase in the salaries permanent?

Tim Sauter: If you go back to those realignment issues the $723,488 is the large portion of that top line.

Chairman Pollert: Of the $797,593? Where the 1 FTE is going to make $350,000 plus all those expanses?

Tim Sauter: No. It includes one developmental disabilities case manager which is $100,000. Then you have $723,488 related to the realignment which includes the two psychiatry positions and another portion of the support position and also another portion of the developmental case manager position.

Chairman Pollert: Are you saying that is in there because they were vacant and now you are putting them in?

Tim Sauter: We are seeing a need for services. We are under staffed for psychiatry. We have

long wait periods for people to get in to see the psychiatrists. We have had to reduce some of the existing services that we had psychiatrists doing to meet the demand. We work with the department to look at how we meet that need. We were able to come up with the positions. We had enough money in the budget to cover it for this biennium. We had to request the additional funding for the next biennium to cover those expenses.

Chairman Pollert: So the $697,000 is for the two psychiatrists?

Tim Sauter: For the psychiatry it is about $650,000. Then we have $100,000 for the DD case manager. There are two portions that factor into that.

Chairman Pollert: So the psychiatrist is making $162,000 a year?

Tim Sauter: That would be correct.

Representative Nelson: If equity is in the administrative budget, I'm assuming that it would be proportioned out to the human resource centers as well as with these increases

Tim Sauter: That would be my understanding.

Chairman Pollert: If you remember the P&A budget, their equity ended up being, if you took it employee wise, 27.5 employees would be $3,196 increase per employee besides the 5&5. If you go to the DHS budget it comes out to $2,250 divided amongst 2,230 employees plus they get the 5&5. P&A is averaging $3,200 and DHS per employee is averaging $2,250.

Representative Wieland: I'm still having trouble when you talk about realignment of staff. Are these FTE's that are already in existence? Are they new FTE's? If they were in existence then they were not funded in previous budgets?

Brenda Weisz: These are FTE's that are existing in our field services area. They might be located in another center whether or not they need that staff. When we are appropriated FTE's for the department we have those FTE's we manage. Westcentral based on their wait times based on the services they need to provide needed an FTE to put in place to do those

services. When we locate an FTE within a human service center where they don't need that we will move the FTE but often times that center can't move the budget as well. We do need to provide this service. To do that we do move the FTE to realign our staff to the resources necessary. We look at our existing budgets to see if we can do that or not.

Representative Wieland: Are we going to see a reduction at some other center?

Brenda Weisz: I'm going to say no. The reason you aren't going to is if we were to just stop today and that is all we would do and not have other increasing needs then you would see that. Because of the other increasing needs that are existing throughout the system you won't see the reduction because of other increases. Even though there might have been a reduction for a particular piece of it, it's not going to actually reflect the reduction because of increased need anyway. We could do something else too. If there is a realignment and a need of staff at a center they work together, collaborate as a team, and figure that out where it would best serve. If we would say we are moving the money out of one center and putting it over here, you will just see a bigger increase in another center. We try to contain it the best we can in each of the divisions we move it to. At times, because of increased service needs, have increased requests.

Representative Bellew: If we are creating two new positions for this center, should not the FTE count go up by 2?

Brenda Weisz: We didn't create two new FTE's in the system. In the center we did. It is reflective in our current budget because we made the move of the FTE's right now. When we present a budget to you when it says the current budget column we show you what is currently our budget for that area and because it was this biennium they are part of our current budget count. That is why you aren't seeing a change.

Chairman Pollert: Is there a ratio in the human service centers how many psychiatrists per clients served?

Tim Sauter: We don't have a specific ratio. It is based on demand. We are serving over 1,000 patients with the 2 psychiatrists. In order to treat them we need that additional position.

Chairman Pollert: How many psychiatrists do you have for a total client base. You are saying you need 3 whether they are outside or in house. That is 3 per 1,000?

Tim Sauter: That is about how many people we are serving through our psychiatry services. At Westcentral it is about 1,000. We are at capacity. Those psychiatrists are booked from the time they walk in to the office from the time they walk out. They are 15-20 minute appointments except for the initial appointment which may be 45 -60 minutes. They are very busy. Continued testimony on case aid services.

Chairman Pollert: I hate to really go there but severe mental illness is different than the global health initiative since they are both mental health problems? What is the difference between the two as far as dollar wise?

Tim Sauter: The global health issue is again a term that the department came up with.

Chairman Pollert: No I mean is it targeted to different individuals and what is their diagnosis compared to what you are doing with severe mental illness at all?

Tim Sauter: They take care of the same people. It's these kind of services that help keep people in the community so that they don't end up transitioning into in patient at the state hospital or local hospitals.

Chairman Pollert: That is why I'm trying to get a correlation. It almost seems like it would be a double up between SMI and global health.

Brenda Weisz: I think one way to look at it with the OAR was the increases for additional needs that we saw for these existing services. If we wouldn't have done that our OAR list

would be 3 pages long. Westcentral would have had one more. Because they were similar in need and because they were doing the same thing at getting at the occupancy problem at the state hospital and residential issues in the communities. Instead of having multiple OAR's they were all part of one problem or issue. That is why they got pulled together into that number 1 priority. It's just to alleviate the problems that we were seeing in the existing services and pull them together in one category.

Chairman Pollert: For global health initiative, how many clients will be served. I'm looking at where the state hospital was at for occupancy probably 3-4 biennium's ago and 85% of occupancy or something. I know the numbers were down. Now they are up to 100-103% of occupancy. Now we have seen the state hospital increase in patient load. We are also seeing the human service centers increase in patient load. Had we increased the clientele to be served by 2 fold? It seems that it is something that is exploding here the last 2 biennium's. They all have to be related somehow. We went from an 85% occupancy at the state hospital to around 103%. Yet, our budgets are exploding with the global health initiative and other SMI cases. I'm trying to wonder why we are exploding so bad in 4 years.

Brenda Weisz: I don't think global behavioral health should be considered a new initiative. It wasn't a new initiative. It was just a way to group the issues we were seeing across the state. It's not a new initiative. It's just because we have capacity issues and the capacity issues at the state hospital. We put it into one number.

Chairman Pollert: How many clients were served mental health wise versus how many you are going to do through the 09-11 biennium including global health. I'd like to have those numbers. Have they exploded and why?

Alex Schweitzer: I have a handout tomorrow for you that will show over the last 5 years the

number of first time admissions with the state hospital. As you asked the question if there is additional, that is true. I think it averages about 285 per year.

Tim Sauter: Continued testimony.

Chairman Pollert: Population stays pretty stagnant in the state but yet you are seeing our mental health is increasing 33% in 4 years.

Tim Sauter: That would be correct. That is the people who are presenting at our door. Again they are having more complicated problems then they were years ago. Continued testimony on crisis safe beds and inpatient hospitalization.

Chairman Pollert: So this is not part of the global health increase in funding that the human service centers are asking for. This is separate? This inpatient hospitalization?

Tim Sauter: I think it's a combination of both. We have had these contracts with the hospitals since about 1988.

Chairman Pollert: Yet you are going up three times total? I'm trying to correlate why that is. Is it because the hospitals are no longer willing to fund it in their budgets and so you guys are doing it? The increase is going to be a 3-fold increase?

Tim Sauter: We have always paid the hospital for crisis stabilization for indigent patients. What the change in the rate is, is relating to the rebasing of the Medicaid that they talked about earlier. In our region we had a flat rate of $2,000 per stay. Now it is going to go to the Medicaid rate based on the number of days that the person is in the hospital. When we did this we tried to look at the average patient days for both regions and we multiplied that by both regions.

Chairman Pollert: So the basic rate was $2,000?

Tim Sauter: In our current contract we are paying $2,000 per stay for each of these individuals.

Chairman Pollert: It is based off of what?

Tim Sauter: The new formula will be based on the Medicaid rebased rate that Nancy had talked about earlier. We took a look at an average of 500 patient days. Then based on what the Medicaid rate for inpatient is, for those two hospitals we figured out how many would go to each hospital and we multiplied it by that rate. That is how we came up with that figure. It covers both centers.

Chairman Pollert: What is that rate?

Brenda Weisz: That will differ by hospital because of how the rebasing report was done. How the rate was set was the lower of cost for the psychiatric hospitalization or the standard deviation of one. Take those words and turn it into this number, $1,020.48. That is the max we would pay. If their costs were lower they would get their cost. That is what the rebasing report did for psychiatric. I will pull the cost by centers and hospitals. There is only one center that actually has costs higher than that.

Chairman Pollert: It's not a correct to say we are proposing to raise those amount of dollars to global health initiative we aren't saving on the hospital side?

Brenda Weisz: No. The increase in the rate of hospitals wasn't to create a savings for them but to pay them at a higher rate just as we did in the Medicaid rebasing. The one thing that might be helpful is the worksheet that Nancy handed out that had the numbers to the global behavioral health. When you look at Westcentral on the breakdown you see the increase in the hospital contract there. That should correlate to that increase on here. That is how some of that will tie together too.

Representative Nelson: Is it fair to say that every one of these individuals is being served in the inpatient hospital now but it is coming out of the budgets of the 2 providers in Bismarck in this case?

Brenda Weisz: Right now the clients we have are being served currently in the $200,000 contract that we have right now. They will continue to be served but that hospital will be paid at higher rates. It won't be flat and locked in at $200,000.

Representative Nelson: There is nobody that is being denied service. It is just that the department or the human service center is subsidizing their care?

Brenda Weisz: Yes.

Tim Sauter: The people we are paying for are people who would not be able to pay their bill. We have entered into an agreement with the hospitals that we would pay them this much in order to serve the people. If we don't pay that they wouldn't get any reimbursement for that. In essence they have accepted less than their cost because that is better than nothing. They are saying it is getting harder and harder for them to lose money on those admissions. That is one of the reasons why we are looking at the rebasing.

Representative Nelson: This might be hard for you to answer. Do you expect if the reimbursement to the hospitals takes place, any change in the level of care that is given to these individuals?

Tim Sauter: I would assume that they receive the same level of care. The main concern I have is will the hospitals keep them longer than we think is necessary. We would be a third party payer regulating how long that person is staying. They should receive the appropriate level of care as they would before.

Representative Nelson: Having said that, currently you provided them a cap of sorts with the dollar amount that you are offering. You can be sure that they won't keep them longer than they need to. Is there a mechanism that you envision that could be added to take that concern and move it into this new reimbursement proposal?

Tim Sauter: I think that mechanism would be in our contract process and looking at who is authorizing the days of service. We should be able to manage that.

Representative Nelson: That would be a physician rather than an administrator.

Tim Sauter: That would probably be the head of our regional intervention service unit who is a professional counselor.

Nancy McKenzie: Our system of control is exactly those two things we mentioned. One is the contract itself. When I talked about it earlier each human service center does have excellent dollars. When we are out of money we are out of money. Our regional intervention services approve and authorize every admission that we are going to pay. The hospital doesn't say that we owe them. We approve that they are going to be covered under their contract. We are involved regularly with the plans to move that person and step them down once we are ready to step them down. That gives us some assurance. Plus the hospitals are going to be considered that if we keep people longer and generate more revenue for that admission, they are going to run out sooner in the biennium.

Tim Sauter: Continued testimony on residential services.

Chairman Pollert: So the $1.4 million in which $900,000 is general fund increase why is that going up 50%? We have an increase in general funds and 07-09 it was $1.8 million. The 09-11 budget is $2.7. Roughly that is a 50% increase in general funds.

Tom Klein: I'm the fiscal manager at Westcentral. If you want to look at the increases and provider inflation was $300,000. The young adult transitional residential services were a completely new facility. That would be part of the $1.4 million. There is $320,000 that is part of the city residential adolescent facility. If you recall that is a facility that we share with both our safe beds and the city adolescent services. There was a substantial increase there because of the provider costs which came in much higher than anticipated. That is the majority of that.

There was also part of that city residential adult which was a $40,000 increase based on their costs to continue the operation as it exists now before any inflation.

Chairman Pollert: You have a new facility come online? It is being requested you said?

Tom Klein: It is being requested as part of the budget. The $750,000 is what that is.

Chairman Pollert: What is that for and whom?

Tom Klein: Right now we don't have a provider. It's for young adults transitioning from the partnership program to the SMI adult area.

Representative Bellew: That was not an OAR?

Tom Klein: No it was an OAR.

Tim Sauter: That would come under capacity. If you need to, you can reference page 4 of my written testimony for that explanation.

Representative Wieland: Under psych social club, the appropriation for last year was $196,122. You show that you are starting off with $204,000 plus the provider inflation which is not 7&7. Can you run through the math there?

Tom Klein: The $204,000 figure that we are starting off with is based on what we project our costs to be this biennium. It would be prior to any inflationary cost that would be needed for the next biennium. We are basically saying that we are going to spend that this biennium as this result. That is where it is going to start off with prior to any inflationary cost.

Chairman Pollert: Any more questions on that? We will get off of the grant summary and go back to the detailing. That is basically just an explanation of what we have been going through. You have a general fund increase on the second page to Westcentral human services of about $3 million.

Tim Sauter: Yes we covered that on the overview.

Nancy McKenzie: In the interest of time, I am thinking if we have the directors doing a small overview even of their written testimony instead of going through it completely because you have heard one. They are all organized the same. Maybe each center can hit on their specific changes or things that are unique to them to save you time.

Chairman Pollert: So you are talking about going right to the detail?

Nancy McKenzie: Well hitting the highlights of their testimony.

Chairman Pollert: I'd rather go through highlights instead of going through the whole thing then go to the detail.

Nancy McKenzie: When you get to the detail you can talk about the main changes.

Chairman Pollert: Let's shift gears and go to public testimony.

Tim Sauter: Continued testimony. NEW JOB.

Representative Kerzman: How are you handling that? Will you walk us through? If you have someone from the county that needs care do they have to go to Jamestown? Is there a stopping point?

Tim Sauter: What we have done and especially in outlining counties there hasn't been much change. What we would do is call a local hospital and outline the situation. We look at if the person is committable or not. We work with the state hospital and the county sheriff would transport that person to the state hospital. We do have some other options. In the past they may have brought that person to St. Joseph's in Dickinson. As I mentioned earlier we do have contracts with the two hospitals in Bismarck to do the crisis stabilization for those people who are indigent. So we would also have the option of authorizing in addition to one of those two hospitals. To deal with the psychiatry issue and not having psychiatrists at St. Joseph's we did contract with Dr. Conrad and also with psychiatric networks to provide those services through tele-medicine. The challenge that we have is that Dr. Conrad is planning to retire. He is

actually going to look at May of this year. In 2010 he will be retiring. We will be down to a few hours of tele-medicine a week. At that point in time we will have to request some money. We might need an FTE to look at pursuing a staff psychiatrist.

Representative Kerzman: Another question with the influx of oil field people, have you noticed the numbers going up or are they staying consistent with the number of clients. We often hear that it brings in a lot of riff raff.

Tim Sauter: As I mentioned earlier we did have a decrease in the number of clients served this past year. It was about a 4.5% decrease. I believe we had 1,942 last year and this year we had 1,854.

Chairman Pollert: How many psychiatrists and clients?

Tim Sauter: I think around 350 clients. That is a guess I will have to verify that. We have less than a full psychiatrist. The other thing I'm going to mention is that we do contracts with the psychiatric hospital here in Bismarck. We have 9 admissions in state fiscal year 2008. Three to Medcenter one and 6 to St. Alexius. Continued testimony.

Chairman Pollert: What is the turnover at Badlands?

Tim Sauter: It is a 7.4%.

Tim Sauter: Continued testimony (Handout D)

Chairman Pollert: You had the rent at Westcentral of $16 a foot and the other rent was $14. Is $16 a high number the highest number we have heard? Is there a reason why that is much more expensive?

Tim Sauter: This is actually in the lower level of the building. I think it is attributing to the reconstruction.

Chairman Pollert: Are you saying that the $16 is going to be cheaper a biennium from now?

Tim Sauter: That is looking at the cost of the utilities and those kinds of things. The rest is

missing. The rate will remain there I'm assuming.

Chairman Pollert: Where did the $91,000 come? Is it in one main area or is it all over?

Tim Sauter: The primary part of that comes from the $3 increase and the slight increase at the VR office.

Representative Nelson: Is that increase due mostly or entirely to the increase utility cost? What was the reason for that?

Tim Sauter: According to the college is that it is labor cost. They do provide janitorial service which is part of the rent. The other part would be utilities.

Representative Nelson: Are you comfortable with that?

Tim Sauter: I would love it to be less. I think it is a pretty good rate. It's office, parking, and janitorial. It's higher than we anticipated but it works.

Representative Nelson: It trips a wire when they go up $3 a square foot in one biennium.

Tim Sauter: Continued testimony on operating fees and services.

Chairman Pollert: I see you are dropping down $11,000.

Representative Wieland: The only question I have is on the one service center going back to the psych social club the increase in provider inflation was general funds on one and here it shows it as federal funds. Is that an error?

Tim Sauter: I would assume that is how they are funding it out.

Brenda Weisz: It was just when the adjustment was made by Office of Management and Budget it got put into the wrong place is all. It is general funds. There were a lot of entries that need to be made. That is where it was placed and that is where we have to report it.

Tim Sauter: Continued testimony.

Chairman Pollert: What I'm going to ask for sure is residential services. Is that the 16 bed facility?

Tim Sauter: Yes it is the 16 bed facility which is actually $910,000 total.

Chairman Pollert: What does that pertain to again?

Tim Sauter: Those are 8 beds for persons who have severe and persistent mental illness and 8 beds for persons who have chronic addictions.

Chairman Pollert: Where is that at?

Tim Sauter: It does not exist. We have to do a request for proposal and see if we can find a provider to do that.

Representative Bellew: Is this an OAR also?

Tim Sauter: This is an OAR and it is on the global health initiative.

Chairman Pollert: Under human service centers on the overview I have down St. Joseph's hospital in Dickinson with a $17 million increase. What is that about?

Brenda Weisz: What overview testimony? What that overview bullet talked about is what the global behavioral health OAR would have funded. In total it might have related to something collectively. I will look at that.

Chairman Pollert: For some reason I have a $17 million increase, 20% general fund increase, $7.2 million of salary increase of 5&5.

Brenda Weisz: It could be globally for all human service centers. I'm thinking it was Nancy's overview where we pulled the centers together.

Chairman Pollert: I was just trying to figure out if Dickinson is in your area. That is why I was asking that.

Representative Bellew: On our green sheet is says Badlands grants $665,000 in general funds. On the sheet we just received it says $770,000 in general funds.

Brenda Weisz: What I noticed is that the reduction that was made to St. Joe's contract at Badlands, that number is a net of that 105 reduction and the other number. Those two numbers are netted together to give you that number. It's the increase of $770 offset by the decrease of $105 to give you that net general fund change.

Chairman Pollert: Any other questions on the grant summary? There are some miscellaneous increases in the psych. Badlands says $829,700 is from the global health initiative.

Tim Sauter: Yes and the 7&7% for our other providers.

Chairman Pollert: Right. Are there any other questions? We will be in recess until 15 minutes after floor session.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/22/09

Recorder Job Number: 7618

Committee Clerk Signature Morgan Rennerfeldt

Minutes:

Brenda Weisz: Testimony Handout (Attachments A/B). I handed out two documents which you had requested this morning. One was just a breakdown of the turn back that I covered in my overview. That is the sheet that is portrait style and shows you the rounded numbers of turn back by division. The next sheet has to do with the inpatient psychiatric hospital rate reimbursement. This schedule is on a landscape form. This one tells you based on the rebasing OAR in Medicaid what the daily rate was based on costs in that study for those hospitals that are included in our human service centers budget. When we did that calculation we took the lower of columns A or B and the number of days we have in the year. If you take column C and multiply it by column D that is where you get your annual costs. Column D finally is your biennial costs for the budget. This will be the amount of inpatient hospital contracts at the centers. This is not the increase but the final costs built in the budget. With the OAR being funded we did take into account that we had some of it in the base budget. This should be on your schedule before inflation.

Representative Bellew: On what schedule should this be on?

Brenda Weisz: This will be on your grant schedule for each of your human service centers that actually do an inpatient contract so when you look at those grant schedules this morning it will be in that area.

Candace Fuglesten: Testimony Handout (Attachment C) 4:44-7:00

Representative Ekstrom: In years past I know you had a fairly lengthy waiting list for psych evaluation for children. Do you have a sense of how many days or weeks you are sitting with at the moment?

Candace Fuglesten: In the area of psychiatric evaluations we are probably keeping our waiting list better than it has been in many years. Children, at this point we are probably within a month time tables to get in an evaluation. Very similar for adults as well. If it's an emergency or crisis we can get individuals within a week. Continued testimony.

Representative Ekstrom: Do you have a pay schedule as to what similar individuals are making in Moorhead?

Candace Fuglesten: I can get you one. I don't have one at this point. Continued testimony.

Representative Bellew: You say you increased by 6 FTE's our green sheet says by 7?

Candace Fuglesten: These are capacity in this particular area.

Representative Bellew: The green sheet says 7. Oh never mind I'm sorry. That is the grant line.

Candace Fuglesten: Continued testimony.

Representative Wieland: Would you explain that particular item please? Why would it only decrease the general fund by $41,000?

Candace Fuglesten: Part of that would have been done with other funds that were not general funds. Continued testimony.

Representative Metcalf: You mentioned that there is $192,000 in adult drug court. Is that the total cost of drug court or do they still have the directions to retain more?

Candace Fuglesten: Within our budget, in addition to the $192,000 that was removed from correction, we also from the legislator last session had appropriated 1 FTE to work in that drug court area. So we have additional in the drug court. The expectations that are in the corrections portion of the budget for drug courts would be to provide the staffing for parole and probation. Also there would be costs within the judiciary part of the budget.

Candace Fuglesten: Continued testimony.

Representative Bellew: Can you explain that?

Candace Fuglesten: Our budget instructions were to build a budget that provided an even level of services from the previous biennium. Some of those costs go up in terms of salaries. There are certain portions of federal funds such as social service block grant or addiction block grant where it doesn't match one dollar for three dollars. It is a certain amount of money that we get. We were that much money short which came out of general funds in order to hold even our budget and expenses.

Representative Nelson: Is it fair to say that a hold even budget is the hold even on programs and not money?

Candace Fuglesten: It is a hold even on level of service.

Brenda Weisz: When the Governor comes out with his budget message in March it is really generally speaking hold even in general fund dollars. Then we start working with Office of Management and Budget because of what our budget does and what the services are that are included. There is the cost to continue. We spend a lot more time together, Office of Management and Budget, and the department works on what a hold even is. It starts with a number and that is how we start building our budget. As we continue to work with Office of

Management and Budget it evolves to a hold even in services.

Representative Bellew: Does that mean that federal funds have fallen? I know the FMAP went down but does this mean that we are receiving less federal funds and that these general funds are taking the place of federal funds?

Brenda Weisz: In some regards yes. Let's just isolate a specific position. Remember I told you that we have open ended funding sources. Some of those sources and adding our DD case managers from this morning, that money would be available at the 50/50 still. Let's take an individual that works and is funded specifically with the substance abuse block grant money. With the increase that was given last legislative session their salary went up from the budget that is in 07-09 to 09-11. The block grant didn't go up. To cover that increase that would be covered by general funds. That is where you are limited with the federal funds and that is what the bullet describes.

Candace Fuglesten: That concludes my overview so if you would like to go in to the detail we can.

Representative Wieland: I would like to go back and cover one point. You talked on page 4 about the Fargo school district. I have never heard the number of 113. I have heard of in the 30's.

Candace Fuglesten: The quote here is from the Fargo Forum.

Representative Wieland: I'm assuming that is 113 languages and dialects. Does the federal government pay for a lot of the costs involved with interpreters?

Candace Fuglesten: One of the requirements for receiving federal dollars is that we provide services to all individuals. If translation services are needed we are required to provide those. That is part of the federal law.

Representative Wieland: That is at who's expense?

Candace Fuglesten: That is at our expense.

Chairman Pollert: Do you have clientele that come across the border from Minnesota?

Candace Fuglesten: If we have individuals who do seek services that are from out of state, it is our policy that they are charged full fee. Another thing to that is that if they are seeking services where we are over capacity, we do not provide those services. By and large we provide very few services to individuals who would be MN residents. There are some exceptions. Sometimes when we have the courts involved and the crime is in the state of ND or the county social service is involved with children. Perhaps the parents have moved to MN, we do make some exceptions because of the courts and where the jurisdiction for the case and proceedings are.

Chairman Pollert: The only reason I asked that question is that I remember last biennium there was a legislator saying that with what we were doing with the human services budget that we were going to be denying services to people from MN. I didn't think we should be supplying services to the people of MN. I take it that statement was false.

Candace Fuglesten: The rules that the human service centers operate under is that a non-resident of the state, if there is capacity to provide services the human service center could provide those services but they must be at full fee. None of the sliding fee scale or any of those would apply.

Chairman Pollert: With Minnesota's budget deficits and with our surpluses dwindling slowly, do you see anything happening as far as the state of MN? Do you ever see that where people would try to come over from MN to ND. Do you keep track of that? It's hard to keep track of what MN is doing but you have Moorhead across the river. If the state of MN ends up reducing services, then will they be coming over here?

Candace Fuglesten: We have a very mobile population. We do see people who may live in Moorhead then move to Fargo. Our process, in terms of how people come in to the human service center, we do have addresses and require all of that. We do know where individuals reside. Again, the policies that we would apply is if we would have capacity we would serve individuals. Again, at Southeast the capacity areas are very limited. It would be perhaps counseling. There are not a whole lot of areas where we aren't at exactly that.

Chairman Pollert: But they are paying what your rate of services are?

Candace Fuglesten: They would pay the absolute highest fee. I will move on to the detail. Continued testimony.

Chairman Pollert: This is just a general question. In your overview you provide behavioral services to 5,029. It then showed 1,500 for vocational rehab. Do they have their own budget or is that included in the human service center?

Nancy McKenzie: The portion that would cover our employees is in our budget. The temporary positions are basically Para-professional or part time.

Representative Bellew: On your salary line items, the $872,000 is that strictly because of the 6 new employees?

Candace Fuglesten: That is part of it. The other things that are in there, you have turnover people come and go, there are some changes that are made. You might hire more experienced people at a higher salary. You might hire some people at a lower salary. Some of these also have to do with the way that it is funded is at a point in time which was in March, we looked at the positions that we had and we looked at the salaries and it was computed with those people that were on in that point in time. That is how the budget is arrived at.

Chairman Pollert: When I look at your temporary salaries, 05-07 was $436, 07-09 was

$500,000, and now you are attempting to go to $708,000? Can I get a further explanation of that?

Candace Fuglesten: Due to capacity concerns we made a decision in terms of the utilization of the money we had. We did bring on these temporary positions, a half time licensed addiction counselor. We have a number of Para-professionals who are human service center aids which are case management extender positions. These are individuals who deliver medications, teach individuals life skills kind of things, and so forth.

Chairman Pollert: Is that like a QSP?

Candace Fuglesten: Yes they are similar. Again with the demand in our case management area for services, we have found that the case aids, especially with the high turnover rate that we have, at any one time we have had 4 or 5 case management positions open. If you take that times the case load of 35 and then that case load, even though we don't have positions does need to be covered. The case load for everybody else that is remaining in those positions has increased during those times because we are trying to fill those positions. We have had to utilize case aid to help us to manage that case load.

Chairman Pollert: Brenda when you handed out the vacant FTE's, the ones that show in the southeast human service center being filled in 1/12. When you told us yesterday that there were 114 but you said 40 of them were filled, that would take example of the ones that were filled just lately.

Brenda Weisz: You are correct. Anything that says filled on your description would be part of that.

Representative Nelson: It would be a lot easier to understand these things in this case you have a $208,000 change. It doesn't show any additional FTE's that there was some way of showing the new positions so we don't always get caught in that trap of asking about salary

lines. They seem to go up more than others. You explained why it happens but to me it should be if your previous line is current and comparing the money from the previous budget that those added employees should be an addition and not a zero in that column.

Brenda Weisz: Temporary employees are not FTE's. For the other thing you are talking about this morning, that is what you are referring to?

Representative Nelson: Yes. If there was some notation of additional persons because it is the same thing. You are paying more people. These addiction counselors are additional staff.

Brenda Weisz: They are temporary so they don't actually reflect in your FTE count and they never will. I can't reflect FTE changes for you because they don't exist in FTE's.

Candace Fuglesten: One of the ways we can do that is that we do identify ourselves which are the temporary positions that we have. The understanding with any temporary position is it is just that, a temporary position. If we don't have the money within the budget to afford that then those positions cease to exist.

Chairman Pollert: I'm looking down at travel and I'm utterly shocked. That is probably the least amount of an increase I have seen in the travel expense. I'm wondering why yours is less than any other budget we are looking at.

Candace Fugelsten: Southeast human service center, because we have had at least 3 bienniums where we emphasized services to individuals with severe and persistent mental illness. That service has been a service that we view as it is a community service. It should be delivered in the community. We need to work with people where they live. We have probably had for three biennium's an aggressive outreach and service to people in the community. I can speak when we get into Southcentral where we will have some travel costs and that has to do with being more aggressive in our outreach and keeping people in the community.

Chairman Pollert: I should have looked at the counties of where you serve.

Candace Fuglesten: That is another good point. In region 5 while we are large in population and while there are rural counties it is a much more compact in terms of geographic distance. I will speak to south central. You will see that we have a very large geographic area so transportation, mileage, and things are more expensive. We have an aggressive plan to staff training and things. We try to do most of that on polycom. We also do carpooling whenever possible. We have implemented very effective measures in terms of trying to keep those costs basically directed to services in clients and the money that you will see when you go to the detail is basically for motor pool costs and in reimbursement for individual mileage.

Chairman Pollert: But to go to Fargo from Steele County, is that distance any different from going to Jamestown to Carrington or from Jamestown and Ellendale?

Candace Fuglesten: The distance within the region is what I would say is larger within Southcentral than it is with Southeast. We have aggressive outreach services and perhaps we would have been in place longer.

Representative Wieland: Just to point out in case you missed it that Badlands of Human Services only had an increase of $787.

Chairman Pollert: I should have recognized for that.

Candace Fuglesten: Continued testimony. We have a schedule with our rent that is attached to your handouts. The rent is what you are asking about?

Chairman Pollert: I just see that it is within par of what we have been talking about?

Candace Fuglesten: The rent currently is $11.44 for the next biennium it is going up to $12.01 per square foot.

Chairman Pollert: That is an increase of $1,278. Do we want to go through that? Let's just move to grants and benefits.

Candace Fuglesten: Continued testimony.

Chairman Pollert: In the human service centers budget it is going to show under inpatient hospitalization?

Candace Fuglesten: Yes. Continued testimony.

Chairman Pollert: Are you under residential? How many beds is that facility?

Candace Fuglesten: Yes. That is 42 beds.

Chairman Pollert: Is it currently being used now or is this a proposal?

Candace Fuglesten: The city of Fargo has allocated resources and assigned the Fargo housing authority to build Cooper apartments. They are anticipating a spring construction date.

Chairman Pollert: So the increases in funding here, is that for the two year part of the biennium? Is it going to be going on July or August 1 or is it a year later so this is only for one year of the biennium?

Candace Fuglesten: When we put together the budget, the plan was that the building. They would start building the facility which the City of Fargo is paying for this fall. They were unable to do that. At that point the housing market sort of tumbled and the investor that they had which was lined up and ready to do this was not ready to make that commitment. What we have heard from the Fargo Housing Authority is that in as early as spring as possibly they will be able to build. In terms of when it goes online, it could very well be later than July 1. The 91 individuals that are homeless in our community are still there whether they have a place to live or not. The services directed to those individuals is not as efficient. If you are trying to assist individuals on staying on medications that are homeless and they have no place to keep them, it is not as efficient as having the housing first.

Chairman Pollert: So if I'm understanding correctly the Cooper house is going to be used for homeless?

Candace Fuglesten: Yes that is the target audience.

Chairman Pollert: So the amount of stay is how long? The turnover rate must be pretty big?

Candace Fuglesten: It is intended that we would be able to intervene with the individuals. Many of the individuals who are long term homeless are individuals who have a serious mental illness, who have chronic addiction disorders. The intent is that by providing a home and wrapping services around these individuals that we would be able to increase the stability of the housing, being to look at employment options for individuals and training if necessary so that we would reduce the number of individuals who are counted as long term homeless.

Chairman Pollert: How are they being taken care of now?

Candace Fuglesten: They are living on the streets. We do have homeless case managers who try to work with them to get housing, and such. There is a long wait to get those resources. It was about 14 months. We are trying to stabilize them and provide them with the treatment they need.

Chairman Pollert: So the city of Fargo is going to pay for the construction of this facility. After it is built it looks like it is basically up to the state at 60-70%federal and very little of funds from the city government.

Candace Fuglesten: They will be providing all of the housing subsidy support that goes on.

Chairman Pollert: The only reason I'm asking is that I'm looking at special funds and I don't know if that means city or what that manes. If it's residential services it shows $7,500.

Nancy McKenzie: Keep in mind that none of the residential costs are part of Southeast budget at all. Everything you see reflected here under residential services relates to the staff positions that will be providing that.

Brenda Weisz: The residential services is not paying for any costs for the Cooper house at all. We don't pay for that at all. We are putting in as part of the global behavioral health is about $315,000 of contracted 24/7 program assistance.

Chairman Pollert: So the city of Fargo is paying for the utilities, the water, and all of that.

Brenda Weisz: We aren't paying for that. That is not what the costs are for. The only piece of that cost that we are paying for are the contracted staff. We add every member for the other staff and we continue to refer the staffing costs. Those are up in the salary line and we talked about those earlier. I don't want you to think they are down here when we say staffing. The only thing relative to Cooper house that the state is paying for is that contracted 24/7 program assistant. There are other residential services they currently provide in the community. There is also a youth transition facility that was added for those children transitioning from the youth system SMI partnership program into adulthood. This is the other one that was an OAR that was funded.

Chairman Pollert: Before it was explained to me it looked to me like we were going to be taking care of all that.

Candace Fuglesten: The other thing that I would add about the transitional living facility is about the number of children that are in custody of the human service areas. We have come together to put a proposal together for providing transitional services. We have a number of children who have severe emotional disorders, severe abuse histories. That facility will be geared for those individuals directly.

Chairman Pollert: So I'm going to refer to the green sheet on page 7. That must be #5. It says the youth are young adult transition services. The $1.1 million dollars, that is going to fund what?

Brenda Weisz: That is a combined number. That takes the Westcentral number that Tim talked about for 750. The part that is actually Southeast is 426.

Chairman Pollert: So I should have probably asked Tim the question of what it does.

Brenda Weisz: That is dealing with the children that are with a serious emotional disturbance as they transition into adulthood. They aren't quite ready to step out on their own when they reach the age of 18 or adulthood. This would set up a transitional facility for them that would help them transition into adulthood.

Chairman Pollert: So we probably had that type of population in past bienniums, we just haven't funded it. Or is this an increase in funding to do more of that?

Brenda Weisz: We have had this. It's the partnership program we have talked to for many biennium's. The children with serious emotional disturbances. Those children are in our system. What has come to light is that some of them need additional supports as they transition into adulthood. This recognizes those needs that have been identified through our stakeholder meetings and predominately the Bismarck and Fargo regions.

Representative Wieland: Then that covers them from approximately age 18 to what?

Candace Fuglesten: It would be all individualized but we are going to be working on vocational skill training. We are also going to be looking at life school kinds of services as well as continuation of the medical services that they have been receiving as children. That can vary. We are looking from a planning purpose somewhere between 9 months to 3 years depending on the individuals that are involved. Continued testimony on the last page.

Representative Bellew: I see all the federal funds are gone? Do you have an explanation for that?

Jim Gebern: I am the fiscal manager of Southeast. The answer to that question is we had a grant that was 75% federal and 25% general. As of July 1 that federal money disappeared. In order to keep our hold even budget we had to replace that 113 with all general funds or drop the programs.

Representative Bellew: Did you reapply for them or anything?

Jim Gebern: I'm not sure.

Representative Bellew: The feds are giving away a lot of money right now.

Candace Fuglesten: I do wish to add to that answer. Respit care is one of the services within the human service center that is truly more of a prevention service. Individuals if we work with them and provide some respite, there is evidence with the groups that we serve that they do not then enter into higher levels of care. That is for children's services, individuals with disabilities, and it is to provide some support and relief to parents.

Chairman Pollert: Any other questions? We will move on to Southcentral. One more question. Is this a verbal agreement with the City of Fargo or is it a signed deal with the city of Fargo.

Candace Fuglesten: It is a verbal agreement. The services are something that they recognize that we provide. The homeless individuals with severe mental illness and chronic addiction are certainly vulnerable adults. It is a verbal agreement.

Chairman Pollert: Is the city of Fargo saying from you that if you get the funding from the State legislator for Cooper house that they will build it if we bring forward the money?

Candace Fuglesten: The city of Fargo committed to building this facility without any commitment from us. They did work with us as partners to say would you come to the table and provide services. It is their commitment. They have a 10 year plan to end homelessness as do many cities across the state. They have been very active because of the large number of homeless that reside there. They have been very active in implementing the pieces of that plan.

Chairman Pollert: Could it be said that the homeless people will be living in a nicer facility than the average tax paying citizen?

Candace Fuglesten: I have a drawing of what the outside will look like. It is going to be public housing. It is modeled much like any other public housing unit.

Chairman Pollert: It's not a current apartment building, but will be built brand new?

Representative Bellew: My understanding is that all you want is a 24 hour coordinator for that building 7 days a week. All of the services will be provided. The money is already in your budget for those services, Is that correct?

Candace Fuglesten: The Governor put that money in the budget for 4 positions to help us provide additional services to that target population.

Candace Fuglesten: Continued testimony.

Representative Nelson: Is there an increased utilization or is it stable? Is there a decrease in those numbers?

Candace Fuglesten: There is an actual increase. The number of clients coming into Southcentral increased by 3% over the last biennium. Continued testimony.

Representative Metcalf: Just as a thought that is going through my head here now, you are taking credit for the fact that you are growing your own and through training you filled all your addiction counselor positions that you had. Has there been a major increase in salary over the last five years?

Candace Fuglesten: In the last five years? Periodically in some of the health professional shortage areas which licensed addiction counselors is one of those positions . We have done some equity adjustments across the DHS. In the last five years I can recall one of those occasions where we did increase an equity adjustment across all of the addiction counselors.

Representative Metcalf: The reason I asked that question is because it wasn't too long ago that the prison in Jamestown was very short of addiction counselors. In fact they only had 1 out of 6 authorized. At that time there was an adjustment made to salaries. I just kind of wondered if that didn't have some impact also.

Candace Fuglesten: Continued testimony. I also have Mark Anderson who can assist with some of the financial questions.

Representative Nelson: I'm quite impressed with the rental lease agreements that you have in Fargo and Jamestown compared to Bismarck. You are able to lease at a discount to what we are seeing at a discount to other parts of the state. Just quickly, the buildings that you rent, is it new office space? Is there anything that would set it apart?

Candace Fuglesten: The answer in the Jamestown region is that we have had a long term rental agreement with our landlord that goes since 1983. In that kind of a relationship the rates of held steady. In the Southeast region many times for zoning reasons, generally we talk about putting a residential living facility in a community or an area. We have quite a publicity that is negative. We have most of our space in the Southeast region that is in industrial areas where we have had to do some restructuring to the buildings. We get that at a reduced cost. Continued testimony.

Chairman Pollert: I see that is a $60,000. Unless someone can take a good look at it. We can move on.

Candace Fuglesten: We will move to the grants benefits and claims. Continued testimony.

Chairman Pollert: Where is bridgepoint at again?

Candace Fuglesten: It is in Jamestown and connected somewhat to the psycho social center in that area.

Chairman Pollert: So you were able to, with Bridgepoint, access federal funds thereby reducing the allowance on general funds?

Candace Fuglesten: Yes. When that was bid it was bid by the ND State Hospital. We are able to collect Medicaid for services that are provided in that facility.

Chairman Pollert: Are there any more questions for Candace?

Kate Kenna: Testimony handout (Attachment D)

Chairman Pollert: Do you outside contract any psychiatrists for 1,000 clients. When I look at the other it was 3 for 7 clients. Can I draw a correlation there?

Kate Kenna: We have one psychiatrist that we contract with for 20% of his time. The other has to do with the poverty in the Devils Lake Region and the people who need the service.

Kate Kenna: Continued testimony

Chairman Pollert: We should take a look at rent and lease.

Cliff Nevere: Our rent on our main building is $10.42. Our basic rent hasn't changed since 1987. What the increases have been over time is that we have an escalator clause. Back in 1987 it cost $45,000 to operate. What our escalator is, is that we pay the difference over that every year. It doesn't include if real estate taxes go up. The one thing we are worried about is that our building is up for sale by the landlord. He is getting up to retirement age. He has a partner in the business and wants to sell it. We are kind of worried about what might happen there with the rent.

Representative Bellew: How much is he asking for the building?

Cliff Nevere: He wants $950,000. I did a quick figure of 7% interest of that and we would save about $27,000 a year if we owned it. The building is fairly old and it doesn't have adequate parking. Continued testimony on rent and leases.

Chairman Pollert: You show 05-07 at $69,000 and 07-09 at $94,000. Yours is at $24,000. If you would double that you get $50,000 and your budget would be at $85,000. Is that an abnormality? I'm glad to see the reduction but when you just split it up a bit.

Cliff Nevere: The reason we did decrease it some is that some of it was in A&D ($7,500). We have a lot of rates from the reservations. We weren't able to work anything out there. We still have some in there from that. Most of the expenses are pretty much in line. Other purchases of

services are in the area. A lot of it is an experience program. There is $40,050 in there. All of that more and likely will be spent. The homeless money is almost used every time. Partnership is the other area where we decrease it some too because we hadn't been using it. Our program has been so-so ongoing. We have a new person in there. I don't think we have been getting that.

Representative Kreidt: I noticed in all operating fees that staff licenses vary from 65-$12,000 for facility. Is part of the hiring of staff required to be licensed. Is that just part of the contract that when you hire those people that you pay for those licenses. Is that how that is done?

Kate Kenna: We do pay for once license for a staff person if it is required for their position.

Representative Kreidt: What about psychiatrists?

Kate Kenna: Not the contracted, just in house staff.

Chairman Pollert: I'm just going down to the grants and claims of $294,000. I'm looking at your overview of $959,000 increase in general funds and roughly $650,000 is due to salary increases 5&5. It really comes down to the $294,000 in the grants. Could we go through that? I don't think you have an FTE increase for Lake Region?

Representative Bellew: Are we on grants? The psych social clubs and provider inflation, I don't understand why we are given this social club provider inflation. Who provides for the social club?

Kate Kenna: We have contracts with the social club.

Representative Bellew: Who is the social club? What is the social club?

Kate Kenna: It is a social place for people to go with serious mental illness where they have some group sessions?

Representative Bellew: But the human service centers don't run this at the time?

Kate Kenna: No. In Jamestown it is with Progress.

Chairman Pollert: So it's independent contracting is what you are saying? So in your overview it shows $208,000, you are saying is that the 7&7? As an example, under the grants under residential that is where you are saying the 7&7 showing up for residential services?

Lynn Bigum: On the grant summary that $200 is listed under all the different areas that we have. The social club gets their share of $17,894. In the psychiatric we didn't include it there because when the person works they do take some time off here and there. He wasn't utilizing the full amount. We felt we could cover it with what our current budget is. We can cover the adjustment with what we already have.

Chairman Pollert: Do you have a drop in federal funds and an increase in general funds> Is that a block grant that you aren't receiving anymore?

Lynn Bigum: That actually started a couple of biennium's ago when we had to have our hold even. What happened is in order to make ends meet we had to cut something. What we cut was our residential unit. The residential services portion of our Rolla program. Well then by the time we come to fall and the Governor gets it, we have a better idea of what our revenues are. At that time we put in the information system. We were able to look at stuff better. We had a lot of increases right away on staff productivity because of the information for us to use and manage. At that time we were going to have more title 19 than what we were going to have. What they did was put it back in our budget and put it back as federal. The thing is that we really need to budget our title 19 so like in clinical population services if you look at the cost center you have a big decrease in general and an increase in federal because that is really where the money is generated. For you to make decisions properly we have to put money in the right places. For the center overall there wasn't a drop just a realignment.

Chairman Pollert: Are you satisfied with the grants? I just look at your overview of the budget and take the total increase and divide it by the 07-09. I see it is an 11.4% increase. They are all different. Do we have anything major in Northeast? We might as well start on Northeast.

Kate Kenna: Continued testimony on Northeast.

Chairman Pollert: What was your turnover percentage at Lake Region?

Kate Kenna: It was 14.13% and Northeast is 10%. Continued testimony.

Representative Bellew: In your overview it says support housing for an additional 8 consumers? What does that mean?

Kate Kenna: Last biennium you funded a facility for us. We have got it up and running in cooperation with prairie harvest foundation. We have additional housing for 8 people with serious mental illness.

Representative Bellew: That is not 8 additional people but the 8 we founded last time?

Kate Kenna: Continued testimony.

Chairman Pollert: On the salaries permanent, what is the $493,000?

Kate Kenna: The majority of the money there has to do with when we took a position and reclassified it to a psychiatrist in the last biennium. That is how we got two full time psychiatrists. We had contracts and were able to hire one of our contract psychiatrists full time for less than the contract. That is the majority that is reflected in there. Also, some of that money is what it took to fund salaries for the second year.

Chairman Pollert: Ok. What does a psychiatrist cost? $150-$160,000?

Kate Kenna: Correct. I think what we are paying our contract is $140 an hour. Continued testimony with lease and rental.

Lynn Bigum: There was a negotiating request by our landlord for a rental increase for the 09-11 biennium that was based on an increase in utilities that they were projecting for the coming

bienniums. That was a 70 cent per square foot increase that was requested which resulted in the majority of that 60.

Chairman Pollert: That is the $13.50 a square foot I take it?

Lynn Bigum: It moves us up to $13.15 per square foot which was $.70.

Kate Kenna: They actually had us up at $3.00 and we talked them backwards. Continued testimony on grants.

Chairman Pollert: Crisis Care Safe beds and then detoxification, I have seen that in other ones just probably haven't noticed it.

Kate Kenna: As far as the detox program, Grand Forks has one of the larger communities in the state that has no way to provide detox to individuals who are intoxicated.

Chairman Pollert: I noticed it is basically an increase of $300,000. It goes from 0-300. You didn't have any detox?

Kate Kenna: That is correct. We did not have any detox in Grand Forks. The committee made up of our county commissioners, our city officials, Altru hospital, and Northeast as well as a potential provider have been working together for about a year. Everybody is chipping in. The county is giving us their old jail to use for a place for our detox. The city is putting in money. We are arm wrestling with Altru to see how much they are willing to put in. Right now what happens is police will bring people to Altru. The police officer will sit with the person in the waiting room for 2-3 hours. Maybe they are admitted and maybe they aren't. Our law enforcement is being tied up. Our hospitals are being used for people who don't really require medical detox but need social detox.

Chairman Pollert: Have we had detox in all of the other budgets? Where did those dollars come from in the past. If we haven't had any, was it in some other section of the grants line item or where was it from?

Lynn Bigum: It was $40,000 in the current biennium and the past bienniums as well but we have used federal funding that is under the substance abuse block grant funds that is used for that purpose. About the only resource that we had was Crookston, which wasn't the best terms of transportation to cross state lines.

Chairman Pollert: But if you see where I am coming from you have about a 500% increase in detox. Do you just have 500% more clients getting drunk?

Kate Kenna: In the other regions that have social detox services they are reflected in their grants. That is where it is showing in the other budgets. They just haven't had it in Grand Forks at all.

Representative Bellew: Can you give me a definition of social detox?

Kate Kenna: Social detox is for people who have drank too much. They need to be in a safe place to detoxify to get the chemicals out. Some people might have the resources to get it done at home with relatives. The people that we plan to see are people who live at the Grand Forks city Mission or are traveling through our community. Maybe university students who don't have somewhere to go. What happens is that there is a cheat sheet. You have the staff person look at safety issues, temperature, respirations, and so forth. It's not medical but it looks at the scales to make sure it will be safe to have them sleep it off. We have had people in Grand Forks die as a result of not having a safe place to go.

Representative Bellew: I always thought the jails took care of that.

Kate Kenna: What our law enforcement tell us that it is not legal anymore for them to have a drunk tank. It's not legal for people to go and sleep it off. They have to be charged with something in order to be in the jail. Many of these people haven't created a crime that would result in that. I think the wonderful opportunity about this is that they are going to be a block

from our office. We are going to be able to have our addiction staff to go over there and offer them a different way of doing things to get them started in services with us.

Chairman Pollert: But if you have a 500% increase I'm trying to find out who was covering the cost in the past.

Kate Kenna: The majority of the cost would be covered by the city of Grand Forks who is riding around with those people in their police car, or Altru hospital who is telling us that they wrote off about $700,000 a year in providing social detox. I think they are willing to pitch in with us too.

Representative Nelson: If Altru does contribute some money, what would be the utilization of those funds. Would that offset some of these costs or would it be in the building? What are you going for?

Kate Kenna: When we get Altru to kick in that will decrease some of our costs. We have a budget for what it would cost us to run a detox center. We are dividing it out among the people who are participating right now. This was our share. We are hoping that our share would be less.

Representative Nelson: In the numbers that you provided us, that is the total cost? If Altru comes in, the $295,000 could go down?

Kate Kenna: Not only is Northeast contributing to the cost but the city of Grand Forks is also giving us some money. They have pledged some money. Along with that the costs will go down when they contribute.

Lynn Bigum: $140,000 of this amount is in the global health OAR.

Chairman Pollert: Let's move on to the next page. There is an increase of $1.4 million total.

Lynn Bigum: There are three parts to what is involved with the residential. There are provider requests that basically were what providers told us that it would cost to continue to provide

services at the levels that they have been providing. The second part of existing providers was the 7% plus 7% inflation amounts. The third component was in the global OAR there is $149,000 of additional supported residential that basically is a capacity issue. We are trying to provide 20 more client hours per week with our supported residential. That is where staff is case workers and they go in to try to assist clients with living in their homes throughout the city of Grand Forks.

Chairman Pollert: So when I look at your overview on page 11 it says $894,000 general funds. Are you telling me that the contracted providers are just raising their kind of dollars that much?

Lynn Bigum: Within that amount we would be getting 20 additional hours of client time as well as sustaining the contracts that we currently have with the residential providers so we wouldn't have to be cutting back on the number of services that they are providing.

Representative Bellew: Basically your providers are raising their rates. In the Governor's budget there is a 7&7 inflation increase on top of that? Is that what I'm hearing?

Lynn Bigum: That is correct. Our providers had informed us that the rates we have been paying in the prior biennium's including the inflation adjustments were not sufficient to keep up with their costs for them doing the service. They have had to put other funds in there as well. This was meant to try and catch them up. The 7% would address a future ongoing cost .

Chairman Pollert: So that is what you are talking about provider increases. Is that in the SMI residential prairie harvest and SMI transitional living?

Lynn Bigum: Everything except transitional living facility

Chairman Pollert: Could you tell me the percentage of rate increase that the providers charged you?

Lynn Bigum: They gave us dollar figures and I did not calculate the percentages of them. I could come up with those figures.

Chairman Pollert: Could you tell me the dollar figure or is it the one I talked about before?

Lynn Bigum: Overall it is about $967,000. It has one exception and that is that there is a service that is called Net monitoring at $45,000 that is included in that. We found a need for that in the current biennium and it's in that $967,000.

Chairman Pollert: In that dollar amount, how many clients would that cover?

Kate Kenna: With the residential programs that we are talking about, particularly centers that offers 21 days of housing for someone that is in our addiction treatment. We would have large numbers that come and go to that program. We do have a daily rate. It is always full. The capacity is 25. People are always coming and going as they move along with their treatment and recovery.

Representative Nelson: Just to get an idea have you seen this coming or is this something that was kind of a surprise.

Kate Kenna: I've been almost 30 years at the center but only a couple of years as director. Yes, we did see it coming in. In fact ,this past biennium we haven't been able to sign a contract with the center. They are providing services for us but we don't have a contract with them because they weren't happy with our reimbursements.

Chairman Pollert: Any other questions? We will recess until tomorrow morning.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1012 – Human Services detail continued

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/23/09

Recorder Job Number: 7798

Committee Clerk Signature

Minutes:

Chairman Pollert: Called the meeting to order. Took roll call and every member present.

Brenda Weisz: Requested handout (Attachment A). What you have before you is what we did as a step down approach to Representative Bellew's request. We tried to isolate the specific areas that you didn't get enough detail when they were up here talking about their travel. If we do it for the whole department it is a manual process. We'd get to it but it's not as easy as just throwing the numbers out on a schedule like this. What we did is took the bars report that you are familiar with, took every section that you have heard from, lined it up on the report and gave you the prior expenditures, the current budget, year 1, total changes, and the request to the house. We just isolated travel only. There were some decreases and increases. What we were thinking if it would be a direction you would want to go is if there are certain areas you want us to do that manual breakout then we would do that. If you would want to isolate which ones that would be. I know yesterday the 6 of 8 centers talked about their travel. Some actually had very little increase that you had mentioned to southeast.

Chairman Pollert: I see at least a couple that I want.

Representative Bellew: This report is good. I'm concerned that travel is up $700,000 in your

budget. Let's do administration, medical services, mental health and substance abuse, and vocational rehabilitation.

Chairman Pollert: Would the state hospitals be attributed when the staff makes a trip from Jamestown to the developmental center?

Brenda Weisz: With the increases in the meal reimbursement and the increases in the motor pool cost to do that, the travel would be in there too.

Nancy McKenzie: Handout Testimony (Attachment B).

Chairman Pollert: I know the price in oil is dropping and they are starting to get layoffs. I suppose it is still too early to see if that is going to make a difference for Northwest or not.

Brenda Weisz: As of yet we haven't really seen it impacting our employment, especially in some of our residential programs and support areas because there are a lot of jobs out there for people.

Chairman Pollert: Turnover would have an effect on this. Are the equity payments if you would look at the percentage, is Northwest getting up at a higher proportion of percentage of that equity because of the salaries in the Northwest and the oil boom?

Brenda Weisz: We haven't done anything with the numbers to analyze and come up with a plan. That would be fitted within that plan to do so because of that turnover. We will look at that.

Nancy McKenzie: Continued testimony.

Representative Ekstrom: That point rang something home for me. How many of our service centers have a dual director?

Nancy McKenzie: All of them. Four of them are covering 8 centers.

Representative Ekstrom: That might explain why the travel has gone up so much.

Nancy McKenzie: Yes. It's not so much this biennium because it has been in place for awhile but it originally had an impact.

Chairman Pollert: I'm sure that is why Representative Bellew didn't ask for the detail.

Nancy McKenzie: Continued testimony.

Keith Welsch: Business manager for Northwest and Northcentral Human Service centers. Part of the reason is we have a lease with a number of renewal clauses. The rent rates have stayed the same for a number of years. I'm not sure what year we are on. There were 5 two year renewals when it was signed last time. He has asked for additional money for utilities, taxes, insurance, and upkeep on the building. We are keeping the square footage rate low too.

Chairman Pollert: Wasn't it P&A's budget that had a huge increase about the building which was about $800 a month? Aren't we getting some questions answered?

Lori Laschkewitsch: P&A was located in the courthouse. The building they were in they were basically getting their rent for free. The building was then vacated and everyone had to move out of it. They are looking for a new place. They don't have the benefit of a renewable contract like some of the existing offices do if they have had rental space in the past.

Chairman Pollert: Did we ask Teresa to get us what that square footage was going to cost?

Lori Laschkewitsch: We have that information. It is like 1,200 square feet and $7.84 a square foot.

Nancy McKenzie: Continued testimony.

Chairman Pollert: Where are the residential services special funds from?

Nancy McKenzie: Third party collections. That is up for us.

Chairman Pollert: Yeah it just shows 07-09 as nothing for special funds. Then it shows in the 09-11 budget a pretty significant one.

Nancy McKenzie: I would think we would have had some client income from last biennium. Continued testimony.

Representative Nelson: I never gave it a thought that people having health insurance coverage, that it would be applicable with regional centers. Can you just briefly tell me where the mental health portion came from? Whether it's a blue cross policy or how that works and whether their party payers are included in the operations.

Nancy McKenzie: Everybody that receives services from any of our centers we do a fee determination process. We find out what the person has available. We bill anything to any applicable payers. Some people who have nothing are private pay. We apply the sliding fee scale to see where they are income wise. I can tell you that the percentage of clients who have third party payers really varies across the state. Typically, in terms of a trend we have tended to see in the smaller centers more paying clients with insurance. Those communities don't have a lot of other providers. When we get to Fargo there aren't very many because of the demand for capacity there. There are lots of private counselors, etc. We do prioritize that. We let people know that we have a high demand and some weight and we recommend other places they can go to. We attempt to not compete with the private or take their customers. We have plenty who really fall into the most vulnerable. Where people do come to us because the service is appropriate or there isn't another person to provide that, we are happy to have third party pay.

Representative Nelson: Another area that is interesting to me is that it looks like every one of the human resource centers we have talked about so far has had a shortage in psychiatrists. I'm assuming that it is a state wide issue. Is there a lack of psychiatrists in the state or is the private pay or practice a much better reimbursement or salary situation? That is why we are having a hard time attracting them?

Nancy McKenzie: Historically we have had trouble keeping up with the private sector salaries. There have been times where we have had to make some adjustments in our salaries. Right now there is truly a shortage. They are really struggling with trying to recruit psychiatrists. It is one of the reasons at Southeast that we keep that psychiatric residency program and be able to get those folks exposed to the centers and maybe interested in working with us. Right now there is a more shortage situation than there has been at times in the past. We are doing more telemedicine with contracted or with our own docs. That will continue to grow. Where we can get them we can use them more for rural service too.

Representative Nelson: Do you track salary guidelines for psychiatrists? If you do, what is the average of a private practice psychiatrist?

Nancy McKenzie: We do look at that regularly when we are hiring. I know that most recently Meritcare was starting individuals at $200,000 with a $20,000 sign on bonus. The reason I know that is they had someone, gave her $20,000 and signed her on and she decided she wanted to come to us for a bit less money. We are about the $160-170,000 range with her. One thing that is a plus for us is that our psychiatrists don't tend generally to have to do hospital hours and weekends. Over $200,000 would be typical.

Representative Kerzman: Does the med school psychiatrist come through the med school?

Nancy McKenzie: We do work with the UND medical school psychiatric residency program. Dr. McLean who is the medical director at Southeast Human Service Center and the state hospital in Grafton is an adjunct professor. We think it is so important to keep that residency program. It's been mostly located at southeast. However, they have a resident who is looking at wanting to do some experience at Northeast in Grand Forks who is interested to relocating to that part of the state after she graduates. We have talked about how we have the potential to place them in the human service center for parts of their rotations. We think there is room for

growth in that area. We have been able to hire some people due to their residence. Candace mentioned the difficult to fill psychology positions. That is why we are pursuing the APA certification for psychology. UND will only send their psychology residents to APA sites. We have got to make sure we have at least one or more in ND so we can get those residents out and have a better chance of hiring them as well.

Representative Kerzman: What is a medication monitor? Is that a person or equipment?

Nancy McKenzie: Where are you looking?

Representative Kerzman: On the grant survey under psychiatric services.

Nancy McKenzie: In various human service centers contract with providers like Western sunrise in Williston, Dakota foundation in Bismarck, those private providers that do a number of services for us. They provide staff that will actually see the clients get medication; they might need to take them to fill the pill box that the nurse at the center has prepared if they aren't able to do that themselves. They follow up and make sure that the person is taking their medications and if they are getting their refills dealt with. They are able to use case level services so that those people aren't coming back in and calling the center saying they are out of meds. That is a regular service they use to make sure they have the support at home.

Chairman Pollert: Have any of us requested a breakdown where all the 7&7 is going and all the dollar amounts?

Brenda Weisz: No but we have that schedule. I can get it for the committee.

Nancy McKenzie: Continued testimony.

Representative Nelson: If you do the math with the people hospitalized it comes out to about 4 days a visit. Is that typical of a hospital stay for a mental illness?

Nancy McKenzie: We really look at these local hospital contracts to serve people that we think we can quickly stabilize and get back home. If someone goes into one of these it can be 48

hours. An acute length of stay is considered 2-3 days. If we get someone admitted locally and we can see that this is going to need to be a longer hospitalization that is when they are going to talk to us about the referral to ND State Hospital. An average of 4 days is long. That means that there was nowhere to go sooner. They had to wait there until a bed was available.

Representative Nelson: I don't know how specific you get but in a number of critical access hospitals they will admit them inpatient. They will swing them towards the end because they have 96 hours for reimbursement purposes. Is swing bed used for mental illness as well?

Nancy McKenzie: It is certainly accurate. I don't know if you think it is exactly the same. They certainly are attempting, because we have a limit in our contract. They are anxious to keep things moving or they are losing money. They aren't so much that they can't have people longer. A lot of the insurance companies are very into that they have to have reauthorization after 72 hours or 36. It's a challenge at both ends. Continued testimony.

Chairman Pollert: Did you tell us what the turnover rate for Northcentral was?

Nancy McKenzie: 10.7%. Continued testimony.

Chairman Pollert: Is the temporary salary for a part time psychiatrist, is that the $56,000 as well as the one counselor position from Bottineau? That is about $94,000 increase. How many psychiatrists are at Northcentral?

Nancy McKenzie: Yes. We have one vacancy. We have some contract hours and are contracting with 2 clinical nurse specialists to help fill some of that out. We also have one clinical nurse specialist on staff. We are getting some tele-medicine hours. Right now it is split all over while we are trying to recruit full time. Continued testimony.

Chairman Pollert: Can we talk about professional development?

Keith Welsch: That cost includes anything involved with somebody going for some type of professional development. It could include the cost of whatever they are going to. It could

include travel, lodging, and those kinds of things. Plus we just feel that professional development is an important part of a person's job as far as needing to continue to evolve in their training. We actually have put more money into professional development. When you look at the original figure of $16,000 you have 110 plus people per year. That is not very much. Most of the time if you send someone someplace it is a way from Minot. You are going to have travel and lodging plus the cost of training. If there are things that do happen in Minot we try to take advantage of those but there is not a lot happening as far as our professional clinical staff.

Representative Bellew: I heard you say that there is some travel in there too? Shouldn't it be in the travel account?

Keith Welsch: Basically we tried to isolate the cost of any professional. That is why there is travel in there, yes. The other travel is client related.

Representative Nelson: I'd be surprised if the policy for professional development has changed since last biennium. I'm looking for a little more information as to why there is a $24,000 bump. Is there some professional development that you weren't able to take advantage of in the prior biennium's that now you are able to?

Keith Welsch: I believe a few biennium's ago we had a $50,000 or so budget for professional development. Because of economic times we have had to reduce it. Now we are trying to get back up further where we had been previously.

Representative Nelson: There are areas that you think you have been shorted?

Keith Welsch: Many of our staff that are licensed need a certain number of Continuing Ed. To keep them licensed they need to attend certain types of workshops to give those particular CEU's.

Representative Nelson: Are you saying that in the previous biennium that some of the employees were falling behind on that?

Nancy McKenzie: We do ask staff to pay a part of those costs themselves. We don't have funds to fully provide everything that someone might need for their licensure. We consider that partly their responsibility too. We try to share in that cost.

Representative Nelson: Is there a policy change?

Nancy McKenzie: We look at the total amount of professional development we have in the center. We look at the number of FTE's. What we will do with someone is say we will pay up to some amount on a given opportunity. We will pay registration, travel, and they can get meals and room. We do that kind of sharing.

Chairman Pollert: Southeast Human Service center was a $3,000 increase. Southcentral was a $5,000 decrease. Lake region had a $75 increase. Northwest had a $6,500 increase. There are less employees there. There is a 0 increase for Northeast.

Representative Nelson: I think it would be good to understand the programmatic costs that are involved. Obviously they have to keep up with certification and there are a lot of professionals in these centers. For no other reason it may be good for us to learn some of your challenges. Your budget is very modest compared to some others. I wouldn't take that as a bad mark.

Nancy McKenzie: I think we can answer that question.

Representative Kerzman: Is there any correlation between that and turnover? Anytime you have turnover you have more training.

Nancy McKenzie: There may be some.

Chairman Pollert: I think it will help with the detail as well.

Representative Wieland: Has there ever been an opportunity for using Interactive TV for the education?

Nancy McKenzie: Absolutely. We do as much as we can. Our staff participate in that where we can call in and sign on to those.

Representative Wieland: How many human service centers have an interactive TV within their offices?

Nancy McKenzie: All of them. We have it in every center because we have computers with internet capacity. That access is there. Continued testimony.

Representative Bellew: When you say operating fees didn't change much, they increased 37%.

Nancy: Ok. It depends how big you are thinking. Continued testimony.

Chairman Pollert: You said the 7&7 was how much on the grants?

Nancy McKenzie: About $409,000.

Chairman Pollert: That is total? Then the global health initiative is under inpatient hospitalization?

Nancy McKenzie: Right. No that is under residential on the grant side. The inpatient has the increased rate of Trinity on their contracts. That is why those two areas are primary here in terms of change.

Chairman Pollert: There is a new 8 bed proposal?

Nancy McKenzie: Yes it is part of the global because we don't have a crisis bed facility in Minot. We could maybe move someone out of Trinity more soon as Representative Nelson was saying. There would be people who might be able to come out of the hospital in 2 days to crisis or go there rather than the hospital.

Chairman Pollert: How much is that?

Nancy McKenzie: That is $1,000,387 million.

Chairman Pollert: A lot of the other human service centers are adding FTE's for global health. I see where you are adding an 8 bed crisis center but you aren't asking for FTE's. Is this a private contract?

Nancy McKenzie: Yes we would be looking to contract that which is primarily what we do in other places. That is why no FTE. To contract that with a private provider, floor space, and staffing.

Representative Nelson: From the program standpoint of the crisis bed, would the patient spend more time there and have a better treatment option than the inpatient hospital?

Nancy McKenzie: The crisis bed facility is a different level of care. While someone in the hospital has an RN 24/7 when we put them in a crisis bed we believe we can provide the supervision. It might be a client we know very well who lets us know they are having suicidal thoughts. We might use a crisis bed for a couple days. It might be someone who has been in the hospital and the hospital says they have stabilized them. They really don't need that level of care. They should still be supervised before they go back to their apartment and live alone. We might use those beds for someone up to a couple weeks. Mostly it is a transitional thing like a swing bed. It's another level of care. We are often to move people out of the hospital sooner and sometimes avoid hospitalization. We have someone who is expressing suicidal thoughts. It provides us all those options. We also move them back to the community quicker from the state hospital. They don't get held up because they are waiting for a bed.

Representative Nelson: How many of the regions have crisis beds currently?

Nancy McKenzie: The larger regions all do. The smaller regions tend have a couple crisis beds. They aren't as large in operation but have something available. In Minot at our transitional living facility we could sometimes use a bed for a crisis purpose but it is not set up

to do that. Usually they are organized physically so people can be in their own area if they are real agitated.

Representative Nelson: Of the 4 major cities in the state, Minot is the only one who doesn't have this?

Nancy McKenzie: Right.

Chairman Pollert: Out of the $2.2 million increase in grants, $1.3 is global health and $400,000 is 7&7. The other $500,000 is scattered amongst that. Are there any other areas where that $500,000 will show up?

Nancy McKenzie: The local hospital increase.

Chairman Pollert: Oh the $1.5 million? Now we are within $300,000.

Nancy McKenzie: Cost to continue current services is $305,000. Certainly the largest issue there is the crisis beds followed by the inflationary increase.

Representative Bellew: Inpatient hospitalization's cost went up almost $700,000 general funds. I guess I'd like a specific breakdown of how that was figured out.

Brenda Weisz: You have that. I handed that out yesterday in the afternoon. It was the landscape sheet.

Chairman Pollert: Those are the contracted rates we are talking about?

Brenda Weisz: Yes with the change to reflect so your contract amount.

Chairman Pollert: This is all part of our continued discussion of the global health initiative and the restructuring of the rates.

Representative Bellew: My concern is that last biennium it was $81,000 and now it is up to $700,000. That is an enormous increase.

Brenda Weisz: It just relates to how we rebase those rates in conjunction with how we rebase them with Medicaid. Plus we weren't compensating them for all the days they were providing. Now we estimated the patient days on the sheet and the client days at the new rate.

Chairman Pollert: I haven't had a discussion with the hospital association but we need to have one with them to further our knowledge on global health initiative. I'm getting there but I'm not completely sold on that.

Nancy McKenzie: We did work with the ND healthcare association. We had a few meetings because of their concerns if they could stay in business and do this. They have been involved in those discussions. You will note that it was in terms of the OAR categories and the first identified priority for the department because we see it as having so much impact on both the local hospitals and the state hospital.

Chairman Pollert: Are you saying the global health initiative wouldn't matter if it was a 501C3 or a critical access hospital. It is going to be working with most of the facilities?

Nancy McKenzie: They will work with our inpatient hospitals that we contract with.

Brenda Weisz: As you noticed on the schedule there are no critical access hospitals that have inpatient for our clientele.

Chairman Pollert: So you are saying that this is a major hospital in the main areas?

Nancy McKenzie: Those hospitals are the ones that we have contracts with that serve our people. In addition to those hospital contracts, yes the crisis beds in Minot would be contracted to a provider. The social detox in Grand Forks would be contracted to a local provider. It's not all human service center. It is local providers as well. They don't have the inpatient mental health units to provide the service.

Chairman Pollert: That helps me clarify.

Nancy McKenzie: If I could just make one other comment about the Minot contract, this might be helpful. When you look at that information about Minot you can see that their daily rate has been one of the lowest prior to rebasing. Our prior contract with Trinity was a flat $200,000 a biennium. That is significantly less than what some regions paid their local hospitals on contract. We probably had our biggest gap in that region.

Representative Bellew: Where did the other money come from?

Nancy McKenzie: That has been accounted for and is already in the budget.

Representative Bellew: The $200,000 is not on your grant line item.

Brenda Weisz: There is an error in that grant schedule.

Representative Bellew: The $81,000 is not right?

Brenda Weisz: What I'm looking at is that it is $200,000 too high for the budget request.

Keith Welsch: The original budget was $81,000. With the psychiatrist position we haven't been able to fill we increased that to $200,000 just to be somewhat fair to Trinity hospital. Then the behavioral on top of that brought it up to the current $600,000. It would have been shown in the original grants.

Chairman Pollert: Is there any other questions on the grants sheet? I hate go to back to it but the inpatient hospitalization that was $200,000 for something and $400,000 for something else again?

Keith Welsch: The $200,000 has been our current contract this biennium. The $400,000 additional is part of the global health initiative.

Representative Nelson: When you look at the inpatient piece of this for Northcentral, the utilization is that it is the second highest in the state. In a lower populated region is twice what Bismarck's is. Does that have something to do with the fact that there is no crisis beds in Minot?

Nancy McKenzie: Certainly that would be a part of it.

Representative Nelson: Is there anything else that would trip a wire?

Nancy McKenzie: Potentially the census at the state hospital as well. There have been times that Minot has wished to send people to the state hospital. We have had to wait for bed space and not been able to send them.

Representative Nelson: So they stay in the hospital longer because of that?

Nancy McKenzie: Perhaps we might have even gone first to the state hospital but if there wasn't census we might have looked elsewhere. There are a number of reasons for that.

Representative Nelson: When this occurred under the current contract, conceivably Trinity is losing money each hospital day that the patient stays there, people that use Trinity hospital.

Nancy McKenzie: They certainly have expressed a great deal of concern about the amount of uncompensated care they are providing and it is being paid for somewhere.

Chairman Pollert: I know that one of the questions we will ask next week is about the global health initiative. I mean he's coming in to talk about medical services and the Governor's request. That is a question we should ask of him.

Representative Nelson: That is the greater question is if we are shifting costs to a provider for example, how that affects healthcare. We know from where we live what critical access hospitals are having a hard time struggling to exist. I don't think it's much different for Trinity.

Carol Olson: I just want to make a comment about the whole global health initiative. I regret that we did this direction. It has led to some confusion I believe. I just wanted to remind the committee why we did this. I said it in my testimony. We had the stakeholder meetings and every region of the state that we went to we heard the same thing over and over again. The capacity for serving those with mental illness and substance abuse problems we heard in every part of the state. So when we went to build the budget we had a decision to make. We

could say ok should we put more money into the state hospital entirely and build up the beds there at a much more appropriation request. It is much more expensive to treat them at the state hospital. Or do we try to move it into communities where people can be served closer to home. That is the decision that we made. We added a few FTE's at the state hospital to assist them with their underfunding of their salaries. Then we moved it in to the community and that is what you have been hearing from your human service center testimony. We really felt that the best way to serve the citizens of the state is to serve them closer to home. You see the increase of FTE's and the appropriations in the human service centers. That is what this is all about. If you can think about it in that way I think it will help with y our decisions on this. I think it makes sense when you look at it that way. You will hear from Alex when he talks about the state hospital admissions. You will see the first time admissions at the state hospital are increased quite a bit. Why a population of ND is abusing more alcohol and drugs now:? I don't know the answers to that. Why we are having more of our citizens with mental illness? The fact is that we are and we are seeing them at the state hospital and we are seeing them in our communities. It is our responsibility to treat them and get them back in a very productive life. That is what we are doing. I have been listening to your questions and they are good questions that need to be asked. Overall, that was the basis of why you are seeing the additional appropriation request.

Chairman Pollert: I can understand that but at the same time we are looking at significant increases. We are giving them a pretty fair glob of money that is being proposed. We are turning around on the other side and taking that away. That will be an enhancement to the hospitals as well. I am struggling with that. The Governor's budget has significant increases for reimbursement. It is almost like a double reward to the hospitals. I understand they have had extra costs.

Carol Olson: I understand what you are saying. You have some tough decisions to make in that regard. That also played into our decision making. You are aware that St. Joe's closed their behavioral health unit in Dickinson. The department has had discussions with other hospitals around the state. We are somewhat nervous about what the future is for other hospitals in regard to the direction they are going to take with their behavioral health units. We know that there has been added focus to Medicaid reimbursement to the hospitals that weren't talked about 2-3 years ago. It was always Medicare rates. Now all of a sudden in the past 2-3 years, Medicaid reimbursement has become right up there with Medicaid reimbursement. In reality Medicaid reimbursement to hospitals is about 10% or a little less. Medicare is really the higher percentage of reimbursement to hospitals. Medicaid has taken almost the same front seat as far as attention goes when you are talking about hospital reimbursement. Our discussions with the private sector in that regard is that we certainly have taken the lime light there as well. There is a concern on our part what happens if other providers follow suit that St. Joseph's in Dickinson did. What happens with our providers. We have been cautious of that. We are trying to figure out a way when we built our budget on how we were going to be proactive and present a budget that allows you to try to come up with a reasonable answer.

Chairman Pollert: I understand that and I understand that we have some Medicaid problems in Devils Lake and Rolla. We don't have as serious of a Medicaid problem in other critical area hospitals. We will have a discussion and see where we are at.

Representative Kerzman: Can you answer this question. They stated that none of the critical access hospitals offer psychiatric care? Dickinson is looking at going to a critical access status. How is that going to affect that area?

Carol Olson: They don't have it and they won't get it.

Chairman Pollert: Any other questions? If not we will take a break and then move on to the Developmental Centers.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/23/09

Recorder Job Number: 7799

Committee Clerk Signature

Minutes:

Chairman Pollert: What you handed us today was for the state hospital?

Alex Schweitzer : Yes the stuff for the developmental center is here.

Brenda Weisz: I have to make a correction to what I said was a mistake because it's not. On the hospital schedule, that number is not a mistake. I got the increase confused with the total requested. That schedule is correct I just have to make sure it's on record.

Chairman Pollert: You are talking the $200,000 that Representative Bellew was talking about?

Brenda Weisz: Yes the number in the grant schedule for North Central. The amount that they are requesting for inpatient is the correct number. The increase was the 400 +. When they did that rebasing it coincided with Medicaid. That number is correct when I had said it wasn't.

Alex Schweitzer: Testimony handouts (Attachment A- Chart)

Representative Ekstrom: Can you tell me the terms of folks that you are selecting to go into the community? Maybe on an average sense of how long they have been at Grafton and how long they resided there?

Alex Schweitzer: It's hard to tell. In many cases they are long term residents. There are individuals who come in on short term basis. The majority of them are long term residents though.

Representative Ekstrom: You are obviously selecting folks that stand the best chance of transitioning into the community. They have lived there their whole lives in Grafton. I'd like to see who you are selecting. I don't mean names but I mean cases that are particularly going to make it and how long they have been there.

Alex Schweitzer: We will do that for you.

Representative Metcalf: I noticed the people going to the state hospital are increasing. Does that red line mean something? Is that something you are going to be expecting to see when we move those last 15 people out in the communities. Do you think that the state hospital will increase that area?

Alex Schweitzer: That increase is primarily because of young folks. The developmentally disabled people that come in between the ages of 16-25. We are actually seeing that little jump because of young people having difficulty in terms of behaviors, some are aging out of school systems. They are having difficulties in terms of placements in the community. That is the reason that number is higher than normal.

Representative Metcalf: It has nothing to do with the reduction of clients in the developmental center?

Alex Schweitzer: It really doesn't. There may be an occasional return from the community. We would get that no matter what. We have some people in group homes that will come into the state hospital for treatment. These individuals that are at the hospital, in most cases we place them back into the community setting. (Attachment B)

Representative Wieland: You have got 445 FTE's for the last biennium. You have 445 for the next biennium. Hopefully you are going to be reducing some of them. It looks like about 20 over the next two years. How have you not allowed for a reduction of FTE's over that time frame?

Alex Schweitzer: In this budget there are 16 FTE's and $1.4 million that are dedicated to transition. Those individuals are in this budget. We aren't asking for additional transition money this time as we did for the last two biennium's because we are essentially taking staff and assigning them to transition. They are in what is called a Cares team. Their role is to make certain that we don't return people to the developmental center. We try to stop readmissions. That is our big issue right now. People are coming back. We can't reduce the population but continue to have people coming back in the facility. The role of the 16 individuals is the working community providers to make sure the individuals stay within their homes and home community and do not come back to the developmental center. In addition, they will be involved with the discharge of individuals. Although the FTE number does not come down to the total, those 16 FTE's are dedicated to transition so we can reach that goal of 97. I think as you look into the next couple of bienniums as you get that number down I think you can reach those goals. You will see a significant drop in FTE and costs. Continued testimony.

Representative Ekstrom: What is your turnover rate then?

Alex Schweitzer: 15% the last two years. 2007 15.29 and 2008 it was 15.5%. Continued testimony.

Representative Nelson: In relationship to your nursing staff, do you experience shortages of nurses and when you do, do you contract service with agencies in times of those shortages?

Alex Schweitzer: Nursing is not the problem. We get a lot of individuals on the professional staff that drive in from Grand Forks. Our issues are direct care staff on the line. Similar to what a nursing home would be.

Representative Nelson: Do you contract services with agencies for CNA's?

Alex Schweitzer: We have not. We try to avoid that and recruit the best that we can and meet the needs of the people. Continued testimony.

Representative Wieland: Under the rentals and leases, are there any empty buildings or potential rentals in some of that space? Does it fall under your budget or somewhere else?

Alex Schweitzer: Yes. We rent now to quite a few community facilities. We are looking for more renters. We do collect the rent and it goes into our budget. We have space because of downsizing we have an entire building open right now. We have one building that is completely full of outside agencies. We have retirement houses on the campus. We have a variety of not for profits. That is part of our long range plan.

Chairman Pollert: With what you are speaking about the 16 FTE's dedicated to that. IF you would look at that number versus where you are at for clientele at the Developmental Center in 03-05. Is the FTE number with that consistent with what we had appropriated in 03-05 or 05-07. Do you see where I'm trying to go?

Alex Schweitzer: You are asking where we are at in terms of FTE's. Of course there is no increase from 05. I'd have to look.

Chairman Pollert: Ok in 05-07 you were a 449.

Alex Schweitzer: We are at 445 now. I'm not sure what we were in 03-05. I'd have to look.

Chairman Pollert: So for clients in 03-05 off of this chart, we would have been on an average of 144 or 145? Then 07-09 our clientele, what was that based on?

Alex Schweitzer: 125. 09-11 is 115. Within that number is you have the 16 individuals that are

pretty much going to be dedicated to transition. Instead of looking at 05-07 at 449, if you took the 16 out you have a lower FTE number that will be dedicated to work at the developmental center. I think it's important to note that the people that are remaining at the developmental center are a higher acuity pack. That is why we are having a little more difficulty placing people now. They have pretty complex needs. It's important to have this team in place to prevent readmissions and work towards transitioning these people.

Chairman Pollert: I know there are groups that say developmental centers should be out in independent settings. I don't agree with that statement. Is the community of Grafton trying to get the DD client to go into the Grafton area? Is that the idea of the 16? Is Grafton trying to do that to help them with their employees to stay around the Grafton area?

Alex Schweitzer: The Grafton community is very concerned about what is going to happen to the Developmental center. I have been invited to numerous meetings over the last five years by the city council, the mayor, chamber of commerce and others. I have sat in and talked to them about transition so they have a full understanding of it. The department from a public policy standpoint has never taken the position that they have never been advised that the closing of the developmental center is an option. We don't talk about that. In this point in time it's not even something that has been established by the legislator, the Governor, or by the department. We don't talk about closure with them. We do talk about transition. There are a lot of services in Grafton now for the DD individuals. We also do some things on campus. We are moving more and more towards a model that deals more on an independent level to people we serve. The bottom line is that the community is very concerned about the facility. They would not have a problem how we provide the service as long as we do provide some services.

Chairman Pollert: For 115 clients in the budget you have 99 FTE's servicing them. Out of your 445 FTE's you have 16 that are for community transition group?

Alex Schweitzer: Yes.

Representative Wieland: You mentioned that people are coming back from the transitional individual group homes. About how many are we talking about?

Alex Schweitzer: I believe I handed a chart out that talked about that. It is attachment C of my original testimony. It shows the number of admissions from 1997-2008. This is a summary. 2005 it was 17, 2006 it was 20, 2007 it was 11, and 2008 it was 20. Those are admissions

Representative Metcalf: Kind of a running discussion, how long has this 16 man team been in place?

Alex Schweitzer: Just starting that up this biennium. We are starting to hire positions and doing some work. We are just starting it up.

Representative Metcalf: How wide of an area are you trying to get this team to operate in? Are they going to operate in Grafton, are they going to operate in Northeastern ND, are they going to operate in their home state?

Alex Schweitzer: It is a state wide team. That is a purpose of having the staffing that we have. It is state wide and there is a need to have it state wide because we get referrals to the entire state.

Representative Metcalf: Is your intention to have these people located in different locations throughout the state or where will they be located at? I'm talking about their private location.

Alex Schweitzer: At this point in time they are located in Grafton. There is discussion eternally to have some of the care staff on a contractual basis to do it in other parts of the state. Out of 5 of those staff there are 5 staff that are behavior analysts. Four of them would be located statewide with the other at Grafton. Their role is to help private facilities deal with people with significant behavior issues. Those four will be located outside Grafton.

Representative Metcalf: At this point how many do you have hired up for the 16 person team?

Alex Schweitzer: At this point in time we have everyone hired except the 5 behavioral analysts. So 11. They are selected from people who work within the facility.

Chairman Pollert: When I walked in you were talking about how you had one vacant building. Can you fill me in on that?

Alex Schweitzer: I was asked about the vacant buildings and how we were utilizing those. We utilize several of our buildings now for outside agencies, rent to them. We have senior housing on the campus. One entire building is a daycare center and head start program. We have a building that became vacant because of transition. The long range goal is to try to utilize that space as much as possible. We have been asked by a variety of agencies about the use of that particular space so we will work towards that. We also have on campus a VA clinic and the migrant health clinic that we rent to.

Chairman Pollert: Are these buildings being rented out for the daycare or donated to the community? Are you making some rental income?

Alex Schweitzer: We make rental income off of that. We don't have any donated space at this point.

Chairman Pollert: Where would that show up on detail? We can wait until we get there but would you keep that in the back of your mind.

Carol Lebertowski: Fiscal director at the developmental center. That is in the other revenue at the developmental center.

Chairman Pollert: I think it is important that we are using these buildings and they aren't sitting empty. There probably is a little bit of misinformation as far as when the clientele

numbers are going down. It is a facility that looks like it is being vacated and obviously it's not. You are doing good utilization.

Alex SChweitzer: Some of the space in the one building, we talked to Northeast and private providers about some possibilities for youth and children. We are working on utilizing it and renting it.

Chairman Pollert: Do you charge by square foot?

Alex Schweitzer: Yes we could get that to you.

Carol Lebertowski: It's generally about $2.50 a square foot. I can give you exact figures also if you want more detail. We work with individual renters but as a general rule that is what it is. We do have Northeast human services on our grounds. They do have a satellite office and they don't pay rent.

Representative Wieland: $2.50 then they pay utilities? Or are you paying utilities out of that?

Alex Schweitzer : We are paying utilities. You would have to do each building individually if you did that. A lot of these are not for profits.

Chairman Pollert: I understand like the daycare.

Alex Schweitzer: It's the crisis intervention center for women. There is a variety of rentals too.

Chairman Pollert: But the buildings are being utilized. That way they are being up kept.

Alex Schweitzer: Yes they have staff there that live in the community. Continued testimony.

Chairman Pollert: Well when you look at operating fees and services it is a 2% increase on a $2 million area.

Alex Schweitzer: Yes. Continued testimony.

Chairman Pollert: Where is the other $120,00 going to come in?

Alex Schweitzer: We have standard contracts and that is what we will probably spend until July 1 of this year.

Chairman Pollert: So you are telling me that you will have an extra $100,000 of expenses in year 2 of the biennium to get you closer to the $263,000.

Alex Schweitzer: That is correct. Overall it is a drop of $6,000.

Chairman Pollert: Is there a timing issue so you aren't going to have more money?

Alex Schweitzer: No its terms of the contract is the issue. Continued testimony.

Chairman Pollert: IT Communications on the $28,000 is that something through ITD or what do you mean by IT communications?

Alex Schweitzer: That is the IT telephones. There is an increase of cost of ITD. We are switching out the IT phones. That is why you have seen that. Continued testimony.

Representative Bellew: How much longer is the bond payment for?

Alex Schweitzer: This is the final biennium. Continued testimony.

Chairman Pollert: These extraordinary repairs, are they one time or continual repairs from the general fund?

Alex Schweitzer: These are onetime expenses.

Chairman Pollert: They are under that then?

Representative Bellew: In this extraordinary repair you have preventative maintenance on the parking lot. To me that seems like it is a continuing expense. That is just my opinion.

Alex Schweitzer: It is a onetime expense this biennium but it may show up again.

Chairman Pollert: What is the total one time expenditures that we have in DHS?

Roxanne Woeste: $4.3 total for the department.

Chairman Pollert: With the $4.3 total, there is one time at the Developmental Center of 700 basically. You have how much with the $3.2 at the state hospital?

Alex Schweitzer: Around that.

Chairman Pollert: So there is $300,000 scattered around the DHS budget?

Lori Laschkewitsch: There is $352,000 of equipment over $500,000 that is one time.

Chairman Pollert: That breaks down to our one time in DHS?

Lori Laschkewitsch: Yes.

Representative Bellew: Did we ever get a printout of what that equipment is. Is it computers? I don't consider those one time spending items.

Alex Schweitzer: It's for hospital beds and mechanical lifts. You could argue that one time. You will have to replace them sometime but hopefully a hospital bed will last a number of years.

Representative Wieland: Is the list provided in the order of priority.

Alex Schweitzer: No it's not. It's what we need to maintain the infrastructure of the campus.

Chairman Pollert: On capital improvements and extraordinary repairs for the developmental center.

Representative Bellew: On your one time funding, is that all general funds?

Alex Schweitzer: Yes.

Carol Lebertowski: In this biennium they are all general funds.

Representative Ekstrom: I'm particularly aware of steam line troubles on other state property like the University system. Has there been an analysis of your steam lines in terms of how efficient they are. Do you have leaks?

Ken Schultz: Chief Operating Officer for the center. We had an energy audit done about five years ago now. As a result of that we did have an energy project where we replaced pretty much all of our steam traps and made major changes to our electrical and plumbing work. What we look at in here and we have had this winter, two steam breaks. It is very difficult to anticipate those. We have an old cast iron system. It's just one of those things when a break occurs. We are not recommending going in and replacing the whole system. It's too expensive

and not necessary in my opinion. Obviously they are all underground and usually require a bit of work to get to them. What we did was put in some money to anticipate that.

Chairman Pollert: We had a discussion on roofs. This doesn't equate to you. The DOCR and Youth Correctional Center they are asking to re-roof four roofs. When we got to the point of which ones are the really bad ones. We found out there were 2 of the 4. We didn't have to do the other 2. My question would be on the Maplewood. I see it says that it is not leaking at this time. Some of the stuff we do have to put a priority on. I do understand that. I have to ask that question. If you look at this list of priorities I'm assuming that the steam distribution system, the pipelines, and that stuff have to be done. I will ask the question about the roof. If you were to prioritize the $712,000 what would you tell me?

Alex Schweitzer: The roof needs to be repaired. It's not leaking at this time is a pretty telling comment. A lot of times there are buckets in offices because we have had to do patch work.

Chairman Pollert: So it's not leaking now because everything is frozen?

Alex Schweitzer: Yes. It is in bad shape.

Chairman Pollert: If I take the $54 million that is the total amount of money that you are proposing with the developmental center, I will divide that by 365 days. If I take that and divide by 115, that is the per day cost per client is $1,287.

Alex Schweitzer: That is correct. What the rates at the developmental center are is $525 a day. You have to add in $94 for medical costs. Our base rate is $525 and we add in an additional $94 for medical costs. It should come out to a number you are looking at. About 58% of that $525 goes to direct care. 28% goes to indirect which is the support plant and dietary. Then you have political services which is about 12% because you have a number of people with behavioral issues and PT/OT. About 2% in administration.

Representative Kreidt: Looking down on the budget totals, what kind of IT funds are those?

Alex Schweitzer: If you look where it says S101, this is the entire department. We are the caboose. It was basically ran off the BARS. That bottom part was the whole department. Our number stops at the 54. We don't have that number. That would be within the Department of Human Services. The bottom part if you look below where it says S101, full time equivalence, that area has nothing to do with that.

Chairman Pollert: Can you give me the difference between the clientele that you are doing and the clientele at the Ann Carlson center?

Alex Schweitzer: I would not have the knowledge of who they serve there to give you that answer.

Chairman Pollert: Can you tell me the difference of the clientele between the Ann Carlson Center and the Developmental Center?

JoeAnne Hoesel: The main difference is age. Ann Carlson center works with children. The developmental center does not. They are both the same level of care. They are both ICFMR's. That really is the difference.

Chairman Pollert: They are both ICFMR's. I am just saying Ann Carlson Center because it is easier to say than all the other providers for the children. Do you have an idea what that cost is per day for that care versus Alex's 643?

JoeAnne Hoesel: I can get that for you.

Alex Schweitzer: The important thing to know on that is to make sure you have the medical costs included. Sometimes they just give you the base rate.

Chairman Pollert: I would like to know that as well.

Representative Wieland: I missed when he was talking about the percentages. I got direct costs 58, medical 28, and the 12% is that operational?

Alex Schweitzer: It's 58% direct, 28% indirect which is food, dietary, plant operations, etc.

$9,365 is additional for costs per day.

Chairman Pollert: Do you have nationwide what the figure for administration is?

Alex Schweitzer: We compare and look at them. There is that information out there.

Chairman Pollert: If it's simple that is fine.

Representative Bellew: What is the difference between medical and clinical?

Alex Schweitzer: Medical essentially is a position doing a medical service similar to you going to a clinic. The clinical side is things like PT/OT and so on.

Chairman Pollert: Any other questions? That is it for the developmental center.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/26/09

Recorder Job Number: 7801, 7802, 7804

Committee Clerk Signature

Minutes:

Chairman Pollert: Called the meeting to order. Took roll call and every member present. We are planning on spending all day on public testimony for HB 1012.

Dennis Sommers: Testimony Handout (Attachment A)

Representative Bellew: Does Medicaid pay for dental braces?

Dennis Sommers: They do on a limited basis. Medicaid requires that you have to qualify. In order to qualify you get so many points for crooked teeth, impacted teeth, cross bite, overbite. Once there is a significant score achieved so the problem is recorded as deeming severe enough the state will provide coverage to those cases to the tune of about $3,000.

Representative Nelson: In your testimony you talk about the need for dental care at a young age. What is the current reimbursement for youth and Medicaid reimbursement?

Dennis Sommers: Are you asking for a percentile?

Representative Nelson: Yes.

Dennis Sommers: Differs from procedure to procedure. I believe it is somewhere between 45-50% of a typical bill service.

Representative Nelson: I thought that it was part of the 2007 bill was that youth would be raised to that 75% level?

Dennis Sommers: The bill in 2007 would have changed the overall funding. All of the services billed during the previous biennium would have been totaled together. Then 75% of that amount would have become the new budget. That was the bill that was approved by both chambers. The final result however was different.

Representative Nelson: That was for the total Medicaid population wasn't it? The youth weren't carved out of that in the bill? I thought after the conference committee report that the youth still were at the 75% percentile? Am I wrong about that?

Dennis Sommers: I believe you are wrong about that.

Representative Kerzman: You quoted other states and how the access went up after reimbursement levels. Have you surveyed providers in ND to see if they would follow those same trends?

Dennis Sommers: We have not surveyed the membership with respect to will they? We have asked the membership of the association to ask what obstacles there are to providing services. We know that there are several obstacles. The primary objection at this time and the years has been inadequate reimbursement. If reimbursement is less than what it costs to provide the service it becomes a stumbling block. There are other obstacles such as failing to appear for appointments and compliance in various levels. The number one issue that our membership says is that it keeps them from opening the doors wide to patients is reimbursement levels.

Representative Metcalf: I've been told from various sources that the level of reimbursements is important. One thing that they run into serious problems with is getting people to show up for appointments. They will schedule them in, have the time set aside for the individuals, and then they don't show up. I'm sure this costs the dentists money because they could have been using that time for someone else. Is this a true statement or is this incorrect. Do you have some statement that you would like to make?

Dennis Sommers: Indeed that is true. It is a frustration for dentists when patients fail to arrive at their appointments in need. It is loss for production for the dentists. It adds to the expense side of seeing Medicaid patients. I point out that it is not the number one reason why we have a problem in ND for accessing care. It is one of the reasons. The ADA report indicates that in states where reimbursement levels have increased, the instance of failure for appointments seems to decrease as well. I don't have an explanation for that but it has been the results in other states. To what degree that occurs I do not know. There may be other things that may be done to assist in that portion of the problem. Perhaps there are ways. In fact the ADA is working on a position referred to as community dental coordinator whose job would be to ensure that those who have appointments are reminded and have access in their transportation and arrive on time to their appointments. The ADA is approaching this from another angle as well to get the people there. That is something that is in process right now.

Representative Kreidt: I remember something different from last session. Could we have Maggie Anderson step forward and have her give us an update on that?

Maggie Anderson: HB 1246 did start out at looking at requiring Medicaid to pay a certain percent of bill charges. I do believe that was 85 when it started out. It went down to 75 and then when it was amended there was a realization that many of the children's services were already above 75%. There was another amendment to do children at 85%, adults at 75% and then at the end we were given a blanket amount of money. We are told to apply that towards the children's dental fee. There was no percentage in the final bill.

Representative Kreidt: Overall average when you did the payments do you have an average of what they were paid?

Maggie Anderson: We are working on that for some information that you requested during the

detail on medical services. We were going to provide that percentage of bill charges on a couple of different areas of where you requested that.

Chairman Pollert: So did the dollar amount that was appropriated last session in that house bill, would that have been 75% of bill charges or higher for the children? I know it's a dollar amount but what would that percentage have figured out for that time?

Maggie Anderson: We did not do that calculation at that time because the bill just threw a certain dollar amount at that. What I can tell you from the portion that is in the Governor's budget right now to pay everybody at a minimum that there are a lot more adult services that are below 75% than there are children's services.

Chairman Pollert: We can get that in our own section since this is public testimony. In your testimony you mentioned that GA, IN, MI, TN, SC, raise their reimbursement rates to approximately 75%. Do you have any idea what those states were before they did it and what it is now?

Dennis Sommers: I do not have those figures at the top of my head but can certainly research that and get that information to you.

Chairman Pollert: I still struggle with the whole medical services in the Governor's budget. What I'm struggling with is that we are rebasing funding for hospitals, physicians, chiropractors, ambulances, and dentists. Of course the hospitals and physicians are on costs, and the dentists are on 75% of bill charges. When they rebase the hospitals, there is 0 inflation the first year and a 7% inflator the second year. Yet when the dentists are done at 75% of bill charges, they are also getting a 7% inflator a first year and the second year. I'm trying to figure out why. In the other segments of the medical services are they at a 0% inflator when they are getting rebased and yet the dentists are at a 7&7 plus getting the 75% bill charges.

Dennis Sommers: I cannot answer that but if could comment on one thing that Maggie alluded to. We are talking about some of the procedures for children are at different levels than others. One problem that skews the numbers for the dentists across the state when they submit their claims to Medicaid know that Medicaid will pay 25 on this procedure when my normal fee is $50, I'm going to submit $25. We have tried to educate them to say to submit their average typical customer fee so that the state has information on where things are. Unfortunately some don't do that and it does skew the numbers.

Representative Nelson: Chairman Pollert talked about the winners and losers aspects of Medicaid reimbursements for different providers. My recollection of last session is that we asked for the analysis of the interim to determine from a provider list to get to a base line where all providers would become part of a system and increase together which would take away some of the winner loser type situations that have occurred in the past. Do you agree with that philosophy or would you rather go alone in the arena or provider services?

Dennis Sommers: I struggle with winners and losers. The losers here are the Medicaid recipients and children in particular. The dentists will be fine. We are not here begging that we deserve. We are asking for better reimbursements so that we can better take care of those children. Those children are the losers. Every system is different between medical and dentistry. Dentistry has a very unique business where we have each operatory equipped with equipment and materials to do things. They obviously have expensive things as well in the operating room. Visits to the physicians are different. Sometimes it is just an examination and prescription. Almost every visit to the dentist involves a dental surgery with high tech equipment and lasers and various pieces of equipment for definitive treatment. The delivery systems are different. It's hard to compare medicine with dentistry. I'd say we deserve to be treated differently.

Representative Kerzman: Does your organization have a suggested fee scale for dentistry? Does it vary across the state rural and urban?

Dennis Sommers: The dental community itself does not have a fee scale suggested. The service corporation certainly has one which is the arm of that organization. They have an allowable fee for different services. Is that what you are looking for? Dentists are certainly aware of that as for what the DSC will allow. Some dentists charge a little more than that. Some charge less. Perhaps what you are looking for is that. States don't all have the same kind of set up for determining their reimbursement as we are talking about here. Some states contract with a private entity like the DSC to administer the delivery system. In some of those states that are listed they have brought their fees up relative to those dental service corporations' fee levels in order to gain access.

Representative Bellew: Can dentists cost shift? Can they shift the costs for different procedures to make up for some of these losses?

Dennis Sommers: Dentists do not typically do that as I understand. It may take place in hospital settings or other medical type settings. Dentists don't do that.

David Zetner: Testimony Handout (Attachment B)

Chairman Pollert: When I look at reimbursement levels of what we are doing and what is proposed in the Governor's budget. In dentists it is proposed that 75% of billed average charges. Which is better? Where is the level field? I wish we could just look at this and say what it is. I think we are struggling with what is right and wrong.

David Zetner: I don't know how to answer that question. At one end you are looking at costs. On the other end you are looking at a percentage. Are they close? I would say they probably are. When you look at this 75th percentile you are saying that 75% of the dentists will get what they are billing.

Dr. Brad King: Testimony Handout (Attachment C)

Representative Kerzman: I want to applaud you for not discriminating and handling all patients. I think that is a very honorable thing to do. We had a dentist back home that as far as I know he did the same thing.

Brad King: I do want to be very honest. We do discriminate in a sense. We take Medicaid patients who we know will show up. There are people in nursing homes which we get the worst reimbursement from but will take them. We see people from all three nursing homes, the prairie learning center, that they are brought in. Someone else is responsible for them. To give you an idea of what our financial losses are.

Linda Kleinjan: Testimony Handout (Attachment D)

Chairman Pollert: When I look at the practice where you are the administrator then, for your business are they then reimbursed on the hospital side of the reimbursement or are you still on the dental side because its oral?

Linda Kleinjan: We are just reimbursed on the dental side. Whatever our fee is to see the patient, that is billed to the patient or the hospital doesn't reimburse us.

Chairman Pollert: So then these patients aren't being put in the hospital?

Linda Kleinjan: We are not admitting them.

Representative Nelson: I'm interested in how many Medicaid patients you have as part of your business? Do you have that number?

Linda Kleinjan: I don't have a specific number. We see them on a daily basis.

Representative Nelson: That is an important part of this. I don't want to appear to be insensitive to your needs. You provide a valuable service but from our position we are going to hear the same thing from every provider that comes up here. They are all right. That is why getting back to the study that was done during the interim that was our goal. We spent millions

of dollars to compare apples to apples, the different Medicaid services that are provided in this state so we would be able to determine a base line and wouldn't have this picking and choosing of who is the winners and who is the losers. The point is that every reimbursement system is different, costs versus percentage of bill charges. Your billing system is more spread across the region as far as predominant charge than with hospitals. Medicare reimbursement would indicate that the hospitals in ND receive less money than those in other parts of the state. In your business, a tooth extraction in Minot is it different in Minneapolis?

Linda Kleinjan: I'm sure it is. I would think Minneapolis would be at a much higher rate because of their cost of rent. I know in other parts of the country things are different.

Representative Nelson: That would be true to some extent. Some providers it is a government controlled system. Are you losing money in your business practice for the total business aspect? Is it fair to say that some cost shifting does take place?

Linda Kleinjan: I don't believe cost shifting does take place. Right now we have been very desperately trying to find another oral surgeon to come to our practice. We have been looking for about three years. The gentleman in our practice, we have got three of them with two doctorates, three specialties, they are board certified in multiple things. Their education is so high. Just that they would be here really says something for them. They could go anywhere. They are heavily recruited out of our practice. To find someone to come in is really difficult. It's to the point where they are already losing money and I just can't imagine that they are going to work for less. They are board certified in multiple specialties?

Representative Nelson: I would invite you to stick around for the other providers because I think you will see the same situation.

Representative Metcalf: I see where you have in here that a number of your clients are juveniles and adults for the control of the department of corrections. Can you give me an

estimate of what percentage would you say are from that department versus the average services they provide?

Linda Kleinjan: I do not have those numbers.

(Recorder quit working)

Nancy Callahan: Testimony Handout (Attachment E). Started new job (7804)

Representative Bellew: They would question that though?

Carla Kelly: I believe they would take cash. I could go down. Each one of these has a different system. A couple of the dentists on here will see the kids. It might take 6 months to get in. Some don't see Medicaid patients at all. Some of them if you miss one appointment then you can never go back to them again. We have one that if you call up and cancel he will no longer take you as a patient if you are on Medicaid. I have heard the stories over and over so I know they are true. I deal with it every day because we have to get the kids in as part of the federal program. The reason I really care is because I see kids sitting in school in pain. A lot of times they are showing that. They don't eat, maybe they have behavior problems. The next thing we know they have a swollen jaw and we have to get them in because they have an absence. I think rural families in our region have an extreme difficulty finding a dentist.

Carla Kelly: I am a hygienist for the southwest region. I work for southwest district health unit. I am on the oral health coalition in the state. We have a dental practice in Bowman. Most of the things I have to say have been covered already. I do want to talk about reimbursement and that I would like to see it not necessarily for the money that it brings to our practice but for the help that we need to take care of these kids and adults. We see an amazing amount of Medicaid clients. We see them from ND, SD, IA, etc. We just have a huge need. We see patients from 100 miles away. There is not a day goes by that we don't see Medicaid patients. It's an everyday thing for us. We do see the correctional center women from New England. No

one within 20 miles of their center will see them. They drive the 60 miles to see us. They bring them by bus. The way our software was set up I could not get all the information as far as percentage wise. It's just the way it was put in. I was able to get out specifically one group which was the correctional center. I do have some numbers here. In last year's production we did $77,000 of work. Our reimbursement rate was $37,500. Our overhead runs about 70% so it's a bit more than Prairie Rose and that could be because there is more dentist work involved. The corrections center does pay us a stipend to see their patients because no one will see them. We do make a little extra money on that but we still at the end of the year, the first things with all these patients we ended up with a $1,600 loss. I think dentists are really good about giving away dentistry to people that really need it. We don't have to leave our home or office to do charity work and that is a wonderful thing we can do in dentistry. The few people that are doing it with the 20% are becoming overwhelmed because there is only so long you can run at a loss.

Representative Kerzman: You don't handle MT patients anymore? Is there reimbursement level less than ours?

Carla Kelly: It was getting to be overwhelming. We do see some SD. We actually had to go to the state to see if we could see the boys and not all residents. We are just overwhelmed. You can only run at a loss so long. It's wonderful to do charity work but I'd like to see someone from Dickinson help us.

Representative Kerzman: Do you know what MT's reimbursement rate is?

Carla Kelly: No I don't.

Representative Nelson: Before we get started I had a conversation with Dr. King during the break and I think it would be helpful for this committee to know the criteria that was used in the interim study as far as the rebasing of providers. It seems as if there were different groups

doing the individual study. The dentists make the point that it was very difficult to provide the information that was needed for them. I would be interested to know how uniform or how easily it was for them to provide the information we need to move forward with the increases.

Chairman Pollert: Do you want an explanation for the bill or someone from DHS to come up?

Representative Nelson: It depends on the answers from some of the groups. Dr. King did say that the questionnaire that you received from whoever was contracted to provide that service was unusable. I don't know if Joe or someone has knowledge about that but if they do, I think it would be important. We did spend a lot of money to get results. If the process was flawed I'd like to know if that was true across the provider board or if it was an isolated case.

Chairman Pollert: All we can do is have Legislative Council read what the amendment said on the SB last session that was done through DHS. If you want more detail we will have Carol come down and explain.

Representative Nelson: I think the intent of the amendment were to know the details of what took place, what firms did the analysis, and how user friendly it was. It would be important for us as a committee to see in case it was as valuable as we thought it would be.

Chairman Pollert: What I would say is that we should bring them into our section.

Beverly Adams: Testimony Handout (Attachment F)

Representative Nelson: I don't expect you to have this but it would be nice if you did. I brought this issue to Blue Cross before and their answer is always fine. We will pay you at other states but then policy holders in ND will have to deal with the reimbursements. You don't happen to have a premium comparison as well?

Beverly Adams: Yes that is on page 16 exhibit 5.

Representative Nelson: On a quick look at this what they told me was true.

Beverly Adams: You are correct. The premiums in ND are currently the lowest in the nation for private healthcare insurance. I believe that NDA or NDHA have done a study. The perception is that the citizens of ND think they are paying very high premiums for health care costs. We are the lowest in the nation.

Representative Kerzman: Prior to the restructuring of Blue Cross Blue Shield it was a wider variety on the board. Did these scales start sliding after that? Can you see the difference?

Beverly Adams: I don't know if I can answer that question. Continued testimony.

Representative Metcalf: ND has a medical school at UND. They graduate so many doctors every year. I think it's about 60% of these doctors or more stay in ND. You say you have to spend a certain amount of money to hire doctors out of the state? How many additional doctors do you have to recruit over and above what we are producing out of our medical school?

Beverly Adams: I don't have the answer to that question but I think this may be the time for me to introduce Dr. Gilbertson who would better address that question.

Chairman Pollert: What is the reimbursement for critical access hospitals versus the big 4, 5 like Altru? Is there a difference?

Beverly Adams: Yes. I can't give you the numbers on Medicaid however on Medicare the critical access hospitals can be reimbursed at 100% of allowable costs versus the large integrated systems are paid on what we call a DRG type of system where we are provided a fee for the service that we provide. It doesn't take into consideration the cost of providing the service. In critical access you have to be in a particular area of the state that is considered more rural and a lower number of hospital beds. For the larger hospitals when you are located in urban areas and have more hospital beds they pay you on a fee for service type program versus a Medicare critical access type concept.

Chairman Pollert: Do you have any idea what that might be compared to the critical access at 100%?

Beverly Adams: I do not.

Dr. Gilbertson: I have four quick points of underscoring what Miss Adams said. The reimbursement system and existing payment system for healthcare in this country is a very complex one. Fundamentally if it is governmental programs or commercial payment it exists as a fixed payment for unit of service. That is done regardless of what the costs might be. This varies a bit across the country because of the ability of people to negotiate. What we are doing is having conversations to negotiate the needs. Basically we have very little control on what we get paid for services. Meritcare is the largest healthcare provider in the state of ND. As Bev pointed out they feel that large size may single us out against the significant challenges that we and others face in healthcare. I can assure you that it does not. The numbers just get bigger. We deal with the acute care setting as an adequate county hospital. We cover a fairly large area of the state. The other thing that maybe wasn't quite as clear was that the integrated systems in the state of ND which is a unique state provide the vast majority of all rural healthcares in the state. It covers 90% of healthcare. We aren't an urban delivery system. We are urban, rural, and remote. We cover the full spectrum. There is an enormous amount of benefit that goes into the communities. I want to point out one additional thing. The idea that having a. There is no question that the profit margins and some of the sub specialties are good. Unfortunately it is going to be fewer. If you look at professional services alone, very few have professional margins at all. When you count the benefits and salaries, having to recruit the number of people you will see that the cost is significantly high. There is a limit to this. The limit is how long we can stay viable. It's not that the work that has been done.

Chairman Pollert: I have this perception too. I have been that way too until your testimony too this morning. Say it is heart surgery or a specialty surgery. I always thought it was easier at the Big 5 as compared to a critical access hospital for you to shift costs. Does the private payer pay more for a heart surgery or liver replacement? I always thought the margins on that would be greater where you can cost shift.

Dr. Gilbertson: That is an important question. Talking about heart services, if you have a bypass surgery the costs are oddly much higher than if you are seeing someone in an office. Because of the supply cost and the other things are tremendously more expensive. The margin on that is also larger as a general rule. In recent times that margin is steadily declined because the reimbursement for cardiovascular services has steadily been eroded particularly on the physician side. In order to recruit and maintain cardiologists we have to subsidize that professional side of it on a continuous basis more and more to retain them. If you look at where Medicare has gone and reimbursement for positions, some of those have stayed over the last three, four years that we are going to have a 9% cut or a 12% cut. There has been a steady decline over the last 5, 6 years with many of these services. The ability to cost shift some of those things is not great. There is only 4, 5 areas of places where margin is made in hospitals these days or in health systems. Most of it is in the hospital. That is where reimbursement is greater. In the large clinics, this amount is about half of our revenue and this is where we lose money big time. Maybe $20 million a year. In order to maintain that level and quality of service. That used to be cost shifted to the hospital which had better reimbursement. Because we can't cost shift, that margin is just eroded down.

Chairman Pollert: So basically you are saying that the specialty services that the margins are high and you are cost shifting because the margins for the physician services are drastically lower. You are cost shifting to try and break even between the two services?

Dr. Gilbertson: I don't want to start saying the profitability for cardiovascular is high. It is in relation to other things. Of course there are marginal costs. I'll give you an example in orthopedics. That includes both hospital and physician component. How narrow the margin has gotten, most people think if you have an orthopedic surgeon you are golden. If they choose the wrong prosthesis, we may lose money or make money. In the variance of those things is anywhere from $1,500 to $8,000. If they take the $8,000 we probably lose money on the case. Part of that whole program is quality and standardization and efficiency with lower costs. We can probably get our costs even lower. Right now we are the lowest in the country. Nobody compares with us in the cost standpoint. We aren't whining about that. The whole context of this conversation is for you to understand as you think about it from the Medicaid standpoint in ND but you are also the legislator for the whole of the state and for all of us in the state. Part of this is an opportunity for us to say this is frail that is going on in healthcare system in ND and a lot of it centers on the reimbursement issue that has ND specific. I can assure you we have talked long and hard to the conventional delegation that we have here. They are helping and trying to help us improve some of these things. In Congress it is hard to change things when you look at the votes in NY, FL, TX, and CA. Some of this goes way back to the 1980's when ND honestly reported their costs to the Medicare office when they were going to the prospective payment system. Our costs were lower and we have been stuck with those ever since.

Chairman Pollert: I have heard that Altru is thinking of expanding in Grand Forks. Let's say it's another facility. I know in Jamestown they are talking about building a facility and going with the critical access. Normally, when you are building a facility you are getting bigger because the profit margins are better so you build. How does that work as far as hospitals go?

Dr. Gilbertson: I don't think Altru is expanding beds in Grand Forks. There is a private for

profit for entity called Aurora that is under construction in Grand Forks. That is probably what you are referencing. Critical Access hospitals change their reimbursement. They were struggling. They are still struggling. Their reimbursement isn't probably different than ours. We are paid on a fixed price per unit of service whereas Bev pointed out, critical access are cost based reimbursed. There are qualifications of how those costs will be used. Fundamentally they are. You will see in the country that many critical access hospitals are actually building. They are looking into that, should they really be building? You can cost that back into a cost and get reimbursed for that. Some of that is made possible by some of those things. Many hospitals when they get marginal from a volume standpoint, if they want to go to critical access so they can go from PPS to cost based reimbursement, that is what Jamestown has done.

Representative Kerzman: One of the big disturbing things to me is how we are going to handle that cost. It just seems like we are way out of whack in this country. I have neighbors who are self employed who are paying close to $1,000 a month. The problem we have here is that if we raise one rate the other rate is going to come up to meet it or vice versa. We just have something that keeps snowballing out here. We have been trying to address this for a number of years and it just doesn't seem to get any closer. Do you have any answers how we can get a handle on costs?

Dr. Gilbertson: Yes I do. I would say that they should have our reimbursement be not ridiculously low like it is. Otherwise they match the system we have in ND and you will save hundreds of billions of dollars of healthcare costs in this nation. There is tremendous waste in healthcare across the nation. Part of the dilemma that we have had for years is that we get painted with the same brush. When CMS pushed the button on the computer to lower their costs, that effects everybody. What they are after when they do that many times is a corruption and fraud in NY, FL, TX, and CA. We get wiped with all of that same brush and everything

drops down. Efficiency in the health care system is not where it needs to be. If you look at ND, if the costs per unit of service in ND and you compare it with someone else it is just about half. We have got the right system. We are part of studies nationally that are going to try to prove that. Our hope is to participate in the reform so that they will embrace these systems that you have and truly reward us for the high quality that you have. I will give you another thing on how inequitable this thing is. If you are in LA, which has the highest cost and the lowest quality in the state, they give them the same benefit for incentive. Now they are the second lowest but they get the same as we would get. We are at the top of the pile. It's harder for us to go over into the stratosphere here with some of this. They should be paying if you are high quality; you ought to be paid at a certain level. If you are less than that you ought to be paid less. That is not happening and it is part of the political process.

Representative Kerzman: Your charts show different. ND is on top in the quality but we are down with the reimbursement. I don't see much correlation between reimbursement and quality. I see just the opposite. We talk about efficiencies. I'm not seeing that happen.

Dr. Gilbertson: You are making the whole point when talking about ND. You are absolutely right. What they do nationally is point to ND, MN, and some of the other states. Lower cost ends up having higher quality. Because you have high costs in LA and the worst quality. What people get paid for is not the issue. People have to look at the quality issue. There is not more money put into that. What we are talking about and discussing with you is that there has to be sufficient amount of reimbursement in the state so we are competitive and we are survivable in the marketplace with this. I would plead to you that in my work with the economic developments are that ND does have an issue with wage scale in the state. We need to raise that. It's not a good deal to have a low wage base. It's not good for us. As we try to improve business and activity in the state and try to retain our youth and all the rest, it is going to be a

big factor going forward. The economic boom that is part of ND, part of responsibility would be that you look at that and see how we use it wisely. Part of that is having a stable and viable health care system. That is a critical part of that.

Representative Metcalf: One of the thoughts that came about was the cost of recruitment for medical doctors. I referred to that to our medical school. How many more doctors should we have in our process of education in order to meet our needs in ND? I realize we can't meet all our needs especially in the specialty areas. Could you give me a statement concerning our doctors and recruitment position?

Dr. Gilbertson: That's a very good question. The context of that is we do actually retain a fairly high percentage of physicians in to ND. Even some of the specialties, we track them from entering med school and try to recruit them back to ND. Once they go into a residency program some place and they are there for 3, 4 years they get surrounded by the area where they are at. The data shows that they end up going into practice within a 200 mile radius of that. They do look at that. How do we attract them? Paying them 10% more or benefits might be better. Workload is certainly not less. For primary care, we have residency programs and internal medicine. Meritcare is a major teaching facility in the state. They have residency programs in psychiatry and internal medicine. Family practice has residencies in Grand Forks, Bismarck, and Minot. We do pretty well with those people. That is going to be insufficient. Someone just told me that the hardest recruit in the nation is a general internist. I think you are going to see a shift in the leverage there that is going to come for primary care. ND medical school is a tremendous resource for us. My own feeling about that with the integrated system and perhaps that is where it comes into effect. If we can also develop some specialty training, not just internal medicine, fellowships for cardiology and some of these other specialties that are going to be critical. We are very easily in sufficient size to qualify to have some programs. I

do believe we should be growing more of our own and retaining some of these people in the state. It's a tough market out there. We contact 100% of all graduates from UND and try to recruit them back. They also get married when they go to residency. Getting the spouse back here is not always an option.

Representative Metcalf: Based on the number of doctors that are retiring and the numbers of doctors that we are training, are we gaining or losing?

Dr. Gilbertson: We are losing. There is a projection to be 200,000 physicians shortage by 2020. The irony of this whole business of a healthcare delivery system that is out of sight from costs. Not even really competitive internationally. It drastically needs reform. We are going through a reform process and lowering costs but we are running into that. The supply and demand issue is going to be a crisis. The physician shortage is going to be worse and worse. That doesn't sit well with ND if we are viewed as a low paid state. It is also a crisis for nursing. The average operating room nurse is about 54 years old. You look at this group of physicians that are about 55-65. In order to replace every one of these people, any physician with the new era, you have to hire between 1.5-2.5 to replace one because of lifestyle issues and other things that have changed.

Representative Nelson: You as well as every hospital in the state is under an increased challenged system. I'm going to limit to one question. We have some students here from Mayville. I don't know how many of those young folks were born in the area. I would guess that in that period of time when they were born, a good many of them were born in Mayville. Now I would guess there are no births there. There has been a shift. The shortage of physicians and shortages in rural hospitals have been pushed to the major centers. Now in your discussion with the internal medicine situation, most critical access hospitals are going to be limited in the scope of who they can admit. To get into perspective what is your volume of inpatient

business. Is that on a sliding scale downward or is that increasing? There is an area of difference.

Dr. Gilbertson: Our admissions are increasing. Some of that has been related to the increase in size of the company. Some mergers and acquisitions. In general our admissions have gone up. 15 years ago a futurist told me that we would only need a 100 bed hospital in 2013. We have added beds continuously during that period of time. The issue of rural health and some of the things like OB and delivering babies is what we will talk about. There are two factors involved. It is less the availability of physicians than it is the availability of patients and population base. They just stopped delivering babies in Valley City. That is now a critical access hospital. Physicians were very upset that they had to stop delivering babies. The reason is you don't deliver enough babies to stay competent. You have to have sufficient volume so people can stay competent in doing that. Otherwise you are putting mothers and children at risk. If you are only delivering five babies a year that is not adequate to stay skilled. That is part of the dilemma in critical access hospitals.

Representative Nelson: This is not reflective on your situation at Meritcare. I know you did have a number of satellite clinics in surrounding areas. I believe that some of them are closed because of the economic situation. I know it's been said in areas where clinics have been placed in outlying areas. Some of them in fairly large communities. Devils Lake for example, where Altru has an association with a clinic. The hospital in Devils Lake has a perception, if not a reality, that many of the patients go to Grand Forks that could be handled in Devils Lake. There is a shift of where the services are being provided. That does skew the imbalance of what critical mass would suggest. If you are going to have 5 births a year you cannot afford to have that. As a shift takes place to the larger areas, it only makes the challenge greater for those communities that strive to keep their hospital, would you agree?

Dr. Gilbertson: Yes I would agree. That migration is going to continue. It's not going to go away. It also depends on the full population. I don't want to talk about Devils Lake because I don't know that market. I think that some of the comparable areas that we have like 40 clinics in eastern ND, western MN. There is a lot. Actually the Mayville people are here and we have a clinic there. We do believe that we think we should optimize the car at the local level to have as much care as we can. I will tell you one of the problems of doing it is getting specialties from the urban areas to go out to the urban areas to see patients is a hassle. We would like them to go out there. We don't have time to go out there. This is where some of the incentives that you have to do to manage a rural and urban organization like we have. You have to create an incentive to subsidize physicians so if they lost time they can deal with it. I don't have an answer for you but I do have some passion for this. We need to assure that rural ND has appropriate healthcare as well. High quality healthcare. The model for doing that I think will change over the years. Probably starting right now as you see this evolving. What that will look like, I'm not entirely certain. It won't probably be a fully fledged hospital in every one of these locations but there should be health facilities. There should be a safety net for them. If it's not managed well there will be nothing. I think it's important for us to look at ND as this ecosystem as well that we need to take care of all the citizens of ND.

Representative Kreidt: Kind of along the lines of going back to the UND school of Medicine and the physicians that we are educating there and the number staying in ND, what are we seeing on the side of foreign physicians coming to ND? Are there still a lot of individuals trying to come here from other countries?

Dr. Gilbertson: Foreign medical grads are getting better and better. I have seen them for about 40 years in medicine. Their quality is increasing, they are improving. I think we are going to see more and more. Number 1, America is not graduating enough physicians to meet our

needs. In the state of ND, we may see some increase in that over the years. If we don't have a better system for retaining our own physicians in the state. Not because they can't go somewhere else but they need to go to an underserved area for a couple years so they can get a green card. Then they can go where they want. In fact some of those happen in the state where they go for two years and another one is gone. That is not a good system. Foreign medical grads are going to be part of the delivery system here. That will be part of the social adjustment that we will all have to deal with. For example, critical care physicians, when we were recruiting a year or so ago we had 10 applicants. Every one of them was foreign. Not one was American. They are all trained in the US. We are seeing that in some of the specialties. I expect some of that to continue. The good news is that they are highly trained and highly qualified. I think they will do an excellent job and often times they are excellent citizens.

Representative Kerzman: I have seen an individual that has been trying to get into med school for some time. The selection process is limited. Going back to med school, the mill levy that goes on to support that. They aren't getting representation out in the rural areas. It is hard to get people in and to get them back out in rural ND.

Dr. Gilbertson: I would say that the quality of student is competitive. The competition for the slots varies depending on the number of applicants and so on. I think that decreasing the qualifications of physicians would be a mistake. As a matter of fact more people think there should be greater screening of physician applicants in med school. The reason I say that is, is because some of these people in medicine probably shouldn't be there. This has to do with interpersonal skills and behavioral issues. UND does a great job of doing that. I think the medical school is rising as a school. I would say that southwest ND should have programs that could enhance that. If you go to Concordia you have an 85% chance of getting in. To me, one of the biggest criticisms I have is in nursing. They have extremely bright nursing students that

can't get in because there is no slots. That is more critical. It is more unjust to them. They would qualify for medical school. I think that the process isn't bad. The state has to create incentives to get them there. You can't assign people out to these areas. It just won't happen.

Matt Schwarz: Testimony Handout (Attachment G)

Representative Kreidt: When you are talking about caregivers are you talking about a CNA or a QSP or what type of care provider does Jessica have?

Matt Schwarz: These are caregivers that go into the home to provide services to people with disabilities. In our case the needs are much higher. My understanding is that one of the problems is when you have people that come into the home and provide services similar to Jessica, there is no extra pay for those people as if they come into a home and help someone with much less intense needs. There is the problem. The people in our home have to know so much more. They have to spend a lot more time training. It's difficult to learn all of those things. Those people that do and have the capability to do that have a tendency to move on to other jobs. Then of course you have that process repeating itself by spending more money on training. Our service provider has treated us very well because he has told us on many occasions that it costs him money to provide services to our family as opposed to the services that are provided in other cases.

Representative Nelson: Maggie is here now. The question is that Mr. Schwarz talked about the level of service that is needed for his daughter and that is paid for under the same pay scale as the people with less training. Does this fall under the QSP program? Help me understand how the pay reimbursement goes in this area.

Maggie Anderson: The services that are being discussed are through the waiver. Those individuals are typically hired through community options that provides the services. They aren't technically QSP's because they are considered DD waiver service providers. They don't

fall under the same fee schedule as a QSP. A QSP typically provides personal care services. The services through the SPED program and expanded SPED program. They can also provide services through the home and community based waiver which is the equivalent of the old age and disabled waiver. Through the DD waiver it is a little bit of a different system where the DD providers are set up. We set those rates and fees based on cost reports and different criteria. I'm not an expert on DD rate setting. We certainly can get into that detail a little bit more when we come back to the committee. It's not the equivalent of QSP's.

Eric Froehling: Testimony handout (Attachment H). If I can address one thing that has come up. Representative Nelson asked about the study for the dentists. Our rebasing study was done by a group called PCG. Initially what they sent us to fill out was somewhat laborious and difficult to discern how to do that. We did work with them in order to revise what they need. They were willing to do that until we got to a point where we were able to provide them the information that they needed. At that point it became a very usable study. I would say that it did seem to work for us.

Arnold Thomas: I'm for the Healthcare Association. If I may, the physician is also going to be offering testimony in respect to the physician rebasing also has an early afternoon commitment. I would be willing to let him go and I will go later.

Chairman Pollert: I will see who is left to testify on this division.

Arnold Thomas: We can be here when you need us to be.

Bruce Levi: Testimony handout (Attachment I)

Robert Thompson: Testimony handout (Attachment J)

Representative Nelson: My question is I have heard that there has been some recent changes in the J-1 program for that. Obviously there are many hospitals and communities that have utilized that program for family practice. Certainly in my community, I can't remember the

last internist that wasn't a J-1. Is that true. Has there been changes that make ND less attractive or competitive to attract J-1 applicants to our state.

Robert Thompson: Yes. Most of the J-1 applicants that we get tend to come from countries that are a bit more tropical. The J-1 people who come here are looking for opportunities. We probably have more luck in the bigger communities. A lot of these people are from large cities and international areas. They want to go to an area that is on the border of being underserved. They struggle in some of the real small communities. I do think that ND in general is a tough place to recruit. I think with the J-1's, I don't know that answer. I am involved in recruiting in our system. We are recruiting J-1's. We have exceptions for kidney doctors and ICU doctors. It used to just be primary care doctors. Now it is global. The number of slots is across different specialties.

Representative Nelson: You also mentioned that you were on a task force with a congressional delegation. I understand the challenges that ND has within the US Congress given the limited role that we have in the House and being as rural as we are. Is this an area where the J-1 program would have an impact to help direct some more applicants to our state. I think the last numbers we looked at we were 400 positions short in this state. I don't think that is changing is it?

Robert Thompson: The J-1 Visa issue hasn't come up as part of that task force. We were more looking at Medicare reimbursement and the disparities there. I dare not answer that question because I would be making it up. We are at the bottom of the reimbursement. I will say our congressional delegation has been very helpful.

Chairman Pollert: Are there any more questions? We will be in recess until this afternoon.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/26/09

Recorder Job Number: 7803

Committee Clerk Signature

Minutes:

Arnold Thomas: *I'm the President of the ND Healthcare Association. Before I begin my remarks I would like to present something to the committee that caused by remarks to be completely re-altered for today's presentation. One of the presenters that we invited to address you was Mr. Terry Hoff who is the President and CEO of Trinity Health in Minot, ND. On his way down he was notified his mother had a serious health challenge. That is one of the reasons why I won't pass out any prepared remarks and we will have those available for you shortly. I am here to support the Governor's budget for the budget request that is before you that will reimburse hospitals at a rebased rate. What is that amount? In the Governor's proposal there is approximately a little over $8 million that we will finish an initiative that you began last session when you took the first step in rebasing rates for hospitals and you applied that rebasing action to critical access hospitals. I would like to remind this committee that you are not comfortable nor are we able to express any confidence in the necessary dollars needed t complete the rebasing for all hospitals. Instead what you elected to do was put money aside in your appropriation request for human services commission study to identify what dollars would be necessary to complete that rebasing project. Those dollars are in the Governor's Budget and that is why I'm here today. With me are other people who have*

appeared before you last session. They indicated the importance that Medicaid has for her particular facility. She is here to tell you what the consequences of your actions were last session have meant for her organization. In the context of arguing for rebasing of all facilities, why? Rebasing is long overdue. It has been 17 years since we have had a rebasing of hospital payments. We think it was timely when we presented the request for you last session. We ask you to basically finish the task this session. The numbers are now known. I would suggest that Representative Nelson's early query with respect to how the studies were done, by whom, and the refutability of numbers that you are asked to address would be put to the department where they would have an opportunity to talk about who conducted the study of the materials that were included and is the department satisfied that those numbers in fact represent costs?

Chairman Pollert: What I'd like to find out from someone is how many critical access hospitals we have in the state. Does that depend on the percentage of Medicaid patients that they have coming in. I would suspect Rolla and Devils Lake have a larger proportion to share with Medicaid. I know that is where a lot of the problems are coming in. I would like to find out if there is a correlation somewhere.

Arnold Thomas: I can get that information. You are really asking what is the percentage of Medicaid business spread throughout the 43 community hospitals in ND. Others also have the same proportionate burden. Medicaid, by itself is what we are talking about today. There are other payers who have different arrangements with those providers as well. The earlier comments of cost shifting are problematic for everybody. Approximately 85% of our rates are unilateral set. The people who wind up with that burden for the most part are those who we have been able to shift the costs too which are captured in our commercial premiums. Or for an individual who walks in and receives treatment but for all practical purposes is for insuring himself but not with an insurance product. Those individuals wind up paying more because of

the ability to shift the cost that is not recognized by other payers. In terms of Medicaid, the difference between the costs for all staff except for physicians, what it costs to turn on the lights, insure the place, to make sure the equipment is relevant to today's standards, and what the cost is to be able to have drugs and supplies to keep the place open. That is what I'm talking about in costs. There are no returns to stockholders and shareholders. It's just basically to keep the place in operation. What our study has indicated and what is in the Governor's Budget is to bring the remaining hospitals up to cost.

Representative Ekstrom: Is this going to be enough? Are we just putting a mandate on it this year, or are we going to be back next biennium?

Arnold Thomas: That question was asked of me last session when you took an action that put the critical access hospitals at a rebased rate at cost. This would be built in as far as that budgeting process. Through your normal process, if revenues were not adequate, you would end up going through the normal process that you normally do in terms of what are the priorities, what are nice to have, etc. We had requested last session, was to give you a figure that was not arguable that showed what the difference was between our cost to operate and what the state of ND was paying. Will that solve every institution? No. Those are factors that are also in addition to payment. I believe others this morning outlined some of those additional pressures. We are here to do is augment with our voice what the Governors requested you to consider and that is the rebasing of hospitals to cost.

Kimber Wraalstad: Testimony handout (Attachment A)

Representative Bellew: What is the difference between the critical access hospital and like Trinity Medical Center?

Kimber Wraalstad: There are two types of hospitals in ND. One is a PPS. Those are the large six. They are paid on a prospective basis. You heard DRG's talked about sometimes. That is

how Medicaid and Medicaid determines that. If I have to go in and have an open heart surgery. They know in advance what they are going to get paid. The critical access hospitals is a definition provided by CMS. We have to apply for it and be surveyed for it and meet certain criteria. It can be no more than 25 beds. We have to be a certain distance away from certain facilities. We have to provide ER services. The differences that we are then paid by Medicare is 100% of an allowed cost. What is not allowed? Physician recruitment is not allowed. Any kind of cost that deals with that, Medicare does not pay for it. They believe you should be paid by your third party payer. Last year when we came and talked about what we wanted was Medicaid to pay the critical access hospitals our cost. That is what happened to the cause essentially. Except they did carve out this lab and anesthesia piece. That is paid differently through Medicaid than Medicare. What we are asking for is to be paid our cost. The critical access hospital is 25 bed. Literally every hospital besides the big six will be critical access hospitals.

Chairman Pollert: This is based on 101% of what?

Kimber Wraalstad: It is allowed cost. Earlier today there was a lot of conversation about how some of these costs are determined and for some of the other providers. From the time that Medicare essentially was established, they required hospitals to do cost reports. We've got many years of history of costs. They have reports that are mandated for us to do. That is the Medicare and Medicaid. Even Blue Cross uses those reports. So when we talk about allowed cost, they will take that cost report and say ok these costs are allowed, these are not. Physician recruitment costs are not allowed. Interest costs are not allowed. One of the things that drives me nuts is cable TV costs are not allowed. Those are non allowed costs. You are supposed to make those up from your third party payer. Blue Cross Blue Shield's not willing to make up all that much difference.

Chairman Pollert: You mentioned in your testimony that 49.5% of your patients are Medicaid. I'd like to know what that percentage of Medicaid patients is in Devils Lake if someone has that. I'd also like to know if there is a correlation between the percentages of Medicaid patients coming into some of the other CA hospitals, and is there a point that it is ok so you aren't losing money?

Kimber Wraalstad: One of the things that I'm also a member of a group that calls ourselves the Gang of Five. We worked with pretty much all of the critical access hospitals in this last year and asked them to give us their financial statements. We wanted to see how everybody was doing. Essentially was what that came down to was critical access hospitals in ND are running at a -3.4% loss. Whether or not you have high Medicaid and that causes you to lose more, it's not. We are all struggling. That is why we are all coming back and saying we need appropriate cost base whether you are Rolla with 49% of the people that walk in to the door being Medicaid, or whether you are someone who has a less volume. That means that all of us are losing money. How are we trying to make it up? Grants. Back when there was investment income. You are probably going to see losses even greater. Some of the communities support their facility with tax funds.

Chairman Pollert: I'm a person who likes hard copy. I would like to get that information to hand out to the committee so we can have that. We are being asked to appropriate funds and somehow we have got to do it in a fair beneficial matter.

Kimber Wraalstad: We actually put together a document that we shared at election time with the Governor and with Sen. Mathern as well. It just talked about certain issues going on with critical access hospitals. Because our advocacy efforts aren't just talking to you in regards to Medicaid. We have been talking to the congressional delegation about Medicare.

Chairman Pollert: I understand that. Dr. Gilbertson said one of the major problems we had was because ND and the federal government that ND isn't treated fairly. I understand our hospitals are very critical. When does the point come that the state has to kick in a substantial amount?

Kimber Wraalstad: I would be happy to give that to you. I will make it available to you.

Representative Nelson: In your operating losses that you reveal here, I'm curious to see what value does depreciation have in your facility?

Kimber Wraalstad: Our depreciation expense in 2007 was $298,000 and in 2008 was $310,000.

Chairman Pollert: Which is a percent of what of your operating costs?

Kimber Wraalstad: Approximately 5.

Representative Nelson: That is pretty common from the facilities that I am most familiar with. These bottom lines are quite familiar as well in many critical access hospitals. The one that I am most involved with is having a 6% Medicaid utilization. In facilities like Rolla I'm sure this has had a much larger impact on bottom lines. Quite honestly this is the best way that we can affect the stability of rural hospitals through Medicaid reimbursement.

Chairman Pollert: As far as that information, if you would get it to our clerk and we will get it distributed out.

Mark Weber: Testimony handout (Attachment B)

Representative Nelson: As I understand the distribution if this bill passes, Maggie if I heard her right, indicated that this would be proportioned out in lump sum and then you would weight a certain area of service you would have the ability to do that. Did I understand that right?

Mark Weber: That is correct. That is what we did in 2007. We got a little bit of money and we got together. What we did we think was pretty fair? Medicare came out with a fee schedule a

couple of years ago in 2005 I believe. They did a study to find out where the ambulance charges needed to be from BOS-ALS non emergent and emergent. What we did in 2007 was we took all of the allowable charges and tried to get them as close in percentage wise to what the Medicare percentage was. So that significantly helped the BOS rural population as well as the ALS people. I believe working with Maggie's office, that she will allow us to do the same thing.

Chairman Pollert: When we look at the Governor's proposed budget, and I take a look at the increases with hospitals, physicians, etc, the increase in funding is probably 15-20% compared to the last biennium. Then we go to dentists and chiropractors and ambulances, and the increase in funding is probably about a 60-80% increase from the last biennium. I'll say to you as I said to Kimber and everybody else, we are trying to figure out what is a fair balance of what we are going to be doing. When I look at and see that yours was based on Medicare rates, yet the increases were so huge compared to the last biennium percentage wise. I'm just trying to get a correlation but I'm not doing well.

Mark Weber: That is because we have done with so little for so long. When you look at what the charges have been, the actual charges are kind of skewed because a lot of ambulance services are volunteer in ND. About 80% of them are. Only recently over the last few years have they started to increase their billings rates. There is at least one ambulance service in ND that still does not bill. When you look at all the Medicaid patients and you look at what was billed the numbers are skewed because some main bill services aren't billing properly. The other thing that you have to take into consideration is that 80% are volunteer. We are actually mandated to respond. We don't have a choice. Some of the other groups have a choice whether or not they accept the patients. We don't have a choice. We have to go, we have to take them to the hospital. Throughout the country the average cost of an ambulance run is

$450. In North Dakota it is a little more than that. When you look at the most rural areas in ND where I come from it costs over $650 to do a call. We have all the expense and very few runs. When we are looking at this kind of money and looking at all of the problems that EMS has, this money will help. Even if you funded what the Governor recommended, it will help EMS. It's not going to solve our problems but it will help especially the rural areas.

Tim Cox : Testimony handout (Attachment C)

Representative Metcalf: To what degree do you expect to increase the number of people that you care for and expand this out to other communities in the state of ND?

Tim Cox: Enrollment is not a quick process. We don't have extensive numbers. We won't have the thousands of participants that Denver and so have. We anticipate being around 50 at the end of this year. If the program works we would expand out. We are developing a model that is unique. We are in Dickinson to use that model.

Representative Metcalf: If the program works what would make it so it wouldn't work.

Tim Cox: What would not make it work would be the numbers not increasing sufficiently so that we can have a critical mass of funding to carry the program forward. Based on our projections there are numbers that will make it work. We budget at the feasibility analysis which indicates that it would. We don't think that will happen but if people decide not to enroll, that would be the reason we could not carry forward.

Representative Kreidt: In your points you eluded to that Medicare and Medicaid clientele, that you would take private pay?

Tim Cox: Yes we do take private pay. We have just done some analysis across the country to find out how many individuals that have been totally private pay in this program. They were able to come up with two. One in Hawaii and one in San Francisco so it is a rare occurrence that someone can afford to pay the entire amount of a PACE program. The care is intensively

managed and the costs are fairly significant. The savings comes because we are able to keep them out of the long term care facility where the rates would be more per day than what it is costing to have them independent at home.

Representative Kreidt: Do you at some point possibly see a long term care type of insurance coming into play as a continuum care for this entity?

Tim Cox: Yes there is some indication that long term care insurance is looking at this type of service. In some states they have paid for it. It is a new entity but most aren't as familiar with it as they are with other programs. I'm sure as more and more programs develop throughout the country that it will become a funding source.

Representative Kreidt: In regards to Representative Metcalf, the number of clientele that you anticipate at some point, in ND the different levels of cares were all competing for staff. Your entity will be drawing out the staff to go to work with you.

Tim Cox: That is a question that we have looked at and in establishing that we have decided it was expensive and that is one of the major components in cost of the program is your payroll. We have tried to cooperate with the members of our organization so we are sharing positions and staffing with them. Because of the way the PACE side is designed, it allows some flexibility in the way that you utilize people in a part time basis. It's not going to have that significant of an impact because of the flexibility that we have. We aren't needing staff 24 hours a day. We are open 8-5 Monday through Friday. That is the period of time. We have some flexibility with staffing then maybe other groups don't have because they have to staff on a 24 hour basis.

Carole Watrel: Testimony handout (Attachment D)

Barbara Murry: Testimony handout (Attachment E)

Sandy Marshall: Testimony handout (Attachment F)

Jon Larson: Testimony handout (Attachment G)

Cindy Vollmer: Testimony Handout (Attachment H)

Dan Howell: Testimony Handout (Attachment I)

Tom Newberger: Testimony Handout (Attachment J)

Charlie Dunseth: *To paraphrase my testimony I wanted to say that quite simply this is the problem. When I started at the center in 1978 we had about 138 people coming to the center. They were all from Grand Forks. We served those people very well. There was about another 150 people that came from Grafton and San Haven that came from Grand Forks. That put pressure on our ability to provide services and on our budget. What did not happen with the institutionalization was any of that money following down to the center or the activity center, both established programs within the respective cities. There was no help to defray the costs of serving additional influx of people. With the tight state budgets over several years and the Governor's request to continually cut back, I'm sure nobody wanted to add another $1 million into the state budget for DD centers so it might have been out of the question. The problem persisted to the point where you heard Tom say that Lutheran Social Services had to give up the program. They could no longer afford to do it. Red River had some extra money that they would be willing to put towards the program. Even after they picked it up they are still owing about $30,000 a year. The bottom line is this. We work hard providing these programs. They are award winning, quality, community based activity programs integrated and meaningful for the people who come there. I'm also sure that we are going to be seeing a small influx of people from Grafton with the continued pressure to deinstitutionalize. All I'm asking for is a little help. The help we are asking for is pretty minimal. If we were to get $50,000 the first thing we would do is not go out and give raises to people. We would go get people to work with people. That is what it means to us. The numbers you have before you speak to about 800 people with*

disabilities that are served between our two agencies. We aren't affiliated with each other besides the fact that we both provide the same kinds of programs. Our requests for the $200,000 for the biennium. To explain the information that you have in front of you, the sheet that has the agency logos contains current numbers of individuals and attendance figures for both agencies. People who have disabilities. The sheet that has the letter from the Governor the numbers that are on there are the full picture showing how many people are served over all. What we are talking about today is the people of ND that are served by us. The one thing I wanted to say before we close is I would like to add that the cooperative effort of the disability division has been positive and unprecedented in the working relation with the providers. I think they should really be commended with their working relationship. I think it's a breath of fresh air and I think it is a pat on the back for all their efforts.

Danetta Agnes: Northern Lights South Advocacy, Devils Lake: *This is Steven. He is also a member. We are here in support of the budget that was proposed. We are looking for increases for services that receive Developmental Disability services. We have many friends that have been living on their own in their own apartments. Because of budget cuts there hasn't been an increase in the amount of money given to these services. They are no longer able to live on their own. They have to go in with a roommate that they haven't met. They don't really know them well or they have to go in to a group home because there is just no funding to stay living in their own apartments. They very much want to be able to live in their own homes, close to their families, and friends, and with a person that they really want to live with instead of a person that they have to live with. We are also looking for an increase for our direct support staff. These staff are more than just workers to us. They are our friends, they help us learn to live on our own, to take care of ourselves, they help us to maintain their independence so that they can live on their own, and they become more than just staff. They become friends*

and family. When they have to leave because they can't maintain their home budget they go to places that pay more with less responsibility. We lose them. It's very painful to lose them. We just want to support this budget proposal. If you have questions I will be able to answer them.

Representative Wieland: I just wanted to get a repeat of the name and organization again.

Danetta Agnes: I am Danetta Agnes and I am the advisor for the Northern Lights Self Advocacy Group in Devils Lake.

Dianne Sheppard: Testimony handout (Attachment K)

Representative Nelson: You mentioned that you are happy with the executive budget, and the department's budget. At the end of the budget cycle they projected a $62 million surplus. With that having been said, where do we find the kind of money that you are asking for DD services and expansion with some of those programs with that carry over?

Dianne Sheppard: Every state that has gone through this process of closing their state run institutions have needed bridge funding for a period of up to two years. We are fully funding our state institutions while we are downsizing and closing. It is upon closure that our state is going to realize savings. In the report closing the State Developmental Center, you will see a financial outline, a structure, to get that job done. It is painful to get that done for those first initial two years. You do need bridge funding. You are going to still have people living at the center while you are going to have people exiting and setting up a residence in the community. It's long term cost savings and is also a quality of life issue. At closing the Developmental Center report does a nice job of outlining what is going to be needed as far as resources.

Shannon Grave: Testimony handout (Attachment L)

Kris Langlie: Testimony handout (Attachment M)

Betty Heuchert: Testimony Handout (Attachment N)

Kimberly Ternes: Testimony Handout (Attachment O) (Attachment P)

Mike Ahmann: Testimony Handout (Attachment Q)

Amanda Chase: Testimony Handout (Attachment R)

Chairman Pollert: What does your husband do if I can ask?

Amanda Chase: He works for the Lennox dealership.

Representative Kreidt: You went back to college, what career did you pursue?

Amanda Chase: Pharmacy Technician

Allan Metzger: Testimony Handout (Attachment S)

Chairman Pollert: Can people from long term care come in starting at 8:00 tomorrow morning? Does anyone else here have to give testimony today? If not, we are going to come in at 8:00 tomorrow morning. With that, we are adjourned until tomorrow morning at 8:00.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/27/09

Recorder Job Number: 7835

Committee Clerk Signature

Minutes:

Chairman Pollert: Called meeting to order and took roll.

Kurt Stoner: Testimony Handout (Attachment A) 3:00-6:30

Representative Kreidt: Do you do any contract nursing at Williston at your facility?

Kurt Stoner: Yes we have had to use agency nursing for CNA's and nursing staff.

Representative Kreidt: Could you enlighten us for what you paid for hour for a CNA and RN when you contract?

Kurt Stoner. It varies by agency but its well into the 20's. We also pay for their travel time. There aren't very many agency nurses or CNA's close to Williston. We are paying for travel time. We are blessed in Williston to have a nursing program so that helps our community.

Chairman Pollert: We as a section have to decide what we are going to do and where we are going to go. We have to decide if we do the 7&7 and the $2 increase. Then we might have to make a decision. If we have to look at something else are we better with the 7&7 or the $2, or is there a combination. What are your thoughts? Are the wages and salaries more important than the inflator?

Kurt Stoner: Saying one size shoe fits all providers would be inaccurate. We did adjust salaries but I don't think a lot of facilities have that option. We did a very large renovation

project about six years ago. We do have depreciation money. Many facilities haven't been able to even do that. They don't have the depreciation money. Long term care is much more than brick and mortar. Right now I am kind of living off of my brick and mortar through funded depreciation. It's our caregivers. If we don't have quality caregivers we don't provide care. I think the salary pass through is a very important part of this. We all have expenses that we incur with this oil spike. It affected a lot of our expenses from transportation costs to paper products to everything. Those are things we have to pay for. Sometimes you pay for those and the salary adjustments you give yourself come after that. We have a membership meeting at long term care. I'm sure those topics are going to come up and we are going to discuss those. It's something we are going to try to keep in contact with all of you.

Chairman Pollert: When we call for amendments if that happens, there will be a debate in our section.

Representative Nelson: As I understand, the fiscal note has been worked on for the wage pass through. Is there an alternative like a targeted group that you would look at? We have heard through the overviews about turnover in staff. I remember that the turnover is 10-15%. That is nothing compared to what you are going through. You are in that 50% range. Is there an alternative of targeted staff that you would look at as a wage pass through?

Kurt Stoner: Although I'm the chairman of the board of directors I don't' know if I can speak for all facilities. That is probably something that we today need to talk about. When we voted on this we unanimously voted for a pass through for all staff. There are certainly staff that are paid more. RN's nurses are paid more than the front line care givers. In different communities are too. You don't have that problem in a lot of communities. I'm sure that is something we will talk about. Overall, the average they have we are right at the bottom. That is our average.

Representative Kreidt: Stating you have done contracting nurses and CNA's, do you feel that with a pass for salaries that you would become competitive enough to attract staff?

Kurt Stoner: I think in Williston you have more people going into nursing if they knew salaries were so much better.

Shelly Peterson: Testimony handout (Attachment B)

Representative Bellew: You have the 3 additional items that we are asked to look at. I'm looking at the list and I don't see any of those three under the OAR's.

Shelly Peterson: The wage and benefit pass through we have been debating this past year, and it was only in December after meeting with the Governor that we decided based on all the data we were looking at that we needed a wage pass through. The department's acceptance of OAR's and items for their budget is during the summer time. We were not in a position nor did we have sufficient data to request it at that time so it did not come in as an OAR simply because they began budgeting very early. We were looking at these issues and only took positions in September which missed the deadline for an OAR in June. Continued testimony.

Representative Nelson: Have you run the numbers on the turnover of LPN's and RN's in the entire industry?

Shelly Peterson: Yes we have but I can get you that information I don't have it in a chart. Continued testimony.

Chairman Pollert: Now those have fallen. Will we see costs drop?

Shelly Peterson: In your cost report it is based on your actually cost. If we don't spend the money it doesn't go in there. That's why some of the rollup you see in DHS you see the utilization is down. The last reporting period I don't believe came in as higher as they were projected to be. People are trying to conserve and operate as efficiently as possible. If that bill isn't as high then you don't get the money in that cost category. It drops the following year.

Cathy Schmidt: Testimony Handout (Attachment C)

Representative Kerzman: You say that 90% are self paid. Are there any long term care insurance providers that pick up assisted living now? Has that changed?

Cathy Schmidt: There are more and more people who are picking up long term care insurance and that is one of the reasons we support tax credit for insurance. I would say in our facility, out of 64 units, 10 of them are being paid with insurance.

Representative Nelson: There is a situation in my local community. We opened an assisted living component in our town. Prior to that, our long term care facility was nearly at 100%. When assisted living opened up, the population decreased in long term and there has been openings ever since. It appears to me that people are using assisted living as a stop gap to the nursing homes much like you testified to. Is there any comparison data to look at to see if that trend is true in other parts of the state? If it is, that is definitely a cost savings.

Cathy Schmidt: The national centers for assisted living is currently doing a survey on that. We do see that. People are choosing assisted living because they are remaining independent in their own home. These are their own apartments. They can have overnight guests and be just like you and I. This is keeping people out of the nursing home. They are getting the care they needed. I don't know if we asked the questions of where the people are going to. More and more people are staying in assisted living.

Representative Kerzman: With some of the services you say are provided, inaudible.

Cathy Schmidt: The assisted living facilities in ND are a little bit different than basic care. They have full apartments and get no funding. There are no asset limits or anything. It's basically an apartment setting with services that are there. We have basic care in ND which other states call assisted living. We have a little different terminology in the state. Our basic

care in a lot of other states is ND. The main difference is we have no funding from outside sources and we do have more of an apartment like setting in basic care.

James Moench: Testimony handout (Attachment D)

David Zentner: Testimony handout (Attachment E) 00:54-4:00

Chairman Pollert: We are debating about the one stop center. I struggle with where people go for information. The only trouble is if we set another phone call to go find out about something. If we fund the one center, than should we not take away that reference from someone else so they aren't calling 4 or 5 different telephone numbers or are we setting another phone call to call to be in another layer to get a hold of somebody?

David Zentner: If it is used properly and there is enough information out there that this is the place you go, I could see that you would be able to diminish the other areas related to this process. If the center is the center for getting the information, you would think that once that knowledge is out there for getting the information that people would go there to get the most comprehensive information. The other aspect of that which many states use is the assessment process whereas you go in and have an assessment made to determine what your needs are. If those needs can be met in the community and that is hopefully where they can be provided. Information and assessment are important. That is what I would see the resource center doing that combination. Testimony continued.

Representative Kerzman: I see where you are going with this but how does it address the struggle that goes along with it for clients and employees. There are different programs that are all addressing the same personalities. It's like a balloon when you squeeze one part it has to be a deflation or inflation for another part.

David Zetner: You are right in the sense that all of these areas are under pressure. If you take the private QSP's they are their own employee. They don't get any benefits. They are paying

their own social security and paying that 15%. I think you have to look at it as a whole. You have this continuum of services out there that are needed and they need to be funded. I don't know how else you get around that aspect of it.

Representative Kerzman: Inaudible question.

David Zetner: You are certainly right. We need cooperation. The balance is important too. If we have beds that are open, naturally you are going to want to fill those beds and do it aggressively. I have experienced that in my own situation. I don't know what the final answer is. Some states have gone to the point of requiring assessment and requiring people to look at what's available before they make that final decision. ND has never decided to go that route. That forces the issue that at least people are looking at the final decision.

Amy Armstrong: Testimony Handout (Attachment F)

Sandy Zaleski: Testimony Handout (Attachment G)

Representative Nelson: On the back page of your testimony you talk about the fiscal impact. The OAR was submitted for $2.4 million and rejected. Can you explain the breakdown between general and federal funding? Than it looks like in the total cost in the following chart that it is $1.9 million.

Sandy Zaleski: We went back and revised the budget to include a reduction to $1.9. The breakdown from general funds to federal funds we got off the OAR from the original one.

Representative Nelson: Have you seen that much general fund and little federal fund split before?

Chairman Pollert: You see it sporadically but I can't really explain it. Basically the OAR is what Representative Nelson is asking. You have done research on this and it is basically a 90% appropriated.

Representative Metcalf: I noticed here that you said the DHS submitted the OAR which was rejected as part of the Governor's budget. Was there any reason given to why this particular activity was rejected?

Sandy Zaleski: I don't know. I wasn't given that information.

Nels Nelson: *Welcome Gentleman and Ladies. My granddaughter was supposed to come live with me at my house but we have nine kids so my wife said no. We started talking to different people and talked to the facilitator for the Village. She said there as a new program and we went through that. I had my daughter and the grandchild live with me at my house. She was registered as a 12 year old. What the Village did was open up the doors and helped with the HIPA laws so we could get all the information together. They opened up the doors for all the family members to come to her side. They arranged for the two sides to get together and facilitate a plan to make this child's life better. It worked marvelously. It fell into place. We learned all this information and got counseling. There was sponsorship, mentorship, working with Social Services, working with all the other agencies was simple. The power we had to get through this as a family was unbelievable. I just see that it saved a lot of time and money. How it ended up today was that my daughter is living in Jamestown with her granddaughter. She has full custody. She was registered as a 12 year old so they couldn't let her keep her child. One of the things that came up in family group was why we didn't treat her like an adult. That hadn't been an option because once you are registered you stay in the system that way. She is probably more adult than most people I know today. That is because of what family group did. They saw the issues. They talk about strengths, concerns, and issues. They write lists of how to deal with all this stuff. It worked marvelously. I read a lot about business and listen to tapes. That is how big business and good church foundations are run. This program to me just came*

across my heart. I will do whatever I can to help. I work with a lot of people and I've never seen anything that works so smooth and helps families.

Sarah Highum : Testimony handout (Attachment H)

Linda Johnson: *I am a peer support worker for Western Sunrise in Williston, ND. I believe in peer support program because it is a program that encourages recovery for people with mental illness. I have a match that has gone from sitting in his apartment day and night to playing piano for the church a couple times a week. I have another match that has gone from just existing to putting on her snow boots and jacket by herself. These two matches have stayed out of the hospital for a very long time due in part to the peer support services they receive. My newest match has stayed out of the crisis bed for one weekend out of three. I believe this is also due to the peer support program. I am always there for my matches when they need me and they are always there for me too. That is what this program is all about. Friends helping friends recover. Thank you.*

Representative Kerzman: How many matches do you have and how often do you meet with them?

Linda Johnson: Three, I meet with one of them every other week. The other I meet with once a week for approximately two hours. The first one for approximately two hours and then the newest one I meet with for about 1.5 hours one day and she is kind of needy so I meet another 1.5 hours another day during the week. That is the one that has stayed out of the crisis bed.

Steve McWilliams: Testimony Handout (Attachment I)

Amber Hammer: Testimony Handout (Attachment J)

Todd Christlieb: testimony Handout (Attachment K)

Susan Rae Helgeland: Testimony Handout (Attachment L, L1)

Representative Kerzman: Are the individuals that are involved in this compensated for the work they do with their peers?

Susan Helgeland: I can't speak to the issue of people that are involved. I don't know the salary levels and where the funding is coming from. I know it started with Olmstead commission funding several years ago. The plan for the initiative is that Medicaid will eventually fund from across the state, peer support services. We have existing programs now that funding may or may not be sustainable. Their outcomes are so good like 50% hospitalization . We would like it to go to the entire state from every region to benefit. We also feel that the Medicaid reimbursement plan, which other states have done, but I believe it is going to require a waiver from the DHS. Once we get that in place we would be able to split the federal and general fund costs. We would have consumer services that would be offered, employment opportunities that they have never had before. They would be able to enhance existing case management services and other services that are already in place.

Representative Kerzman: It looks like your outcomes are really good. I'm not disputing that point but just trying to understand what it involves.

Susan Helgeland: I suppose you could say that. I don't know how our consumers would do that. It's a little different but I understand where you are coming from in terms of someone who has experience of that. The point is that our consumers at mental health services who are in recovery already have been there and done that and they can talk to people who are perhaps more fragile and having a more difficult time in transition. I'm thinking particularly in Fargo about the new shelter we have there. We are looking to transition people into apartment living for the first time. With a peer support specialist someone could go visit them and take them. These folks are not used to living independently. We don't have existing human service center staff that are already stretched to the max with their case management services. They don't

have time to do as much as the peer support specialists could do. They could visit and see if they need groceries, see if they want to go get a cup of coffee. I think in the testimony that was given, it illustrated how these kinds of things can get people over the really tough spot of that first coming out of the state hospital or first coming out of being homeless for many years. I think you have heard personal testimony to that. The folks that spoke before me can much better speak to that than I can. I have seen it work. I know peer to peer is a very good program.

Carlotta McClearly: Testimony handout (Attachment M)

Andi Johnson: Testimony handout (Attachment N)

Chairman Pollert: Are they voluntary admissions?

Andi Johnson: A large part of them are voluntary but we are seeing an increase of legal admissions as well, where probation is contacting us and saying that they have the ability to enter that person into treatment to defer incarceration and ask if we are interested in receiving this person. You are receiving voluntaries but you are receiving people that are involved in the legal system but because they do not have minimum mandatory's connected with their sentence we are able to provide treatment.

Chairman Pollert: I am trying to get an apples to apples contrast. Robinson Recovery Center, you don't' deny anybody unless they have a legal problem?

Andi Johnson: The reason for the denial on page 3, denied admissions, these are the reasons. We offer treatment but they refuse to take it. Keep in mind that the Robinson Recovery Center is the highest level of care for addiction treatments that is known. There are other levels of care but if they do not meet the criteria for the highest level of care they cannot come through the doors of Robinson recovery.

Representative Nelson: Can you give me an example of unresolved legal matters.

Andi Johnson: They might include a class A felony in addition to a class C felony, where you have the combination where the person can either service concurrently or consecutively. If a person is scheduled to go before a court and to be sentenced, it is very difficult to involve them in treatment if they will be sentenced on a minimum mandatory which means we could start them in treatment but one month later they will get moved to a penal system. There is no such thing as in lewd of incarceration. Continued testimony

Representative Metcalf: You inferred that people who entered Sisters Path came from the Robinson Recovery Center, is that the way they have to go?

Andi Johnson: They can go many different ways. One of the things is when we see a CPS involvement with a woman we automatically refer to Sisters Path. They may or may not meet their criteria for homelessness. If they do not meet their criteria for homelessness, our tendency is to keep them a little longer so we can enable an intervention and help them get their children. Many times these women will stay longer in the residential program for Meth and then we will try to get housing secured for them.

Representative Metcalf: How many of them go directly from the Robinson Recovery Center to Sister Path?

Andi Johnson: Sisters Path is predominately a female program. We are eliminating half of the gender. If you were to just look at women I would have to say as a guess, roughly 30-40% of the women. Continued testimony.

Chairman Pollert: So you can't give me a success ratio a year or two after graduation?

Andi Johnson: For those people who have not only successfully completed but not successfully completed we have close to a 65% success rate.

Chairman Pollert: How long has Robinson's been in place?

Andi Johnson: January of 1906.

Chairman Pollert : So what was that percentage again?

Andi Johnson: Close to 65%.

Chairman Pollert: After how long?

Andi Johnson: This is a comprehensive overview from the day that we opened so three years. Thank you for allowing me to testify.

Tom Alexander: Testimony Handout (Attachment O)

Representative Nelson: Tell me where North Central got the funding to institute their $65,000 program.

Tom Alexander: They received their funding through the Human Service centers budget. The first project that was established was in 2003. Some seed money from the Governor's Olmstead group put some money in the human service center developed a peer support project that had extreme success. The center director has established some funds allocated to peer support specialist services.

Representative Nelson: That having been said, is it possibly that the other regions could find that same amount within their budgets?

Tom Alexander: I can't speak for what the human service centers directors would say. In my opinion the grant that was funded is a well written plan that has been approved which can be implemented. It just needs the funding in order to do that.

Bruce Murry: Testimony handout (Attachment P) 33:30-39:46

Susanne Hanson: Testimony Handout (Attachment Q) (packet) 40:00-42:44

Crystal Farmer: Testimony Handout (Attachment Q1)

James Baumgarter: Testimony Handout (Attachment Q2)

Valerie Koivunen : Testimony Handout (Attachment Q3)

Taylor Petermann: Testimony Handout (Attachment Q4)

Katie Storm: Testimony Handout (Attachment Q5)

Paula Storm: Testimony Handout (Attachment Q6)

Gail Eckstead: Testimony Handout (Attachment Q7)

Lynn Fundingsland: Testimony handout (Attachment R) 8:00-14:30

Chairman Pollert: If we decide to fund the staffing, I would just want to make sure that everything is good and the money is in place. The only reason I'm asking the question is we acted way to quickly on the Veteran's home and now we have a mess. I would like to avoid that as much as possible. That is what I'm trying to do is make sure all the funding for the Cooperhouse is all in place and is in writing and not a verbal agreement.

Lynn Fundingsland: All the funds are committed. A lot of them are already spent to require the land and demo the project. Frankly, we had intended to put this project in the ground last fall. As I stated a big piece of our financing is private dollars that are coming through the low income housing tax credit program. Late in the fall, due to the economy collapsing around our ears, our prior investor was a bank. In the fall they retracted from the project. We postponed it until May. If you are familiar with the low income tax credit program, the dollars for that program are syndicated by a syndicator and they will collect money for insurance companies and banks and whoever might want to invest. We have a written commitment from a syndicator. Our syndicator tells us he has a first tier investor that needs to have ND investment which tells us it's a bank that meets credits in ND. I can't tell you that this is 100% because there is always a chance in our current economic environment that the particular bank that has committed to invest at the last minute could find themselves in the position where they can't use tax credits. Last year ½ of the low income tax credits awarded nationally didn't get funded. That is the first year for that program ever. It's a tense time we are in. We have been assured repeatedly by our investor that they are in. They have spent a lot of money underwriting on

their side. It's an issue that is out of our control. Everything that we know at this time is we have a firm project. The public dollars are firm and the private dollars are committed. It's not an irrevocable commitment.

Michael Carbone: Testimony Handout (Attachment S)

Janell Regimbal: Testimony Handout (Attachment T)

Representative Wieland: Did you receive funding from the state in the last biennium?

Janell Regimbal: Yes in the last biennium we received $300,000 for our Grand Forks and Nelson County Projects which have been included in the department's budget for this upcoming biennium.

Representative Wieland: I noticed that there was an OAR for an expanded Healthy Families which was $385,000. Is your request a part of that?

Janell Regimbal: Explain the discrepancy between that request. We had been on the OAR list for our Burleigh Morton country project. Also, we had a federal grant which is a competitive grant process that we had written to expand this project into Ward and Mountrail counties. We were not successful in receiving that federal grant therefore we revised our request down to the $200,000. Unfortunately, on the OAR list we did not make it through the Governor's office so we aren't currently in the budget. That is why we are here today.

Representative Wieland: To use these services, there are no means or requirement on the part of the recipient.

Janell Regimbal: Correct it is all voluntary and at no fee to the families.

Representative Wieland: To any family?

Janell Regimbal: Correct.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012 –Public Testimony

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/27/09

Recorder Job Number: 7941

Committee Clerk Signature

Minutes:

Chairman Pollert: Called meeting back to order.

Jonathan Holth: Testimony handout (Attachment A)

Lisa Vig: Testimony Handout (Attachment B)

Representative Kerzman: Are you able to use the same counselors to say as they do at the alcohol place?

Lisa Vig: My initial training as an addiction counselor provided a marvelous foundation for my work with compulsive gamblers. I didn't learn anything about gambling addiction in college nor in my training/internship practicum. There are some very unique differences and some specialties about working with gamblers that make it different from working with alcoholism. The state has made a recommendation in following with national standards that people who want to work with gamblers have 60 hours of gambling specific training.

Representative Kerzman: I've been reading where a number of states facing financial difficulty have been talking about expanding their state programs. How do you address taking care of people who are addicted?

Lisa Vig: Jonathan experienced two opportunities for treatment. He had inpatient treatment program for his alcohol and an outpatient program for his gambling. Initially he came to us for

gambling help because of some legal difficulties and because his gambling was the thing that was getting the attention. He was brought into our program but he made very little progress until we told him to go get help for his drinking. Once the drinking was addressed he came back and was able to complete his gambling addiction treatment and has been a marvelous role model and mentor and peer supporter for people in the group.

Representative Kerzman: Inaudible Question.

Lisa Vig: There is a variety of ways and means that other states are using to fund treatment. Many of them do just like we are doing. They go and lobby the state and say that the state is benefitting to such a degree from the profits of gambling that a certain dollar amount or percentage needs to be set aside to deal with treatment. There are some states that are beginning to see insurance companies provide some coverage for gambling addiction treatment. Those are efforts that are being put forth. Most of the states have a state funded treatment program for gambling and awareness. I think if we, in comparison, look at what we as a state spend on advertising for the lottery and what is spent on providing help for people, there is a great difference. If we are in the business of promoting and encouraging gambling for the benefit of the state and for recreation and entertainment we certainly need to be having the forefront of our mind as a concern for people who are damaged from gambling. Not everybody gambles in a reckless, pathological destructive way. Those who do should be a priority for us. Our state is benefitting greatly from their destructive behavior.

Chairman Pollert: Is the $300,000 that is being proposed in the Governor's budget, is that going to be spent similar to how the $400,000 is now or do you have any idea?

Lisa Vig: The problem gambling advisory group that I am a part of have been brought together to make some initial discussions or bring forth some initial recommendations about how we would spend some of that money. Initially we would put a lot more into public awareness and

advertising and awareness building so that people are getting involved in treatment and prevention programming. I think the total now would be $700,000 for the biennium and we would look at a much heavier load of the first year of the biennium being placed on awareness and educational opportunities statewide.

Frank Redeye: *I'm from Fargo and I am a compulsive gambler. I want to use myself as an example of treatment that works. I just completed my 19th year of not gambling on November 12th of 2008. I can tell you for a factual part of this thing that it works. It will work and continues to work because the challenge never stops. When a person is consumed with gambling in their background it stays with them on a lifelong basis. I made my mind up along with my family to give myself enough time to be with their program to represent a part of my life. It is just like going to the grocery store. If we have 4-5 meetings a week in Fargo, I try to be at least 2 meetings a week. They do an inspiring thing for me. To listen to peoples success stories and unfortunately their failures. A normal success story would be someone who has come into the program completely down and out. Their financial status is completely in ruins. Their family is about ready to leave them. Their work is up in the air. To see that person have the ability, with listening and working, to turn their life around to the point where they become citizens that care about themselves first. In this program that we have, if you don't have a love for yourself it can never happen. There can be no success. You have to care about yourself. Then you have a pecking order of the people that care about you including your state. What I mean by that is most of the people that I work with over the years; I work because I've been there 19 years. My job is being an example of what can happen if you work hard enough and listen to enough people to be free of gambling. This person that comes in stays their long enough and watch them. You see a personality change. You are so personally excited about the way that person looks at themselves. There is a whole change of who is doing the gambling and where they*

are doing it. To be able to see these people that have a caring effect, they bring their wives and family to a Thursday night meeting which has become like a community meeting of family and learn everything about the whole picture. The requirement is that you have to come to meetings. The other thing for me is that gambling is all over, including our fine state. The state of ND chose to be in the charitable gambling business. The gambler didn't choose it. Consequently these dangers that are out there from all the gambling sites that we have like horse racing, we have to do everything we can to make them understand that each and every one of those things are not the way they are going to recover long term. There is no two way streak. You can't have it both ways. You either have to believe in yourself or you have a situation that is talked about. The other part that I wanted to visit with you about is self destruction. I have seen everything in my time in Fargo from suicide all the way though the worst financial things that have ever happened to anybody. I have tried to be as big a part of that as I possibly can because I listen to what they had to say. Those things do in fact go on. When a compulsive gambler doesn't realize that he can find help and he starts re-gambling again, we have a task on our hands. They call it how do you hurt your wife either verbally or physically, how do you steal. I'm convinced that if we charted embezzlements in the state of ND, we would have more of those to do with gambling than they would with anything else. We don't chart it that way but I do know several instances myself where that has been going on. All the things you have on the one side of this problem and the other; at least we are able to still come back to their program. This is a welcome hand. If someone relapses we welcome them back. If somebody is having trouble we try to do anything we possibly can to have an opportunity. I will be willing to answer any questions.

Representative Kerzman: I know some alcoholics that won't even take a taste of wine. Do you ever buy a church raffle ticket or anything?

Frank Redeye: Never.

Chairman Pollert: Do you currently have a waiting list for people with addiction gambling?

Lisa Vig: We don't have a waiting list. We do whatever we can to get a person involved as quickly as possible because we know when we establish a waiting list for services, they usually find a bailout and they don't have a problem anymore and we lose them. It is very imperative that when an individual calls for help that we make an appointment with them that day or the following day. If we don't have room in the group we work with them individually. We don't want anyone to have to wait.

Chairman Pollert: Are you talking outreach on the $300,000? I'm trying to figure out if the need is out there. I understand that Alan was in here two years ago asking for the $300,000. I'm asking a similar question. I know the services are out there but is there a demand for these services?

Lisa Vig: That is why we want to front end the advertising like the public awareness and marketing opportunities. We want to teach the general public that help is available. We have a manageable demand right now for services. However, with the instances and prevalence study that shows 12,000 compulsive gamblers living here, we aren't accessing this to the level that we believe they need to be. We'd like the opportunity to try to educate them about the addiction and that there is help.

Jon Mielke: Handout Testimony (Attachment C)

Carrol Burchinal: *I apologize for not having written testimony. I was driving by the capitol and had miscommunications about the hearing. I stopped in to see when it was going to be conducted and found out it was now. I will send you a written testimony. My wife Arlene and I*

have been foster parents 35 years. During that time we have cared for about 260 children and youth. It has been a great experience for us and we have enjoyed it. We are still doing it and it is making a difference in our lives. We have been in Burleigh/Morton County for most of those placements as well as Standing Rock. Most of our placements have been preschool although we have had elementary and a few adolescents. Jon mentioned some that are medical fragile. One that came to my mind who had a broken arm and severe head injuries the first time we received him. Then he went back to his parents and a few months later. Six months after that we saw him back with a broken arm and two broken legs. We had him quite some time. He was eventually adopted. The other night I had a chance to visit with him when he called me from Minnesota. He said he is doing very, very well. He still is handicapped of course. He is living with his adoptive parents. We do have calls from them. We seem to have more calls from the earlier ones we had. They want to know about their early life. Those are the things that foster parents work with. Not only the caring we give them, but the emotional part of it all that keeps coming back to you. It is a reward when they do come back and say thanks for what we did for them. I might say that I am pleased to see this increase. There was a national report a few years ago that was related to the maintenance payments that we receive. It showed that we were at the bottom of the region and the lower part nationally. We started working on that and talking about that. We are pleased to see that the report and the recommendation that we receive some kind of an increase in the payment has been recognized and is included in HB 1012. For many reasons we have received no increase. What we received was 6 cents an hour. When I started doing the study I realized that there was more to this than the daily, monthly support. You must remember that 56 cents an hour is with two people. It is something to keep in mind. I would be able to answer any questions you have.

Leanne Johnson: Handout Testimony (Attachment D) 36:45- 45:10

Representative Nelson: The additional $200,000 you are asking for is for a coordinator position? That would be a program position that wouldn't go to the parents and foster parents?

Leanne Johnson: That is the basis for the request. Right now we do not have a post adoption coordinator for ND. The pilot project that we have offered is that the adoption worker would follow a family for three years. What is happening is the case load is just getting to high to manage. Meeting the needs of the front and back ends have gotten too great. What we are exploring is that a post adoption coordinator could then be a contact for families as well as providing the flexible funding and support for RESPIT care and other supports. At this point we are looking at a post adoption coordinator and the supports for that.

Representative Nelson: That $200,000 completes that and the entire amount would be used for that person and the position?

Leanne Johnson: That is my understanding yes. To be clear that the department on the pay point with the upcoming RFT that is issued, they would be asking that anybody's responding to it, to address how they would provide post adoption services.

Nathan Aalgaard: Testimony Handout (Attachment E)

Representative Ekstrom: You and I have had multiple conversations over the years. I think one of the things that would be good for the committee to know is that for the folks that are not accessing your services, are they going to more restrictive environments. Are they winding up so to speak institutionalized because they are not getting the kinds of services they need in the community?

Nathan Aalgaard: I think it happens. One thing I'll talk about is ramps. Sometimes having a ramp on your home when you are in the hospital will make a difference between going back to that home or to a nursing facility. It is a pretty simple deal but a major thing when you can't walk or are in a wheelchair. What we have done is got some funding that we have used to buy

some portable, temporary ramps. We can bring them over to the house and have them for a month or two. While we help that person work on funding for a permanent ramp. Something like that can make a big difference. That is just one example.

John Johnson: Testimony Handout (Attachment F)

Tonia Johnson: Testimony Handout (Attachment G)

David Shove: Testimony Handout (Attachment H)

Ron Sandness: *I just recently retired 8 months ago as a state employee. I worked for the rehabilitation consulting services in Fargo at Southeast Community Services. I am retired. My wife wanted me to go do something. I chose very carefully and became a board member of freedom result center which is a natural to my former employment because freedom result center and now independent living centers have a realistic view of human beings who are disabled. I can further my expertise in this area through freedom and other independent living services. As I have had cerebral palsy all of my life. I am thankful for the opportunity of being able to continue the activities I learned as a rehab consulting services staff person. Thank you and are there any questions?*

Charmaine Yvette Boehler: Testimony Handout (Attachment I)

Michelle Barth: Testimony Handout (Attachment J)

Tammy Theurer: Testimony Handout (Attachment K)

Jo Burdick: Testimony Handout (Attachment L)

Representative Ekstrom: We have been hearing a lot of testimony about radio towers and obviously telephone towers. Are there simply areas in the state that we cannot use telemonitor?

Jo Burdick: No. As of now the technology that we are currently utilizing, there is a number of them out there. I could talk for a long time about the technology. The service that we utilize is

through the telephone line. It is also now expanding because so many people are dropping their land lines. We are going to admit 3 patients last week. Because we haven't updated our technology we haven't updated to the new web based technology. We were not able to put that monitoring on those patients. It will go both ways. We will be able to use different types of technology that way. This is basically through a land line phone.

Representative Kerzman: Inaudible question.

Jo Burdick: We actually don't. Through the state we currently are asking for by the visit. That is on the skilled side. These patients are on our skilled program. It would be by the visit. As Tami was explaining our skilled program has registered nurses, therapists, and more professional care. Our personal side care of the business we do bill by the 15 minute increments for state services.

Representative Nelson: Tell me exactly what telemontoring is. Do you monitor vital signs or how detailed can you get with diagnosis?

Jo Burdick: I'm very excited about the program. I absolutely love this program. What it allows us to do is on a daily basis. On a daily basis we can get blood pressure, pulse, respiration, blood glucose. We can get protein monitoring with INR ratios if we choose to do that, and also weight. The most common diagnosis is congestive heart failure and cardiac problems. We set our parameters on our central station. Each patient's vitals come in. It's not an emergency response system. The vitals come in. They can take them more than once a day. They appear on a screen which is hard to see right now. It tells us who is outside those parameters, who is in the middle, and who is green and doing fine. To give you an example, we just put a patient on last week 39 miles out of Lisbon. If you look at some of the areas that aren't being served, not a problem for us to go out, put that unit on, and not having to go back for a week. Before we would have to go every day. It really is a time and cost saver. Most of the patients when we

discharge them and take the unit out really appreciate it. They get involved in their care and it is a great tool to enhance what we do.

Representative Nelson: I would agree that it is very exciting to see this because there is so many underserved areas in the state which begs the question. Does the monitoring go to Meritcare itself, to a clinic setting? Where are the units placed that you have now?

Jo Burdick: The 30 units that we are using right now go out to the patients homes. What happens is it feeds back to a central station which is a computer in our office. What we do is each day we have a telehealth monitoring team. Each day someone is assigned to monitor those vital signs. They come in, look at them, depending on where that falls they will talk to that patient's case manager or immediately call the patient themselves. It makes you feel like you are there. It is an interesting kind of situation.

Representative Wieland: Can you tell me what a skilled nursing visit, what the rate is? How many visits would you anticipate?

Jo Burdick: What our rate is, is $102. Our actual cost is $126. We continue to bill our $102. We don't get reimbursed at that amount but we continue to do that. One of the things that we would want to work with is many states that provide home telemonitoring have a variety of ways that this might be reimbursed by the department. I'm actually going to be visiting with the executive director of the Minnesota Association this week to discuss their new legislation. They have current legislation and we are going to talk about comparisons. We have looked at other states. It could be that if you were going to monitor that patient every day you would not to bill the patient every day. That is going above and beyond what we would normally do. It might be that write in the legislation that it is so much for this certification period or something of that nature. I think there is a lot of details to be looked at so that it is fair to both the department and us.

Representative Wieland: How many QSP's are there now and what is the average number of hours that a QSP works?

Tami Theurer: I can only speak for the home health agencies that provide QSP services. There are many independent providers as well as proprietary agencies that also provide those services. For example, my agency at St. Alexius, we have certified nursing assistants. We would provide services to those patients who have chosen our agency as our QSP provider. I don't have the number of what the total number of QSP providers is. In our association about 17 of our members are QSP providers.

Representative Kerzman: Inaudible question.

Jo Burdick: I think that most of the time, unless it is a real outlier case our costs are less than institutionalizing or having a patient have to go to long term care. It is a rare circumstance aside from that. We have a lot of special needs kids. Those cases begin to reach that maximum of $10,500. We have over 800 patients on service. We have nobody that would come close to the cost of long term care. This service actually reduces the cost to the department. As I was saying, if we can put somebody on a monitor and keep them on the monitor forever, it will improve their outcomes. It will reduce the cost.

Representative Kerzman: Inaudible question.

Jo Burdick: Yes depending on what the patient has. We don't come anywhere close for any of our patients except our special needs kids to even $5,000 a month.

Representative Metcalf: I believe this question would probably go to Tami. I see that Valley City has two services. City County and Health and Home Care and Mercy Home Care services. It kind of runs a little bit difficult in our area because they give somewhat of the similar services. One may be a bit different as far as extension and full services. There is a

definite difference in the amount of money that they are paid. It's been bothering me for a long time and I'm trying to get a handle on this.

Jo Burdick: I'm not sure which one is getting paid more right now.

Representative Metcalf: Mercy

Jo Burdick: I started that agency. It's a hospital based agency. At that time it was City County Health. They have a certified home care agency. Twenty years ago when I left Valley City I met with the county commissioners. One of the things I think we have to be careful with when spending public dollars is I'm not sure why we should be paying someone to do something that private enterprise is already paying for. The county did not and was not certified to do some of those things but has taken a more active role. In the past they hired a consultant to look at who should be providing that service, should they combine their provider number, could they continue to serve together? The way that I would see that, and this is my personal opinion is that the reason the hospital has more is that they have more of the acute care patients that the physicians refer to them. The county doesn't get as many of the skilled patients because their basic rule is to provide public health services, screenings, immunizations, programs that serve the needs of the public. I think that is why you see more state and federal dollars going to the hospital than you see going to the county.

Representative Metcalf: The only thing I want to say is basically they are very compatible as doing the same services.

Jo Burdick: Yes in a very small community.

Representative Metcalf: Why are we paying one of them more than the other? This is not your decision and you may not even be able to answer that but it is something that I've got to find out.

Jo Burdick: Are you saying that the hospital is receiving more state funds than the county? Probably because they have more Medicaid patients that are skilled.

AJ Klein: *My name is AJ Klein. I'm here to speak in favor of the Aging and Disability Resource Center. My family has just experienced one of many examples why there is a great need for the type of services that this bill would provide. Our father recently suffered a stroke at his home here in Bismarck and was hospitalized. He is now a resident of a nursing home here in Bismarck and receiving excellent care. While he was hospitalized, we believed dad would be coming home again, we started doing extensive research into what his options were regarding home health care, the agencies involved, assisted living, and their qualification requirements. We were also trying to coordinate the three types of therapies he needed, medications, nutrition, and personal hygiene needs. We contacted the veteran's administration, county services, and anyone we could think of or who we were told that knew something of the information that we needed. It's a good thing we have a large family. We split up the list and did a lot of calling. We held meetings to coordinate our efforts. Many of us took leave from work to do this. Our mother has her own medical needs and physical limits so we had to be concerned with what was best for both mom and dad. Once it was determined that dad needed to be admitted to a nursing home the process started all over again. Social services as the hospital was very helpful with the information but we needed more answers. There are 11 nursing home facilities within a 60 mile radius and we did research into many of them. At one point it looked like dad would be placed out of town and that meant inquiries of a different kind. We also had concerns of dad being away from mom and his family and home and what impact that this would have on dad impacts and health. This process was overwhelming and stressful for the entire family. If there had been one source of information to go to , one contact person to speak with and build a trust with, it would have enabled us to make the best decision*

possible minus all the anguish. That is what this bill would provide. Myself and many others ask you to give this bill a favorable consideration that it deserves.

Chairman Pollert: We have had a lot of discussion so far and we aren't done yet either.

Representative Nelson: We have sat through a lot of discussion today. The same issue comes up not only in aging services but the center of independent living people. Because there is no grant money now for the ADRC, we would have some flexibility in this program. Could you envision incorporating more than just aging services to include some of the disability situations that we have talked about today. I that worth exploring and bringing into this whole one stop shop concept?

AJ Klein: I thank you for your consideration of my opinion on this. Speaking for the public and the many experiences I have heard of from my family and friends since this has happened, I would say yes it could be incorporated. There are many agencies involved in this. I don't know if I'm the best person to answer this. I think I should defer to someone who is.

Representative Nelson: I'm just curious. There is always turf. If we are going to go down this route it would seem to me that there is room. It covers more than just one event.

AJ Klein: This would take care of those questions and concerns. If there was one person to go to and hear it from and have the information, it would greatly enhance the decision making process.

Chairman Pollert: There was a comment made that the one stop centers should be in every community or maybe every county. I struggle with that. Why wouldn't we just invest $200,000 and have a media blitz and an 800 number to call aging services. They will be this one stop center for the whole state .

AJ Klein: I don't know that it would reach all of the people who would need this information. I think this would be best served if you are going to have the money dispersed that it is done through the services that were touched on earlier.

Chairman Pollert: At the same time it shows us the struggle between calling a one stop center or calling social services in the same county.

AJ Klein: I don't think social services could answer all those questions. They couldn't for us. They were helpful but they weren't able to give us all of the information they needed. It has to go beyond just social services or assisted living. It required a lot more. The therapies, who are the organizations, all of that. The assistance my father would need. That fell on us to find out. We couldn't go to one place. Social services couldn't tell us everything. Veteran's administration was helpful.

Representative Kerzman: Inaudible question.

AJ Klein: Speaking from our experience we had a large extended family with many members involved in various employment that could help us disseminate that as well. I can't speak for everyone else but our mother was still capable of making a determination of what was best for her father and for herself. It wasn't like we were making these decisions for them. Then it goes beyond are you capable, it goes to hopefully you have a living trust or attorney who can make that determination for that person if they aren't able to. Most families are able to make the determination once they have all of the information. Then they can make the best decision. If you have to scramble everywhere to get that information, it really sets everything back.

Representative Kerzman: Inaudible question

AJ Klein: I'm sorry I misunderstood. Now that I know it's the individual that you are concerned about having assessed, I think once the policy is drawn up by the agencies or the agency that is involved in this, that determination would be determined. I don't feel that as a public person I

have the qualifications to settle that up here. I'm coming to you with my experience but I would think that there would be some type of something in play that would determine that.

Brian Arett: Testimony Handout (Attachment M)

Representative Nelson: Just so I understand this, the request that you are making is in addition to the federal money that we are receiving in a block grant. If we would match more state dollars there wouldn't be any additional federal money that would come along with that.

Brian Arett: That is correct. The federal dollars are capped so the amount received from the federal government will not go up if the state share goes up.

Pat Hansen: Testimony Handout (Attachment N)

Edith Armey: Testimony Handout (Attachment O)

Chairman Pollert: Recessed for the day.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/29/09

Recorder Job Number: 8143

Committee Clerk Signature Morgan Pollert

Minutes:

Chairman Pollert: Opened meeting and took roll call which every member was present.

Representative Bellew: How many policy bills are we going to get?

Chairman Pollert: I'm not sure how many we are going to get. I don't know exactly what we will have to deal with. The only thing I know for sure is we have HB 1267. As far as the other bills that are re-referred we don't have to have them on a schedule. They already had the public testimony. We are here this morning because we still have detail to do on long term care. After long term care we are going to go to VR. If we don't get this done this morning we will have our hearing on HB 1267 and then we will go back and finish DHS. I also understand that there are numerous reports that we have asked for that Brenda and Maggie are going to handout.

Clerk Handed out Attachments A and B

Maggie Anderson: I will start by handing out a few things then going to explain each of those items. You should now have three handouts. The first item which is the BARS report (Attachment C) is just a summary of the prior biennium expenditures from 05-07. Our current budget for 07-09, what we have expended in year 1 of the biennium, the total changes , and then the amount to the House .This of course will include both the long term care continuum

which includes the DD grants which are within this number. This is not going to tie out to this page. It will tie out to the other pages that we have provided to you including the one that shows all of the changes by the different funding that the governor placed in the budget.

Chairman Pollert: When we get to that point I want to make sure we spend a little time on it. I don't remember the exact dollar amount but there has been a pretty sizeable increase in the dollar amount for home and community based services.

Representative Kreidt: Under the IGT funds, the $3 million, can you tell me why that was taken out of the fund and where it has been used in the department's budget or has it just been spread out in there?

Maggie Anderson: That funding is all in the nursing home area to fund the increases in that area.

Chairman Pollert: Did we ask for a draft where that is going and all that kind of good information? Are you requesting that information?

Representative Kreidt: I am.

Maggie Anderson: The next two items that you have we will actually use together. (Handouts D,E). I can walk you through the services in the long term care excluding DD. The grant summary sheet you will want to have available because that is how we will be tying the numbers out. We will walk you through how we got to the case load and the average cost that is on your grant summary sheet. With nursing homes, you will see on your grant summary sheet that they incorporate all of the items that are listed on the bottom of your page so you're in state nursing homes, etc. You can see what the monthly averages are running. This is a service that we don't use monthly averages. We don't use that when you budget because nursing home rate setting is its own rate setting mechanism. We establish rates annually from cost reports. With swing bed rates, those are always based on the previous year's average.

Those are always dictated on what the nursing home average rate was in the previous year. We are always one rate year behind swing bed and that is how the federal regulations tell us to pay swing bed. Our out of state services are what we average pay for those. Those are individuals primarily in Minnesota where we have that reciprocity with them. The limits were increased 1-1-09, based on the average number of beds and individuals. That adds $1.39 per person per day for each day of the biennium. The nursing facility rates were also increased for property related costs. That is $3.15 per day. Of course not every facility has property increases but based on the facilities that are either constructing new or remodeling that is what the average per day ends up adding out to. When you consider when you are looking at the average of $1.35 we have a new rate year that starts 1/1/09. Those increases are not in that number. The increases are 1.1.10. Those are not in that number. The rate increases for the last 6 months of the biennium starting 1/1/11. There are three rate year increases that are tied to the first bullet where we say we have to establish new rates annually based on the cost report. When you add those three rate year increases plus the limits plus the property related costs plus the inflation of 1089 per day, we are coming up with an average of 170.78 per person per day in nursing facilities for the 09-11 biennium. That is how we arrive at that number. I did skip over the bed movement bullet. You will see that currently our monthly average is running $3291. Our final budget is $3388. The reason for the increase is actually a combination of increases and offsetting decreases. If you go to the rather large bullet you can see that we increased 125 nursing facility beds to correspond with the known bed movement. Keep in mind that when we talked about all the additional beds, it's a much larger number. Those are total beds. We only budget for the expected Medicaid use of those beds. We added 16 general psych beds during this interim. Those beds became operational in the fall of 2008. As of December 2008 they are fully occupied .Those 16 beds are not accounted for in your

average above of $3291. In addition, we had 9 new beds at Dakota Alpha that were added during this interim. Those are the beds that are specifically for long term TBI clients. Those beds were added to accommodate the clients who need that service so they don't need to seek that service out of state which is generally where they would otherwise need to find that level of care. Then we had a 19 bed increase of the utilization because of hospice when we were building the budget. Last time we had around 67 beds for hospice that we budgeted. At the time when we built that budget we were running an average of $81. That trend was increasing up. We increased that to a trend of 86 that you see at the bottom which is an increase of 19 beds for that area. Finally decreasing 63 beds for individuals that we expect to receive services through the PACE program rather than nursing facilities. When you put all that together it gets to our average of $3388.

Representative Kreidt: Are you anticipating those PACE beds to be all out of nursing homes?

Maggie Anderson: No there are some other services where we have pulled people out of those.

Representative Kreidt: What is the rate for PACE in ND?

Maggie Anderson: For the 07-09 as well as the 09-11 because we don't build inflation is $4,053.57 per person per month. It's the second to the last one on your grant summary sheet. We tell you 76 individuals and the rate is there as well.

Representative Kreidt: The PACE beds, are you anticipating all of those to be out of nursing homes yet, the 63 beds?

Representative Kerzman: Where do we stand with the moratorium on this?

Maggie Anderson: It is on both nursing home and basic care beds. Are you looking for the number or how it applies?

Representative Kerzman: How can we keep adding beds when we have a moratorium?

Maggie Anderson: The moratorium is on basic care and nursing home beds. We are not allowed to bring additional nursing home beds into the system because of the moratorium. With basic care beds there is an exception where the facility can apply to the department of health and human services. We look at that request to determine if there is a need for basic care. There is no additional basic care beds. If someone does receive basic care beds through that process they can't turn around and convert them to nursing home beds. Facilities can convert nursing home beds to basic care beds if they want. What you are seeing here in terms of when we are saying increase the beds is these beds have existed out in the rural areas and in areas where their occupancy was not using all of those beds. We were trying to represent that movement. Those beds were unoccupied and are now moving into the Bismarck/Fargo/Minot/Grand Forks areas. Once they move in we know they will be occupied at our current Medicaid penetration rate. They aren't new beds coming into the system but new beds we have to take into consideration as we are budgeting.

Representative Kerzman: What is the maximum amount of beds we can have in the state?

Maggie Anderson: We don't have that at our fingertips but can probably get it from the Health Department.

Chairman Pollert: Did I hear you say that basic care beds can increase if there is a need shown?

Maggie Anderson: That is correct. It is an exception within the moratorium where the facility has to apply to the Department of Health and Human Services. Then the two agencies meet and review occupancy information within a certain mile radius. What the aging statistics are showing in terms of how many people are aging to a place where they may need that service. We look at the other beds and during the last session the legislator did add an extra consideration there that if a facility is requesting additional beds that they would be given

priority consideration if they are willing to accept Medicaid clients. There are basic care facilities that don't accept them. There was a concern to make sure that the Medicaid clients had access to that service. That was an additional provision added to the language last session.

Chairman Pollert: So basic care beds cannot be switched over to nursing home beds?

Maggie Anderson: Correct but you can switch nursing home beds to basic care.

Chairman Pollert: So is there one or two bills out there dealing with bed and capacity? Is it on the House or Senate side?

Maggie Anderson: There are three bills to my knowledge. There is the nursing home moratorium bill which is the bill that the legislator typically sees every year. That started in the Senate which is SB 2044. That passed and is now over in the house but hasn't had a hearing. Then there is HB 1327 which is a bill that would create an exception to the moratorium. That was introduced because of the facility in Steele. It is also my understanding that perhaps other facilities may fall under the criteria as they are written in the bill. That bill hasn't had a hearing and is in the house. The final bill technically doesn't touch the moratorium. It's HB 1433. It's about the Richardton facility and transitioning from a critical access hospital to a skilled nursing facility and their need for a Medicaid supplemental payment in order to do so. They want to take their critical access hospital designation and convert to a 20 bed skilled nursing facility. Those are the three I'm aware of. I don't have the fiscal note with me. It's not large on 1433 and the supplemental payment contains no general funds. Its city and federal funds. There are no general funds.

Chairman Pollert: But it would still affect the moratorium.

Maggie Anderson: Richardton actually purchased their beds. They purchased their 20 beds from Wishek and Williston.

Representative Nelson: I don't know if you or the health department track the exceptions to the Moratorium but I think it would be helpful that each biennium that it is part of the material that we know if there has been some exceptions granted and where they are granted to.

Maggie Anderson: Absolutely.

Representative Metcalf: You said you cannot transfer basic beds to long term care beds? But you can if the beds came to long term care then down to basic care. Then they wanted to take their beds back to long term care, can they do that?

Maggie Anderson: Yes. You have one year. Continued testimony on handouts.

Representative Kerzman: When I look at the chart on top and it starts out at about 600 people receiving, we actually lost about 50 clients. Yet when you build the budget you are adding in 5 per month. Can you give me some rational on why you did that?

Maggie Anderson: We look at where we were. Of course we had some very high months and some very low months. These are always unduplicated recipients so it's possible that you had two claims for one recipient in a month. It varies. We were continuing to expect, based on the communications and the information we received from counties, case managers, clients, about the need for home and community based and personal care services and to have the choice. We considered that for continued growth. It's not tied to a specific other than the personal care tier 3 where we can say we are going to have an additional 20 people because of that on average of the biennium. The 5 is what we believed where the numbers when we built the budget. Again, the continued expressed interest in the home and community based services.

Representative Ekstrom: In that tier 3 that expands services from 8 to 10 hours, with that small addition we made by keeping people out of nursing homes.

Maggie Anderson: We would expect current clients that are receiving at an 8 who may need to seek that higher level of care at a nursing home if we didn't have the personal care tier 3 in

addition to those individuals that are already receiving. We expect another average of 20 over the biennium. If you would like to talk about any of those items that were funded in the Governor's budget request as we go through this I would be happy do discuss the details on those as well.

Representative Bellew: Explain the 7&7 inflation again, the $86. The reason I'm asking is the 5% for one year is $60 but then the 7&7 is $86.

Maggie Anderson: The 7&7 is in the Governor's Budget where he provided an increase for all providers. I'm guessing that since we are adding people it is pulling the average down. You have growth in people at the same time when you are adding dollars and so those number of people are going to skew that inflation. You can't go double that number. At the same time you are adding people to the service.

Chairman Pollert: Let's go a little further. I think I will understand your question. Why not 4&4, 5&5, etc. I mean how did the 7&7 come about? Was it discussions with long term care saying this is what we have to have? I would suspect that part of that discussion would have been because natural gas has gone up, utilities have gone up, but now we are in a totally different environment. Does the 7&7 have to be there because you the reimbursement costs should probably drop next year.

Brenda Weisz: We did work with Office of Management and Budget and the Governor's office with the inflationary factor. Yes, long term care did talk about the 7&7. We did run scenarios then for all providers at 7&7, etc. With looking at what the providers thought they were costs were and things they needed to cover in their operation, we did submit the OAR at 7&7. That was what was improved in the Governor's budget then.

Chairman Pollert: So do you have some formula you are using and coming up with. Insurances went up 15%, etc.

Brenda Weisz: What we actually look at is the CPI that exists at that time. There is CPI for various services. There is the medical CPI, there is the CPI that the long term care association has to be cognitive of. I think a lot of it just ties to what is the CPI. We take a look at that and what providers have talked about as to what their increases are. Like you mentioned in utilities, gas prices, travel costs for their staff, things that aren't directly reimbursed in that nature, and then land on a CPI that would accommodate.

Chairman Pollert: Let's go to human service centers and you got 7&7 in human service centers. Could it be saying that the 7&7 might be overstated for some of the human service. Nursing homes are facilities. They have electrical bills. They have a lot of costs. Could it be said in other parts of the DHS budget that the 7&7, do they have all those costs?

Brenda Weisz: Some of the human service center providers are residential provider facilities. They would have similar costs too.

Chairman Pollert: Let's take a psychiatrist that is an outside contractor. Why should he have a 7&7. Won't his billing charges by the hour be automatically in there anyway so his costs are going to be up?

Brenda Weisz: That is a tough question. That does become a matter of policy.

Chairman Pollert: That's fine. I'm just doing some correlation. I am still struggling with the dentists getting rebased at 75% of bill charges. Then you are getting a 7&7 and everybody is getting a 0&7. I might as well ask what is the number if we go 0 the first year on dentists and 7 the second year. I have already asked for the numbers all the way up like 4&4, 5&5, etc. We are going to want them as a committee. I know there are amendments coming that are going to talk about wages for long term care. I know there is going to be an amendment coming on DD.

Brenda Weisz: You did ask for a request and was that to do a 0&7 on dentists?

Chairman Pollert: I can ask for that amendment anyway so maybe that is when you want to give it to us. I have talked to the dental association asking how come you are the lone people getting a 7&7 plus rebasing.

Representative Nelson: The one request that I would have because this has bothered me since the overview was the dentists were the only ones of the providers part of the study that complained about the methodology used in the study. I would be interested in knowing and seeing the differences between their requests and some of the other providers. All the other groups said it was easy to work with and they had no trouble with the information. The dentists said you should have gotten somebody else. It sounded like it didn't go well.

Maggie Anderson: We can provide to you the instruments that were used. The two studies that are similar that were done were the chiropractors and the dentists. It was the same company that was hired in a very similar instrument keeping in mind that chiropractic codes and dental codes are different. Other than that the study was very much the same. We can provide that to you. Certainly we didn't collect information directly from the physicians. We used those surveys that we worked with. We didn't go out to Dr.'s and ask that. There was national, regional, and statewide information available. For hospitals there is a standardized cost report. Then for ambulances there was a totally different vendor and a very different service. We can provide you what we asked for from the chiropractors and dentists and you can do that side by side comparison.

Representative Nelson: In your opinion, I have asked for the information and when you give it to me will I understand it.

Maggie Anderson: I know that both the chiropractors and the dentists struggled with the instrument. I don't think it is any fault of the vendors. I think this was a very unique request. I know when I went out to my colleagues in other states once we knew we were going to do this

study, they all wrote back and said good luck. Nobody had ever really done something like this. I don't think that we perhaps had to criticize the vendor or the dentist. It's just a reality that the records that are kept for a small dental practice versus a hospital who has a responsibility to report to Medicare on an annual basis are very different. I think all of the groups involved did the best they could with the vendor to prepare an instrument. It turned out to be where it was difficult for some to understand.

Representative Kreidt: Going back to your example of contracted services, your 7% wouldn't play into that. Under contracting services you are negotiating with a psychiatrist or a physician for a set rate. There could be a 20% increase per year for those services as you are contracting. The 7&7 really wouldn't play into that to a great degree. You are probably looking at more of an increase on that type of situation. Going back to the 7&7 on the heating bill, that is a moving target. Last year we had a mild winter so we probably got by with the 5. This year the 7% probably isn't going to cover the heating costs because of the extreme cold. You have great variations on that. Costs go up. We all think that fuel costs have gone down and commodities have gone down but the people that are supplying those food products, they forget to put the price down.

Chairman Pollert: I have that in my business. I know prices are going to drop but it takes about 6 months to a year when this thing starts.

Representative Kerzman: I'm making an assumption that the 7&7 is a bit of a catch up because of the underfunding. In the next biennium are we going to be down more than the CPI. I think the last time I heard it was down like 2.6 or something like that. I'm just making the assumption that the 7 is a little bit of a catch up because of the underfunding. That is why I thought I could probably support it.

Brenda Weisz: I can take you back a couple of bienniums. We all remember 2003 when there was a shortfall in Medicaid. That year we weren't able to give a second year of inflation. We did hear the providers talk about how that year was never made up for that inflation. In 05-07 we approved an inflationary increase of 2.65. I'm not sure that it exactly matched CPI of that year. The medical CPI was lower than the other. For the legislative session that approved the budget for what we are in right now. In 07-09 it was 4&5. Part of it can be said that there was some make up that was being done for the years that the inflationary increase didn't match CPI being about 4 years ago. That has been a comment that we have heard as well.

Chairman Pollert: So having said that though and maybe I'm off, wouldn't have the costs being direct or indirect, wouldn't they have gotten that back on reimbursement since everything is behind about a year because of the way the pay system is. Wouldn't we have caught that in the next biennium.

Brenda Weisz: You are talking about in the whole rate system if the cost would come in as allowable?

Chairman Pollert: So wouldn't the costs have gone up in the next biennium? We have never decreased the spending for long term care. We have always increased it so if we did it 2.5 inflationary and say it was actually 4, wouldn't those have shown on the direct costs or indirect costs that came in the next biennium to do the rate structure for the nursing homes?

Maggie Anderson: With the nursing home rate setting we have increased the cost because it is rebased every year. Because they file a cost report. The limits are rebased every four years. So when they have their costs that they are incurring now they will come in on their June 30 cost report. For January 1, 2010 rate setting. So when you build the increase in, we have a known cost increase that we know we are going to have because their costs are going to go up. We have to reflect those within the limits that are out there. We have historically budgeted

depending on where CPI is at. That has nothing to do with inflation. That is just cost increasing. On top of that you have the inflation. So in a way you are always behind in catching up with those costs because they are incurring those now. I don't know if it is a catch up as much as behind.

Brenda Weisz: The inflation would inflate the limits as well. Until inflation is put on the limits their costs might increase and we might add to the costs but the limits are still lower and not increased because we have not added inflation to those limits. They are going to bump up to the limits quicker if we don't add the inflation. Nursing homes were unique that one year because it was in statute at the time and they did get their inflation that year both years when the other providers didn't. The inflation is important to the limits so that those are raised as their costs go up.

Chairman Pollert: So my statement might be half true.

Brenda Weisz: Yes we will go with that.

Chairman Pollert: So do you have what the CPI has been since for the 03-05, 05-07, and 07-09?

Representative Bellew: If we approve the 7&7 for the nursing homes, they won't get a 7% increase July 1. They will get it January 1 based on their costs?

Representative Kreidt: Maggie did a good job of explaining the percentages and increases but you have to realize right now with what we have done with the 4&5 last session, the 5% right now of January 1. At this point with what we have done we have facilities out there that are over the limits that are eating costs close to $4 million. They eat those costs.

Chairman Pollert: I can understand that when we did a 4 and a 5. Actually our costs were probably 8 or 9. Or maybe they were 10. I think anybody in business has run into that problem this last year.

Maggie Anderson: Continued testimony.

Chairman Pollert: So when I look at the growth of 125 or the 10 per month, do you have the historical data to show that up or is it kind of a guess?

Maggie Anderson: It is similar to personal care in terms of what we were hearing about for needs of the services and clients desire for those services. We estimated that growth. You will see a bit of a decline here. Some of that has to do with the new waivered services that we will talk about when we get to the waiver table that were added in the current biennium. Some clients, because always choose Medicaid as a funding source before SPED because of the federal math, you will see that some of our wavier numbers are going up. The second half of the biennium and some are going down. It's just that those clients might be receiving those family, personal care through the waiver versus some of that they may have been receiving through SPED before.

Maggie Anderson: Continued testimony.

Representative Kreidt: Last session we didn't do any inflator for basic care? They didn't fall under these categories?

Maggie Anderson: They would receive that inflation. We built it into the cost that we do because of the cost report. We kind of build that inflation into that cost change piece. We are just showing what the 7&7 is for the current biennium and acknowledging that the other difference is those annual cost reports. Continued testimony.

Representative Bellew: Can you explain that hospice waiver to me again?

Maggie Anderson: That is a hospice waiver specifically for children where typically when individuals elect hospice it's because they have been diagnosed with a terminal illness. The doctor has certified that they are likely to have less than six months to live. The Medicaid

program as well as the Medicare program only pay for palliative care for that time. With children there is often a desire to seek curative measures. There is a lot of grief, counseling, and support that is necessary to try to keep the children and their families in their homes and supported during that time. That hospice waiver would allow us to serve children whose families have elected hospice to provide that curative service component and the additional therapies that are needed. All of which the intent is to keep the child at home. If there is a curative measure that may help for the family to be able to seek that. Continued Testimony.

Chairman Pollert: You talked about $1.5 million targeted case management. What was he talking about?

Maggie Anderson: I wasn't here for Mr. Bernhardt's testimony and I don't know what he said. Was it an increase?

Chairman Pollert: It said the targeted increase of $1.5 million on the county reimbursement. This says child welfare services? So maybe I'm on the wrong section.

Maggie Anderson: It is children and family services. It's related to the change in regulations. That's not my area.

Chairman Pollert: Maybe it's not even related to this. It was just something in his testimony that he had talked about.

Maggie Anderson: It's related to the targeted case management regulations that the centers for Medicaid and Medicare services issues. When they issued those last December they indicated that Medicaid program could not pay for certain kinds of targeted case management including the targeted case management provided by the counties. I'm guessing it's related to that.

Deb McDermott: The counties would not be able to bill Medicaid. However those costs were included in the maintenance rate within our budget. The counties actually would not see a loss

in revenue. That revenue instead of being generated from Medicaid will be generated from 4E funding. Actually it is pretty much a wash in our budget.

Representative Bellew: I need this explained again. Is it those federal rates? We have to do that because of the feds? This is to me an unfunded mandate.

Maggie Anderson: With the federal regulations that came out with targeted case management, they were very detailed about the types of rate setting mechanisms that they would allow states to use. They do not care for bundled rates. For example with this service, typically clients are seen upon receiving the service and then every six months. There is an annual visit then a six month visit to make sure all their services are what they need and make sure to recess their care plan. So we pay this annual fee and pay it every six months. They are saying no they need to know if the case manager was with the client and how long. They may let us go to a daily rate but we haven't negotiated that. All those were currently in negotiations with state plan amendments. We do know that they will not allow us to continue to retain the rate setting mechanism that we have. By doing that we have to unbundle this long standing rate that was to cover a six month period or a twelve month period. We know that in doing that we have to prove to CMS that we have used some kind of appropriate cost collection and rate setting mechanism. For example they won't let us take that rate and divide it by 6 months and come up with a rate that we actually have to prove to them how we set that rate and does it correspond to what commercial individuals would do or what other payers pay for something like that. It is a federal mandate.

Representative Kerzman: It sounds like it would be an exemption for the contract providers like PACE if I'm hearing it right.

Maggie Anderson: Since we pay that one fee to PACE how they negotiate paying for services within their system is up to them. They wouldn't need to account for that. They need to follow

the requirements of providing services under Medicaid. How they establish that is negotiated. If you are a physician they are going to negotiate with you as to how much they are going to pay you for delivering services. Continued testimony.

Chairman Pollert: Did I hear you say that the non medical transportation, is that something new that was proposed in the governor's budget or did I not hear that right?

Maggie Anderson: That is funded in the Governor's budget in the 09-11 budget. It was funded prior to the department submitting our budget to the Office of Management and Budget. It was not an OAR that was funded it was something we funded before we submitted it. We included it in our budget.

Chairman Pollert: But it wasn't in any other biennium though?

Maggie Anderson: This service did exist previously and it was removed. This was a service removed from SPED and expanded SPED. Continued testimony.

Chairman Pollert: This gets us through the three forms that Maggie handed out this morning.

Maggie Anderson: It does but there are two services that don't have charts and that has to do with timing of payments. So you don't necessarily have expenditure charts. One of those is the PACE program which Representative Kreidt had talked about and I referred you to the chart with the 76 individuals at an average monthly cost of $4,053.57. The other one where you do not have a chart is the children's medically fragile waiver. We are just beginning to see the expenditures come in from that. How we built the case load and the dollars, you might recall that the waiver is funded for 15 slots. We currently have 3 individuals on the waiver. We are working with other families going through what is called the level of care. Then they have to meet the level of need. They have to meet the nursing home level of care and have to have a certain level of need to qualify for the waiver. As we are working with that and we see the applications and requests coming in, we built our growth over the 09-11 budget to average out

to 11 children for 09-11. The way we achieved our cost is when SB 2326 was passed last session we provided an estimate of what the average monthly cost was. We inflated that forward by the 5% for the second year of the biennium and the 7 inflationary increase for the 09-11 biennium. That is how you get to the average monthly cost there. That should take us through all the handouts so far.

Representative Kreidt: Looking back at the bed transfers and we are using 125 beds. The way I read this, the way I assume is that we are going to have 125 beds banked. There must be a breakdown on how those beds are going to come online. I think for the committee that it would be helpful.

Maggie Anderson: I was planning to hand out an updated version of the nursing facility bed movement. As I was thinking about that I realized I didn't go into the detail with you that would lead you to that assumption about the 125. We use the information from the long term care association and we worked with Shelly and her staff as we were building the budget. For example we know that Manor Care is bringing beds in August of 09. I believe we figured the penetration rate of that particular facility was 12 beds. We also knew that all 12 wouldn't be filled the first month. So we put 3 in August and 3 in September of 09. Then Good Samaritan is also bringing beds on in September of 09 so we also put those beds on. So it's not 125 from the get go. Every month of the biennium we built them based on what we knew and what the long term care association knew at the time we built the budget. We would be happy to provide that to you if they would be helpful.

Maggie Anderson: Testimony Handout (Attachment F)

Representative Metcalf: Are there any PACE recipients currently in the nursing home?

Maggie Anderson: I don't believe there are. They are all in the community. The three that were in the nursing home came out of the nursing home and back into the community and are

providing the services to them. Currently we haven't had anyone on the PACE program return to a nursing home or need to go to a nursing home.

Representative Kreidt: Going back to Stark County and Richardton, have those critical access beds been transferred to Dickinson at this point? Where are we at?

Maggie Anderson: Dickinson doesn't have the critical access designation at this time. Richardton will maintain that designation until the point when they transition over. I understand from Jim Opdahl who is the CEO of the Richardton Memorial Hospital, did testify for HB 1433 on Monday. He indicated that their giving up the designation will happen. When they accepted the grant funding that Congress passed this past year, part of accepting that grant funding was a contingency that they give up their designation. If HB 1433 does not pass, they are still obligated to give up their designation. I further understand that the centers for Medicare and Medicaid services were involved in the health care task force that was meeting out in Southwest ND this past year. Mark Gilbert who is the regional administrator for CMS has assisted in helping move that Dickinson application along. Typically you can't apply until that is available. There are some concessions being made to overlook some of those federal time lines to assure that once the designation is given up that Dickinson can secure that as soon as possible. It hasn't transitioned yet because it is my understanding that Richardton wants and needs that designation until they go to a skilled nursing facility because they want that payment structure in place .

Representative Kreidt: Did the department take a position on HB 1433?

Maggie Anderson: No we didn't. We only provided the information for the fiscal note and that was the extent of the department's role.

Chairman Pollert: Are there any other bills on the house side that are DHS related that DHS supports that are going to be coming into this section or to whole appropriations? If there are, are they OAR's and are they a priority?

Maggie Anderson: I just jotted down the list from memory.

Chairman Pollert: This afternoon when we come back let's talk about it. I'm just doing this so our section knows what might be coming after us.

Maggie Anderson: Testimony Handout (Attachment G) 35:00-39:00

Chairman Pollert: We are on ISLA's right? When I look at 09-11 case load growth and the developmental center has an increase from there, are we going to see a corresponding decrease in that budget?

Brenda Weisz: When Alex was in and discussing the detail last Friday, you won't see a corresponding decrease specifically in the developmental center but you will see was the 16 FTE's that was set aside to operate the CARES team that would enable us to do the transition up to the community and then assist those providers in and across the state to maintain and deal with behavioral issues to keep them in the community. Although they didn't have the reduction of the FTE what we do have is the change in their focus to move towards transition. Then as we get those individuals transitioned out, then we can actually see some decreases in future bienniums. It's not so much a direct reduction of staff but a reprioritization of what they are doing when you talked about the 16 that goes towards the CARES team.

Chairman Pollert: I remember the talk about the 16. At some point are we, in this budget, to go down to 67 in 09-11?

Brenda Weisz: I don't know?

Chairman Pollert: But that is our goal in the next biennium?

Brenda Weisz: Our beds were based on the 115. I think we have to get to a goal of 97 first and then 67. We have some time to work through that. It won't happen all next biennium.

Chairman Pollert: So you are telling me that we have to keep 445 FTE's at the Developmental Center, including that 16, even though we are dropping to 97?

Brenda Weisz: That is accurate but I think the distinction needs to be made with the 445 FTE's. 16 of them are there to no longer be functional and operate at an institutional setting. Their focus will change. Handout (Attachment H). Continued testimony.

Chairman Pollert: Do we have 32 levels of care in nursing facilities?

Brenda Weisz: 34

Chairman Pollert: ISLA's were at 2 and we are going to go to 5 right?

Brenda Weisz: No how we reimburse for administrative costs for ISLA is we are currently in our biennium at 2 levels. We are moving that to what already exists in the system. There is already a PAR evaluation tool that is used. We are just making our reimbursement which was thrown out there at 2 rates to say whether it is enhance or normal. We are going to spread that based on our client needs. Why don't we pay administrative reimbursement based on the par level as well because that is what dictates how much time is spent with the client.

Chairman Pollert: So you said we were basically doing this in the past. What we are going to **be doing now with this structure is putting it in statute.**

Brenda Weisz: No we just changed our reimbursement methodology.

Representative Nelson: Can you tell me what the increase percentage in that column?

Brenda Weisz: I don't know the percentage. We either paid them 275 or 420 a month. Now we are going to pay them either 340,390,415,440, or 540. We didn't do it as a percentage per say. We actually looked at what we reimbursed them. We are paying them right now under 2

rates. It is either regular or enhanced. Now we are going to reimburse you based on the functioning of your client.

Chairman Pollert: I'm trying to get this into perspective. Let's take an example such as the Ann Carlson Center. What their needs are is getting reimbursed which we have been told is day and night. Now is that set in administrative code, how that is done? I'm trying to correlate this as to how we do nursing homes. Now with ISLA's you are setting in a rate structure that yes you are kind of doing it in previous biennium's but now you are putting it in as this is what you are going to do.

Brenda Weisz: We weren't kind of just doing it in prior biennium's we were always doing it.

Chairman Pollert: So you are telling me that you have always been paying these five par levels at these rates plus inpatient.

Brenda Weisz: No what I am saying is we always paid them an administrative payment at 2 levels. Now what we are doing is taking those two levels to be more representative of what it is costing them as to what they need to do. We are breaking it into five.

Chairman Pollert: I understand that. Basically you are going to be reimbursing more for the higher levels of care for them individuals. Now could you turn that and switch that over to people in the Ann Carlson Center. I'm not just saying Anne Carlson Center. It doesn't matter what service we are providing for what clientele. I'm just trying to figure that. Now you are raising this level to ISLA's then are you going to do that for the people like Ann Carlson Center?

Brenda Weisz: ISLA is an entirely different service than what is provided in the ICFMR's. That is why you aren't going to see a consistent treatment. What we have found in the movement from our clients in the developmental center and throughout the DD system, we always have to keep in mind the Olmstead commission decision which says that people need to be residing in

the lease restrictive setting. The least restrictive setting for many of our clients would be an ISLA. What was happening for the DD providers is they were struggling because of the higher functioning of the individuals that are coming out of the Developmental Center to pay them at a two level structure isn't going to allow for us to keep them in that facility with the amount of reimbursement that DD providers are getting for that. ISLA is a service that has changed over time with the fact that as individuals go in to the community as we move more, it is a service that is demanded. A waiver program is very similar to the Medicaid plan that once you are deemed eligible, we have to provide the service. We also have to be cognitive of the Olmstead decision which is least restrictive setting for the clients.

Representative Nelson: Is it safe to say the five levels will treat us well as more people are coming out of the developmental Center and going into this type of setting? Do you see the expansion that might be needed in that area.

Brenda Weisz: The PAR system already exists in our system. It's plain well what we currently do for service direct service dollars. All we are doing is changing the admin to correlate with what already exists.

Representative Nelson: So there won't be a need to expand this? That will serve us well?

Brenda Weisz: That system that we have in place is what we continue to go forward with, with our current clients and services. That PAR won't change. This is just to make this more consistent with how we pay other services based on PAR.

Representative Kreidt: Going from the 2 to the 5 par, have you already done some type of screening to see the numbers that are going to fall under the different PAR levels?

Brenda Weisz: Yes when we worked as a work group we did take a look at who is in what areas. Like I said the system already existed in the DD system. We already know who is at those PAR levels. When we built this budget and how we arrived at that when we used these

rates or the cost to do this, we did look at specifically what individuals were at what functioning level and how they would be reimbursed.

Representative Kreidt: So we are looking at 790?

Brenda Weisz: What you want to know out of our clientele what level of PAR for administration of ISLA and what caption they fall under?

Representative Kreidt: Yes.

Brenda Weisz: Ok we have that.

Chairman Pollert: So if I can answer Representative Nelson's question and tell me whether I am right or wrong? The question was what was the percentage increase and it showed as a 22% increase on ISLA's total. All I did was take the grant summary and took last year's total expenditures of $59 million and took $13 million divided by $59 and you get a 22% increase to ISLA's.

Representative Nelson: My question was in the administrative reimbursement level. I was trying to understand how this related to the 07-09. I know we are comparing apples to oranges.

Brenda Weisz: We didn't base our increase on a percentage increase to say we were going to increase them 7%. We did it a little different.

Representative Nelson: I didn't quite understand Representative Kreidt's question. Was it the assumptions you used to build from 767-790. What par level was used? You have that information for those?

Brenda Weisz: We have that too. We would have our existing clients that when they were on the 2 system payment reimbursement we know where they fall on one of the 5 pars. There is also growth in that number and we also know where those growth numbers fall into PARS.

Representative Nelson: My guess is it is going to be a par level lower.

Brenda Weisz: Pretty fair yes. Par 1 we have growth of 9 and 8 individuals. The other areas is 6 and 5. We will get that for you.

Deb McDermott: Can I just make a comment about the ISLA service?

Chairman Pollert: I understand that the 22% increase also includes case load increases, I understand that. I'm just talking total dollars that you have in your grant summaries, a 22% increase in total expenditures. That's a pretty easy figure to come up with. How you got there, I know it is explained. I know it's not the same figure if its 500 people treated.

Deb McDermott: It is about ISLA. I just want to make the point that this is directly related to the efforts. Providers are telling us that in order for them to be able to serve individuals in the community at these higher intensive service levels. The reimbursement as it had been structured was not reimbursing them. Unless we find a way to better reflect the intensity of care that is following the individuals out to the community of which this does, we would have difficulty moving people out of institutions.

Chairman Pollert: I understand that. With these individuals moving out of the developmental center I know it would be done less expensive in that DD setting. I am struggling with as to why we aren't starting to see a reduction in the total expenditure of the developmental center. As of now I support the developmental center and why it has to be there. At the same time though we are getting questions from other people in the legislator asking when the total expenditure of the developmental center going to drop. I can't give them an honest answer. That is just a statement.

Maggie Anderson: Continued testimony.

Representative Kerzman: Would any of these individuals be going to the Cooperhouse?

Maggie Anderson: No. Continued testimony.

Chairman Pollert: Thank you for breaking down on that. That lets us really get down into the numbers. I know it takes more time but we appreciate that.

Maggie Anderson: I just have one more handout (Attachment I)

Brenda Weisz: Just a clarification for the sheets we are handing out, for the developmental center when you look at their rate they include medical where the DD providers don't include their medical costs.

Nancy McKenzie: Testimony (Attachment II)

Representative Ekstrom: What page on your overview are you on?

Nancy McKenzie: Page 5

Representative Nelson: As far as that handout goes, this is mostly federally funded. The question about your portion of the equity pool, could any of it be used for the reclassifications and workload increases? Do you apportion any of that into this area?

Nancy McKenzie: As you have heard other people say we haven't really finished our formula as to what equity would look like in our department. I might refer that question to Brenda. These are reclassifications and work load increases that have happened.

Representative Nelson: So this is built into the budget on a cash basis and the equity is added later?

Nancy McKenzie: Equity is the different part of the picture. Continued testimony.

Representative Bellew: We notice throughout every budget that you are almost doubling travel. Do you have a breakdown of federal and general funds in that category?

Nancy McKenzie: Specifically or operating? The reason I did that so quickly is because VR is one of the four areas you asked for more detailed information on in the travel. Rather than really diving into that information, Brenda wanted to do an overview of the travel.

Representative Ekstrom: This doesn't have to do with operating and I apologize. Looking on the OAR sheet, VR had no additional requests above and beyond?

Nancy McKenzie: That is correct. When we were asked to put together our original hold even budget, our federal funds and state match were adequate that we didn't ask for enhancements to that specifically.

Representative Bellew: Operating fees and services shows an increase of $343,000. You did give us a breakout. I don't see the increases on that breakout.

Nancy McKenzie: That breakout lets you know what is included in that budget. In my overview testimony, if you go back to the lower part of page 5, it does breakdown for you some of the things in terms of rental increase is 48,6. We have that travel increase that we are going to detail more for you. The public awareness campaign. We talked a little more about the printing.

Chairman Pollert: On Representative Bellew's question about the $343,000 it just says public awareness media campaign. What does that entail?

Nancy McKenzie: That is the piece I just referred to when I talked about our input from our federal requirements as well as our state rehab counsel and stakeholders about reaching out to consumers with disabilities to make sure they are aware of the services provided. We have those federal standards and indicators that require. We make sure that we addressed minority groups, persons with significant disabilities, etc. This is a number of different materials. For example, a number of years ago in our federal review we did not meet the level we were supposed to on percentage of minorities in the program. One of the things that we are looking at in this budget, which will have an attached cost, is that in all of the HIS health centers and different areas around the state and all of the reservation areas, we will be doing some television spots in our in house in lobby. Or when we are asked to provide materials for doctors and clinics that we can share with clients who may have become disabled.

Chairman Pollert: You are talking the media blitz. Do they do the advertising or does the DD portion of the DHS budget? I didn't notice. Do they have any blitz as well?

Nancy McKenzie: I don't know that I could really speak well to the DD. I know within mental health substance abuse we do have other parts of our budget that block grant dollars ask us to do a piece of that. Some of the information on substance abuse prevention. It would be like that.

Nancy McKenzie: 79% are. Continued testimony.

Chairman Pollert: This is all general funds?

Nancy McKenzie: Yes.

Representative Bellew: Do you have a breakdown of who gets the grants and who is awarded them, and to what degree?

Nancy McKenzie: I don't have a breakdown of amounts but I do have a breakdown of the entities that we do have the grants with. Our Older Blind Vision Services which is for client purchases.

Representative Bellew: Could you just give us a list?

Nancy McKenzie: Yes I sure can.

Representative Bellew: And if it's possible an amount that goes with each one?

Nancy McKenzie: Yes we can do that. Finished testimony.

Representative Wieland: I have noticed throughout all of the budgets that the rental leases that we have are from anywhere from $2 to $4 in the state. I'm wondering who does the negotiating for this lease space and how is that done? Is it just done by how the rent was going to be?

Brenda Weisz: Individually the agencies work with the landlords to figure out a rental rate but we also involve facility management. A lot of times because they are private landlords, and we

need space, you end up being between a hard place. What I am handing out is a request from last week. (Attachment J). This just lays out the inflation at 7&7 by the major groups. That way you will have it before you. I think when we put our scenarios together, what we did last time was put the 5% right underneath this. That way you can see the difference if you move to the 5. If you move to a 6 what the difference in dollars would be. This is the framework for what is in the budget at the 7&7.

Chairman Pollert: It seemed to me that it was a colored matrix?

Brenda Weisz: It was probably in color. It was colored when we showed you the difference between 1%. (Attachment K). This is the handout dealing with the reason for the increase. We did do a report so you could take a look at what divisions you wanted to look at further. I asked to go first for admin and support. You had also requested medical services and voc rehab and mental health and substance abuse. If I could lay the framework for you I will explain he changes for admin and support and then the other three areas will be explained for you with at least half of the schedule being already covered. What we did for you on the top was to show you what the comparisons were in the rates from the current biennium and what the rate increases and changes were from the new biennium. The lodging changed. It went from 50 plus tax to $55 plus tax. Continued explaining Attachment K.

Chairman Pollert: We are in recess until 2:30 this afternoon.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/29/09

Recorder Job Number: 8188

Committee Clerk Signature

Minutes:

Brenda Weisz: Testimony Handout (Attachment A). I have a TANF schedule if you want to do that first. This is how the expenditure is appropriated for the 09-11 budget. I think I want to explain a couple things first. Our TANF block grant for a biennium or two year period is $52.8 million. That is the revenue we take in. You would have to add a few numbers together and the carry over. So $52.8 is the grant award for the biennium. The amount of carry forward that we are bringing in to this biennium if expenditures stay consistent will be $11.6 million. If you look at your schedule and look at the top at the revenue for fiscal year 09-11. The number of the revenue for the TANF block grant that we plan to have available for expenditures is $18,244,000. $11.6 million of that is carry forward. The rest is $6.6 million which is the 25%, because since we are on a state fiscal year we divide our TANF block grant in the first year. In the third year you have 25% available for the first three months of the biennium. 25% of that grant award is that $6.6 million. If you add it to your carry forward that is how you get the $18.2. Then for 2010 we have a full year of grant award money which is the $26.399 million. For 2011 you only have 75% for 9 months. The $500,000 that we have subtracted out of there is out of the revenue what is going to happen is a continuation of what was SB 2186 during the 2007 legislative session. The $500,000 that goes to work force development for quality child

care. We transfer that to the child development block grant on purpose. We have held that even and it was enacted during the 2007 legislative session. That gives you your available revenue for the next biennium. The estimated expenditures are in the column right next to it. The bold number is $62.9 million. Our estimated carry over then into 2011-2013 is $1 million. That compares to a carry forward we are bringing in to the $11.6. If I would just cut to the chase we are going to have some trouble in 2011-2013

Chairman Pollert: That was my next question. We are going to be short $10-12 million.

Representative Bellew: Is that $500,000 an ongoing expenditure or is that limited time?

Brenda Weisz: The reason we carried that forward is because it was enacted in 2186. There is still additional development that they are doing and we continued the effort forward.

Chairman Pollert: Will the $52.8 block grant stay constant. There is going to be a decision that is going to have to be made on about $10-12 million on funding. That would have to be general funds

Brenda Weisz: Before it even gets to you we will have to have some discussion on Office of Management and Budget and amongst our department. I will walk you through the expenditures to refresh your memory on what they are. That $62.9 million breaks down by categorizing it by assisting needy families. That is your transition child care. I will just refer you to where that is covered in testimony. That was when Tove Mandigo was talking about Economic Assistance. The general and other funds are to meet our maintenance of effort. So I'm just focusing on the federal funds. That is where our problem seems to lie for carryover of funds. Job preparation is the things that are needed to comply with the federal regulations in relation to what participation. That would be the work activity special payments are the PRIDE program that was discussed previously. The jobs transportation client services and support services are those jobs contracts that we enter in to in order to assist our TANF clients to seek

employment and make sure our work participation rates meet those of the federal requirements. The next area of the budget is the formation of maintenance of families. This is the TANF funding that is actually included in our child welfare program so Tara Muhlhauser talked about the child welfare services foster care. There is TANF money in that part of the budget. It's allowed for expenditures that were previously authorized under Title IV a Emergency Assistance. That is when they had the program aid the families AFDC. What that is, is that covers part of our wrap around case management and our parent aid and in home which are the services to keep children in their home that are at risk for placement. Child abuse and neglect investigations that are the work we do when we have the complaints that are filed or the reports that are filed and the follow up work necessary there. Foster care is the funding of our foster care for those that qualified under the previously authorized IV a emergency assistance.

Chairman Pollert: Foster care is all federal dollars? Do you remember during the interim Human Services committee there were a few questions asked about foster care. How much has it increased from the last biennium?

Brenda Weisz: $1.4 million is the increase of the TANF use in foster care compared to the current budget for this biennium. That is because anytime you have an increase to foster care whether it is a 7&7 or whether it is moving the payments to the mark for the family foster home. Based on the funding formula for the foster care grants a part of that will be an increase to your TANF funding. That is why you are seeing an increase there. The other area, because they don't really fit nicely with the categories above, is we call it other. It is system maintenance and operations. Those are the CPU costs for the text and vision eligibility system that are used to determine eligibility. That is also where we list our alternatives to abortion program. That is steady at $400,000. Then there are expenditures that the county incurs. The first one is we still

use the old title of emergency assistance. That is the targeted case management that they do. We pay that out to the counties. The next item is TANF assessments. This is the work the counties do that is direct service things like information and referral for the TANF clients and any assistance they provide for the counties. That category accounts for $4.2 million rounded. Then you get to the administration area of the budget. Along with our jobs contracts to help with work participation rate with our clients, there is an administrative component. The reason it is not grouped up with the other jobs payments under job preparation is that we do have to track our administration separately. We are held to a 15% limit on our TANF program. Right now we are at 9.56%. We cannot exceed 15% of the total TANF program. That is why we have to track that administrative component below in that category. You have your state office administration. That would include funding for the individuals that work directly on TANF policy. We do draw down federal funds for the indirect and support services that people do for TANF such as the reports and the work of the fiscal administration staff, the HR staff, and the IT staff, things that are allocated and assist that TANF program. County administration that is where the counties actually determine eligibility. That ends up being a claim against the TANF grant. The human service center administration, we mentioned before that there are people out at the human service centers that actually oversee some of the child welfare work and licensing that goes on. Because some of our children are TANF eligible, the funding of their salaries then were able to tap some TANF funds for their salary as well or we would be using all general for their salaries. That outlines for you the TANF expenditures. They haven't changed in concept. They haven't really changed on how we use the money. What probably has changed is our carry over is dwindling. Our expenses have continued to grow when you had inflation and you add higher reimbursements for child abuse and neglect.

Chairman Pollert: Are there are any bills out there attempting to tap TANF dollars.

Brenda Weisz: I'm not aware of any.

Nancy McKenzie: (Attachment B). I'm going to start with the Voc Rehab grant information that you requested. Let me introduce Lynn Derman who is our liaison accountant. I need to apologize because Lynn had this all ready for me just how you like it and I put the wrong copy in the packet. We can walk through this a little bit. This breaks down our grant budget for you. Just to tell you a little bit about what each of these are, our older blind services client purchases means anything specific that is directly for client use. It doesn't include any staff time or anything in grants. We assist older blind individuals who might be with materials who can help them to read or access information. That is federal in general split there. The Randolph Sheppard program is the vending machine program that is out there in a couple of places in the state. This is just past the federal money for us. That money goes to the individual with disability who manages those vending machines. The IPAT contract that used to be part of VR's budget is not now. This money goes through the department's budget to IPAT for better services.

Lynn Derman: We have the funding source for basic support transition services and basic support grants are the same grant. We have specific grants that we write for transition programs which are dealing with transitioning youth from schools to working situations or from high school into a trade school or college situation. We set aside some of our basic support grant for that program specifically. The funding source is the same grant with the same federal/non federal breakdown as to 79-21%.

Nancy McKenzie: The next one I will identify is the Centers for Independent Living and we walked through that a little bit this morning on a separate handout that is in your packet. As you can see that too has some federal funds but a lot of general amount funds.

Representative Bellew: Is that the part that has $800,000 increase in general funds?

Nancy McKenzie: Yes. Extended services is to support ongoing employment. It's for ongoing needs for persons who need support in their job setting. You heard from some of those folks in public testimony. This particular budget covers just those that are not part of the DD waiver or the budget for individuals with serious illness. It might be someone with a traumatic brain injury. It could be any number of different things. Supported employment is another level of vocational readiness in which people get a lot of supports training and assistance and hopefully can move on to extended services. That is fully federal dollars. The disability determination services grants. A lot of theirs is about payment for medical services and medical consultation as I mentioned earlier.

Nancy McKenzie: (Attachment C) If you look at the travel information for Voc Rehab, As Brenda explained that whole top section are the rates that are applied to department wide. Unless you have additional questions about that I would just skip over that and go to the bottom to what is specific to VR and DDS. We show that broken down as Brenda had for admin and support into non employee trips or in state trips. So you can see the difference between the current 07-09 budget and the 09-11 budget on both growth and the number of trips as well as an increase of what the budget would be for those trips. Then you see the section that breaks it down by what part of that is attributable to the rate increase. You can see both the rate increase and utilization. Some of the notes on the bottom are non employee trips that have increased. That really is about involvement of people on our state rehab counsel. We have been very fortunate to get an active counsel and keep it fully staffed. People participating in services is full as well. Within DDS, their medical consultant is doing more outreach services. Those become non employee travel areas as well as our state independent living counsel. That is what those are. Our instate trips cover a lot of things. We are responsible for state office staff going out to all of the regions to the human service centers and working with

our regional staff. We do care reviews to make sure we are doing what we need to do with federal monitoring and so forth. When I did my overview I talked a little bit about the client assistance program which is available to anyone seeking services or in services who has a concern and wants special assistance from someone or may want to appeal something. That all falls under in state trips. The increase there is really because of needs for more federal monitoring. I mentioned earlier that we had our triennial every three year review in October. We know we are going to have a number of follow up things we will be doing with staff state wide in relation to their recommendations as well. Out of state trips increased based on the meetings required by the agencies. Also, social security administration is starting to work on a whole redo of their computer system nationally. We know that there are going to be additional training trips required for staff because everything they do is connected to that national computer system. (Attachment D) My last handout is in relation to a question that you folks had brought up. I believe it was Representative Ekstrom who asked about compensation for case management. That is what this is. It shows you the comparison on top of the ND Classification and pay scale. The range is there. The bottom the information we got from Lakeland Mental Health in Minnesota. You can compare the salary ranges from a mental illness case manager 1 & 2. The main distinction is the bottom paragraph says that in Minnesota when someone comes in to that system every January they have their cost of living adjustment. On their employment anniversary date they automatically move steps of 4-6%. That tends to move people quicker in to the range than our staff.

JoeAnne Hoesel: (Attachment E) This is the travel information for the division of Mental Health and Substance Abuse. I'll go right down to the bottom section and start with non employee travel trips from 07-09 to 09-11. That did increase from 36 trips to 417. That is in the explanation for usage increases at the bottom. The first paragraph under non employee trips.

We have a number of grant programs that have come forward where we reimburse consumers and family members that participate. The first one is the youth advisory council. That is directly tied to our underage drinking grant that we get from the Department of Justice. We have a gambling advisory council that meets quarterly. We have several members that are compulsive gamblers in recovery. We reimburse them for our travel costs. We have the State Epidemiology outcome work group that I talked about earlier. (Attachment F)

Chairman Pollert: So you are telling me that we pay for people's travel to go to these meetings like compulsive gambling?

JoeAnne Hoesel: No. This is to come to the advisory meetings. That would cover the costs of non employee trips there. We have peer support groups, mental health planning counsel, and the traumatic brain injury implementation grant. Those are the grant and funding specific initiatives. I mentioned the increased licensed substance abuse programs in the state that are requiring more follow up visits. We also have non division individuals that participate with us. That is the individuals that are involved in that process.

Kerzman: The State Epidemiology group, how do you determine if that would be in your department instead of the Health Department or AG's office?

JoeAnne Hoesel: That is a grant that came through the substance abuse/mental health services administration. It is tied specifically to substance abuse prevention work. That falls within our department. That was predetermined at the federal government. Representative Wieland had asked to get a brief description about who were some of the groups that were represented at the public testimony for mental health and substance abuse and developmental disabilities. I just took a partial list that appeared before you on Tuesday and identified if they were funded by the Department of Human Services and what their role was. He was wondering whether the department was funding them. This is a response to that request.

Maggie Anderson: (Attachment G) First I'm going to provide the travel information and then all the items related to traditional Medicaid grants. The travel document is the same format as the others you have seen. Going down to the box at the bottom, you can see trips that non employee trips were 0 and now it's 80. Our footnote indicates that this primarily consists of the money follows the person stakeholder committee and the Medicaid advisory committee. Neither of which were budgeted in 07-09. We do pay for mileage and meals and sometimes lodging for the stakeholder meetings. That is the non employee piece. The total of in state trips you can see there were 402 trips budgeted in 07-09 and in 09-11 684. Again most of that increase is related to money follows the person with the individual who is the money who follows the person grant administrator travels around the state quite a bit to nursing facilities to institutions that serve the DD clients to the counties and the purpose of that is to fulfill the expectations of the grant which is to transition 110 people out of the institutions. That is a big portion of that. We also have some dollars budgeted to train once the new MMIS is up and running.

Representative Kerzman: I had an individual that talked to me and he said he was transporting a family member and they weren't getting paid mileage for that. If someone else transported that family member they would get that mileage. Is that true for out of state?

Maggie Anderson: We do have an administrative rule that indicates that we don't enroll family members to transport Medicaid eligible individuals. Within our state plan we do have an exception to that to look by a case by case basis if they have exhausted all other transportation that might be available. The free or volunteer transportation is supposed to be looked at prior to requested the exception. The total of out of state trips, 53 to 74, primarily there are some extra trips related to myself, the assistance directors needing to be in Denver and or in Baltimore with CMS on issues and discussing those. I have shared a few times during

testimony about the complexities and the oversight and the program integrity areas increasing. Sometimes that necessitates face to face meetings. We also have some meetings with the new MMIS system coming up where there would be some products that our staff would be needed to be trained on. (Attachment H)

Representative Ekstrom: I ran into a lady the other day at the hotel when I was here during the interim. She was up here from the Centers for Disease Control coming into the Department of Health to do some training. You also have folks that come here from the federal government to assist in training?

Maggie Anderson: We do have people from the federal government who do come here. Certainly they provide technical assistance but doing mass training of staff, they don't. Typically our regional office will have a training and the expectation is that you take your staff and go to Denver. We ask them on a regular basis to provide those opportunities via a web or interactive video network. Sometimes they do sometimes they will not. There are just required trainings. For example there is one coming up in February because they are coming up with a new reporting system for all of our federal reports and we have to send somebody because we are required to do those federal reports. Typically they do not come out here to train us. (Attachment I). I think we will start with the cost survey instruments and I will get into a little bit more information that you requested specifically about percentage of bill charges. You did ask to see the information for the cost surveys to understand whether the dentists were asked to provide more complicated information than the other providers. I indicated that what I would do is provide to you a comparison from the dental survey to the chiropractic survey. The reason why you have multiple pages stapled and labeled dental is the first two pages were the same on both two surveys. I didn't want to provide one more piece of paper for you. The instructions that were provided to both provider groups were the same for the first two pages in terms of

offering the assistance providing their fax number, their phone number, the contact person, that they could submit the information electronic, they could send it online or fax it to the vendor, whichever met their needs. Then getting in to discussing each of the items in the cost survey. It's just contact information, total expenses, net revenue and encounter information. You can see both instruments are fairly close to the same. The differences in them relate to that coding issue that I talked to you this morning where the chiropractors look at more of a RVU. That is the system that they use to do a relative value of the service that is provided and the dentals have CDT which is a dental code used for each service. They were asked to provide their fringe benefits. The information for the chiropractor, the administrative support that they would have, the facility operations and maintenance and other costs to specify those. The vendor provided the definitions of what would be included in each of those areas and again provided their phone number and other ways to contact them should they have questions. The way that this whole process worked from beginning to end is we did release an RFP to higher vendors to do this survey. We involved all of the associations in the process. We had members of the hospital association participate in reviewing the proposals for the hospital portion of the rebasing. We had members of the medical association do the same for theirs, the EMS association, the Chiropractic association, and the dental association. Those individuals were involved in scoring the proposals and making decisions about who would be hired as a vendor. Then when the vendors came in to do what they call their kick off meetings, we once again brought those individuals from the associations to the table to participate in those discussions. So the vendor not only heard from the department about what we understood was directed to be from SB 2012 but to hear from the providers about how they perhaps see the new cost and financial information within their industry to be unique and assist the vendor in trying to capture the information. In this particular area with dentists and

chiropractors, once we receive the draft cost collection tool, we did send that out to both of the associations. We had conference calls with the vendor to walk through the tool and for associations to provide feedback and make the necessary changes that they felt would be needed to be included in order for their members to be able to complete those surveys. Then we mailed the surveys out to everybody. There was a lot of discomfort in completing the surveys. Some of that is the information of salaries and benefits and information like that there was concern about the information and what would be done with it. Certainly if you have a multi practitioner practice that information is a little less obvious than it is if it's a sole practitioner. There were difficulties in completing the instrument. The vendors tried to assist in both the chiropractor and the dental area. With the chiropractic area there really was a particular one who was the champion who individually took the responsibility and said we wanted as many of these surveys returned as we can. He got on the phone with the vendor so he could totally understand what was being asked. Then he got on the phone with his colleagues and called them and offered his assistance to his colleagues. I'm not aware of that happening with the dental survey. It certainly could have but I was not aware of it. We did have a couple of subsequent calls with members of the dental association who had recommended alternative ways after the survey had gone out. All of those surveys would have certainly led to estimated costs that we couldn't have substantiated. They would have been too specific to be an individual provider. We didn't believe that was what the legislator was looking at. We understood that we wanted us to look at the practices of a whole statewide. If we only collected 3 or 4 practice information we could potentially be skewing that final data. Again, is the survey instrument perfect? No. It was certainly something that the vendor we hired had never done. In fact none of the vendors that bid on this had ever done anything specifically on chiropractors or dentists. They all had experience doing hospital rebasing.

Representative Ekstrom: We heard in public testimony that there are some people who know what they are going to get back from Medicaid. Therefore that is what they bill. They do not bill what their actual costs are.

Maggie Anderson: That is certainly a possibility. It's actually a possibility with all provider groups. Our guidance to providers is you need to bill us your usual customary fees. We pay off of our fee schedule. If in fact they are doing that, it is not under our guidance our knowledge and we just don't pull that kind of information to look at it. If they are doing that it is not because we directed them too. Our rules are bill usual and customary.

Chairman Pollert: The hospitals were done on standardized cost reports. Are ambulances the same?

Maggie Anderson: Hospitals you are right with the cost report. It's an annual report that the hospitals have to file. It's called the Medicare Cost Report. Physicians were done a little differently than everybody else. That partially was because the magnitude of trying to survey all the physicians in ND would have been great. We worked with the medical association to locate and use data that they use and their salary offers and knowing they have to be competitive in the market. We used regional and national and statewide data that they already provide to these practicing groups. We use that information to calculate the physician estimates. Probably more than any of the groups the Medical Association, we met quite a few times with the vendor to review the data from those entities and to make sure that it was ND targeted. Ambulance providers were done very similar to what happened with the chiropractors and with the dentists. It was a different vendor. That vendor happens to have multiple businesses and one of them is that he is an ambulance provider. He understands the ambulance system. He also developed a cost collection tool for ambulance providers. The EMS association took an active role in working with the ambulance providers to assure that we

had a good return rate. The ambulance providers are certainly one of those where you have the big and little. The big was of course, very sophisticated accounting systems and billing systems in some of your small rural ambulances that operate with some paid staff but a lot of volunteer staff don't have those same types of systems. They collected the information and developed the model based on that data collection. Those are the tools and if Representative Nelson wants more information I can provide that to him. The numbers at the bottom in terms of the trend didn't change they just did prior to that. The next item in the packet is the information that was requested on where we are at with the services that were rebased in terms of billed to pay. This is dates of service of fiscal year 2007. It is now over a year old in terms of data. In order to get that claims run out and make sure the claims were paid we use state fiscal year 07. For physicians the amount of paid to billed is 40.5%, hospitals were 40.48%, ambulance 29% and chiropractors a little over 35%. Dentists are on a separate sheet (Attachment). The first sheet shows you the 75%. This is what is funded in the Governor's budget. The 75%, if you look at the first numbers as to where we are today for children on average we are about 74%. For adults it is about 59% overall putting them both together. 66% with the 75% that would go to 78% for children, 76% for adults, and 77% for an overall average. You might question if we are going to a minimum of 75% why would that adult one now go from 59% to 76% and be higher than the 75%. The reason for that is there are some services today that are over 75% for adults. Not a lot but enough to take the others up to a minimum of 75 will bring that average up 1% point. It's not rebasing everything to 75. It's just bringing everything up to a minimum. The blue sheet is the same information but is just based on the 60% rather than the 75%. I believe that was the information you wanted on that particular item. The final one is the ambulance rates. A request was made regarding the Medicaid fee schedule as compared to the Medicare fee schedule. Keeping in mind that our

fees are affected July 1of each year typically. Medicare's are typically effective for the calendar year. We are off a little bit in our comparison. You can see the Medicare and Medicaid percentage just as one example. The ground mileage for basic life support, our fee is $5.41 a mile – their fee is $6.87 a mile. We are currently ay 78.75% of Medicare. If you will notice at the bottom we footnoted that we are using the urban base rates and mileage here. With most things there is never anything that is straight forward. Medicare has multiple fee schedule for ambulance services whether they are urban or rural. They have different specialty codes. We just have to pick one of them and do that. We picked the urban one to do the comparison.

Representative Kreidt: Urban v. rural. What is the proximity to Bismarck that is considered urban. In New Salem we are considered urban on our Medicare rate.

Maggie Anderson: You are in a metropolitan statistical area. You want to know the rural rate?

Representative Kreidt: Is there something like from Bismarck a circumference before you fall under that?

Maggie Anderson: My understanding is that it is the location of the service or where they pick them up. It's where they pick the client up. It's where that is established whether it is urban or rural. This information I am passing out is the critical access hospital detail (Attachment J). As with that information in regard to the dollars that were placed in the department's budget for the 2007-2009 biennium. We were asked to provide some detail on that. I will quickly walk you through this. At the end of the legislative session when that payment methodology was changed, there was 31 critical access hospitals in ND. Since that time there have been 4 additional hospitals that have converted. We have those listed there and the dates in which they converted. That brings the total to 35 at this time. We are aware that there are two additional critical access hospitals in progress. Jamestown and Richardton which we talked about a little earlier today.

Chairman Pollert: Can we go in to this a hair more? Representative Kreidt's question was about how the critical access designation was coming for Dickinson and how it relates to the HB 1433. My question is can you repeat what you told Representative Kreidt so I can hear it again?

Maggie Anderson: It's our understanding that when Dickinson accepted the grants from the federal government, there was a grant that was authorized last summer that allowed critical access hospitals who are converting to a skilled nursing facility or to an assisted living to access these grant dollars. Richardton applied for those and they were awarded $990,000 and the grant could be up to a million. Those dollars can be used to help them renovate their facility to make sure they meet the certification requirements to be surveyed by the health department under the CMS requirements. They could use those dollars to purchase the nursing home beds that they needed to get there 20 and other infrastructure that they had. Those dollars cannot be used to retire the debt. When they accepted that $990,000 it's our understanding from what Mr. Opdahl has told us is that at that point they agreed to relinquish their critical access designation at the point that it is going forward. If they didn't that day they are under obligation to do so. I want to say it is of six months when they sign that grant form. They are going to a critical access. They have purchased the beds that they need. They want to be a 20 bed skilled nursing facility. They have purchased those from within the system with the dollars that they have received. They have HB 1433 going through the process which would provide them a supplemental payment. The board at the Richardton Memorial Hospital has indicated that based on the current limits that are in place and the Medicaid rate setting for skilled nursing facilities, they cannot be financially viable without receiving dollars above those limits. They can receive a supplemental payment up to their cost as long as it doesn't exceed what is referred to as the Medicare Upper Payment Limit. So we have prepared the estimates of what

that would cost. That is the basis of that fiscal note for HB 1433. If the bill passes then we would apply to CMS to get approval to begin providing a supplemental payment . It's my understanding that everything is moving through the process. They are planning on or around April 1 of 2009 to convert to a skilled nursing facility.

Chairman Pollert: Does HB 1433 have to be passed in order to make sure Dickinson gets a critical access? That doesn't have to happen. They are two separate issues right?

Maggie Anderson: That is my understanding that because they accepted that federal grant that it was a contingency on the federal grant. The last two paragraphs that we have there is that our appropriations bill from 2007 contained $4.3 million to increase the critical access hospitals from the previous payment methodology to cost. The change was implemented right away at the beginning of the biennium. Just as a footnote that $4.3 was information that the ND health care association had calculated for the committee as based on their interest of moving the critical access to cost. Looking at our current information and the first year of the biennium and taking that forward for the second year, we are expecting to spend $2.7 of that $4.3. You already have the document I'm sending you. We thought you would need it as we go through the spend down table so you didn't have to try to find the other one in your folder. (Attachment K). You will see in your summary that the services that were provided in the detail encompass 90.4% of the traditional medical services budget. Indian Health Services, about the 6h item down is 100% federal funds. We do not have a break out table for you on that particular service. In patient hospital is one that you are going to need the reminder of the salmon colored sheet. At the time where we started building the budget our cost was about $65149 and our unites were around $6,800. We can add the inflationary increase and the rebasing of the 7&7 inflation. Then we have this gap of both units and dollars. That ties back to this example that we provided you that where we are doing the payouts and doing the offsets

they don't reconcile correctly as those offsets are happening. (Attachment L) You will see the footnote that indicated that this area is affected by the payouts and offsets resulting from the claims backlog. This impacts both the units in cost and the earlier handout. In addition the new reporting system that we discussed on pages 13 and 14 of the overview testimony tells you that we are using different payment methods. That reporting system looks at things a little different. It just contributed to it being off. Finally with the critical access hospitals being paid at cost and the other hospitals still being paid off of DRG's. Our out of state hospitals being paid at a percentage of bill charges. You mesh all of those together and it's a combination of those that are just throwing those off and the utilization is also showing a negative from the time that we built the budget. Outpatient hospital has the same type of methodology. We use November 07-September of 08. Those areas where we sunk down more into November, we did remove May of 08 from the data. You can see from looking at that, that the actual cost and units are quite a bit different from the other months. Something was going on there with the system and payment issues. The 5% inflation comes out to $1.29 but if you try to calculate from 1703 to 129 you won't get 5%. The reason that is goes back to having critical access outpatient, out of state outpatient, and in state outpatient. When we build those we can now get to the level of detail where we can build them very distinctly. When you roll them up they don't always roll up to 5%. The 7&7 inflation, when you look at the utilization you will see my footnote about that. We try to account for the growth that we knew of the two new critical access hospitals moving over from non critical to critical. We try to account for those units in the appropriate spots. Those services were rolled up into the overall outpatient again. Our utilization went down a little bit from the 138 that we had when we were building the budget to 137. Physician services were averaging out about $13.20 at the time we built the budget. The same inflation, the money for rebasing, the 7&7 inflation, and this is another one of the offsets and payouts. We

are up to 12 cents. That is a matter of how those things don't balance out. We are also seeing a difference in the units of a negative $920. Our average on drugs when we built the budget was $3724. Inflation and the loss of pre2008 J Code rebates. With drugs we don't apply the 7% or 4% on July 1. Its natural inflation is with the price of drugs. To cover that inflation to the end of the biennium and in addition to that we started invoicing J Code Drug rebates during this interim. When we did that we were able to go back as far as we were allowed to go back with those. Essentially we caught up in terms of expenditures but then we had to account for what that would reflect in terms of cost in the next biennium. That is the combination of the inflation and those pre J Code losses. We still have J Code rebates Budgeted. We won't ever be able to go back and invoice them for past years. We have already done that in this interim. Then we have a 4&4 inflation. I have a footnote at the bottom that says inflation is not 7&7 for drugs. This service is impacted by the actual cost of the drugs. As noted on page 13 of my overview we actually used 4&4 for brand and 2&2 for generics. Even though you will notice on that page of my testimony that we have a 68/32 split of generic brand. When you look at the cost of the brand drug at $149.13 vs. at $22.13 the weighting usually goes in favor of using the 4% inflation versus the 2. You are putting that 4% inflation on a much higher number for prescription. The next chart is t e Healthy Steps SCHIP chart. We used September 2008 which is our actually number from 9/2008 to begin with the final numbers for the SCHIP area. We also added 3911 what we expected for natural growth for the rest of the biennium as well as the growth we were expecting when we implemented 150 for SCHIP on October 1. We had an average of 984 additional. Then our 09-11 growth for expanding the 150 because that growth for the 150 actually is calculated out over a longer period of time than just the current biennium. That would still be going on for a little over a year into the next biennium. Then we had the growth for expanding to 731. That is an average of 731 over the biennium to get us to

the number of the house of 6021. Our premium is 243.93 which we have footnoted that is the premium from Blue Cross Blue Shield. Then a little explanation as to why we used September 2008. We looked at those numbers as late as possible in the process to make the best projections that we could. The next item is Premiums. Premiums for both our Medicare savings programs and they are also the premiums for Aids and other group health insurance that we refer to as cost effective. In other words it is cost effective for Medicaid to pay their existing health insurance premium. Otherwise we would be paying all of the expenses first rather than as a secondary payer. Our average cost when we began the budgeting process was 88/25. Plus the inflation on those premium costs effective January 1, 2009. Because most premiums inflation is for the calendar year. You get notice of your increase going up. You will notice here that you have inflation going up and broken up by the portions of the calendar year that are applicable to the time periods within the biennium. Both of those are 11.5% increase. That is based on what we are experiencing with those health insurance premiums and what we are dictated to pay by the federal government. So when you add all of those together you come up to the 111.51. Our case load of 9134 and below we provided for you our expectations for case load growth for the Medicare Savings programs. That information is available there. The Psychiatric Residential Treatment Facilities, these are our residential treatment centers for children. Our average at the time when we built the budget was 295.74. We did remove December and February from that in terms of cost. We have those whited out there because they were outliers in that process. We included the 5% inflation for the second year of the biennium. Then you will see an annual cost report increase very similar to the information we provided to you for nursing homes and basic care. This type of facility is an institutional level of care. It has the same type of cost reporting. We have to recognize those increases of cost in our rate setting. That is again for both in and out of state facilities. Then we have our 7&7

inflation. Our estimated growth of 1 child per month for the biennium bringing our case load to 93 and our cost to 381.18. Then on to dental services, the average of 4785 the 5% increase, the rebasing of 872, the 7&7 inflation of 623 gets you to a total of 6519. If you go down to the bottom and see what our to the house is, is a hold even case load. Our cost is a little lower in our budget. We have a little explanation. It is a 66 cent difference per unit. We budget children and adults separately. When we roll them together everything doesn't average out perfectly. You can see one is higher than the other. That is mostly attributable to that children services are at a higher rate on average than the adult services. It's throwing that average out. If you went to each of the tables there, they match perfectly as you roll them up. They come off 66 cents. The last thing you have in your packet is Durable Medical Equipment. This is one where on your grant summary sheet when we walk through that, last week you will see that the units went up significantly. We talked about that it is because of the new reporting system where we used to report a case of diapers is a unit. Now it is every diaper is a unit. The units went up. You can see the months that we used as an average. We did pull out September of 2007. That was an outlier. That is for the units. The costs were pretty significant. For the units the 145 then at the time if you look at the months as you were building the budget, you look at December, January of 08, March of 08 we were seeing an upward trend in our utilization. We trended that forward. We budgeted for an additional 62 units per month again keeping in mind a unit might be a wheelchair, it might be a diabetic testing strip, or a diaper. Units are very different in durable medical equipment. An additional 62 per month would get us to what is in the budget. (Attachment M) This is the request you had about the bills that the department is supporting. There are four bills in the house that the department is supporting. You have HB 1307 which is related to nursing home rate setting. This has to do with education. The funds for that would actually come out of the ACT fund where the match would come not from the

general funds. If those dollars would be needed in this biennium then we would receive the transfer of those dollars into the budget so we could draw the federal dollars down. The other three bills that you are familiar with are the 3 bills that were pulled out of here to place for the policy.

Representative Ekstrom: That should be $3,000 to $7,000.

Maggie Anderson: Yes. Thank you for pointing that out.

Chairman Pollert: We are in recess until tomorrow morning.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012- Committee Work

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 1/30/09

Recorder Job Number: 8206

Committee Clerk Signature

Minutes:

Representative Bellew: Called meeting to order, took roll, two members absent.

Alex Schweitzer: Testimony Handout (Attachment A). This is the information that you had asked for in respect to the Developmental Center. First on the chart is a breakdown of 1992-2007 in respect to comparison to the D.C costs and the national average daily cost. This is the Medicaid base rate. This wouldn't include medical in there. It does show you what is going to happen. I think one of the things that you might note about the Developmental Centers is that it is happening nationally as well as in this state. As you downsize costs for awhile will continually go up because you end up with a more high acute individuals living in your facility because of the smaller population and they have more behavioral issues and medical issues. Someone had asked a question about the budget and why there hasn't been a decrease in the budget this time. During testimony I said that is going to happen in the next couple of bienniums. If you remember that there is a $1.4 million that we actually did take out of the inpatient budget that we are utilizing for cares. We asked for a transition budget in 05-07 of $55,000 and last biennium of $1.1 million. We aren't doing this now. That is really the decrease which actually goes for work in the community to keep people out of the Developmental Center which has been our problem. We almost readmit more people we discharge. Until we get that

under control you will not see that population drop. I think that with this initiative and everything else we are doing, what you will hopefully see is a drastically reduced budget in the next biennial period.

Representative Ekstrom: On those readmits, the cause is primarily behavioral or care?

Alex Schweitzer: It is a combination. A lot of it is behavior but there is also some medical care. We also do short term stays for people. This week is a prime example. An individual went into surgery and the facility that the person lived at would not deal with them when they left the hospital so he was readmitted to the Developmental Center for that period of time until they were certain they could function in their facility. We get a lot of that. The majority is behavioral. That is why we put the CARES team in place. We were working on the mandatory screening so that the CARES team absolutely has to see everyone before they come back into the Developmental Center. WE think that will help as well. People can be worked with and kept with their home. That is where a lot of the $1.4 million is going towards.

Representative Metcalf: This is just a statement. We are transferring those 16 people over to that project you are talking about. I hope they understand that they better keep no the ball and work as hard as they can because their job is definitely on the line. If this does not work out they are probably history.

Alex Schweitzer: I think the team will do well. This is an effort that will help us maintain people in their home settings.

Representative Nelson: There have been a lot of questions about the lack of savings in the DD center. I know it's a challenge to lower the numbers with the acuities you are talking about. Also, we hear in the public testimony that there are advocates of in home placement that are dissatisfied with the slow rate of the drop in numbers. I'm curious on what year you are going to be able to get to this goal. You have a big challenge ahead of you.

Alex Schweitzer: I heard the same thing you heard but I would disagree somewhat that we haven't made progress. In 2000 we had 150 people in the DD. Today we have 123. That is significant progress when you consider the type of individual that you are dealing with. We expect to be at the 115 goal. You are looking at 150 to 115. That is 35 people which are very significant. I think it's a challenge but it has happened. We will continue to move people out. The 67 has been an argument. The advocates would like to see a lower number. I think it's likely going to be between 67 and 97. It's going to be difficult but I think we can get to the 97 number. That is the number that the staff have told me is a reasonable number to look at. When you get to that number you really start closing suites which we need to do. That is where you get a reduction of staff. In addition we are looking at different ways to deliver service there. That will also help in terms of reduction of staff. It's going to happen but this is really a transitional thing. You heard someone say to close a facility you would have to have bridge funding. That basically means you would have to have $50 million so you could maintain a Developmental Center and $50 million to transition people out. We are doing that without those kinds of dollars. It's a slow process but we are doing it in more incremental ways but I think we are getting there.

Representative Nelson: I'm glad to hear that because my guess was that you wouldn't get to 67. That explanation of closing suites does show some significant decreases in operations at the DD center. The legislator is going to expect that in some point in time. I think that we do understand your challenge today.

Alex Schweitzer: That is the goal. The goal is to get to that 97 number. We are working towards it and if we can start closing suites you will see some change in budget there is no question. The next handoff is about how we prioritize our capitol and repairs at the DD. I don't know if there are any questions about this.

Representative Metcalf: Do you have a viable working group or something that is looking at what needs to be done to downsize physically so that we don't have to have to cost of this large facility. I know we have discussed it but I'm just wondering if you have a group of people that are doing this as a requirement.

Alex Schweitzer: Yes. It's part of our strategic plan. We have people within the senate working on a variety of subcommittees, infrastructure, if we can utilize our buildings as rentals. We are doing that. We are looking at the whole plan. We have what we call future of the DC initiative that continually looks at staffing, operations in general. That discussion is ongoing with the DHS cabinet and Director Olson. These things are part of what we do and part of the overall strategic plan of the DHS.

Representative Metcalf: I assumed that you are looking at the possibility in providing individual homes within the community rather than this facility that has the power plants and heating systems.

Alex Schweitzer: That is correct. That is part of the excessive costs because there is a big campus. You have to have a lot of support staff and all of that. We are looking at more individualized living situations so we are talking about more direct staff and less support staff.

Representative Kreidt: Going down to the bottom of your list there, the sprinkler system, are these buildings not sprinkled now and you are going to be sprinkling them? Are these updates? I know there are some new federal requirements coming out in regard to that.

Alex Schweitzer: What number are you looking at?

Representative Kreidt: 18

Alex Schweitzer: We have sprinklers throughout the system and a lot of times when there are any changes here it is because of a change in regulation. That one is specifically for that reason. The next handout is dealing with when you asked with the DOCR pays us in the

Tomkins program. Essentially they pay us $4.7 million. The 09-11 it was $4.2 million with a 10% overhead cost that they pay for infrastructure, utilities, and part of the back costs. The total that they pay us is $4.7 million for this biennium.

Representative Nelson: How many beds are in the Tompkins unit?

Alex Schweitzer: There are 90 beds. There are 60 male and 30 female beds. The last handout you asked for is for extraordinary repairs at the ND State Hospital. Those are there for you. We are of course only looking at the 09-11 area there and they are prioritized down to 40.

Representative Bellew: These are all general funds and considered one time funding requests?

Alex Schweitzer: That is correct. That is pretty much what you had asked for in terms of additional information.

Representative Metcalf: When was that building built?

Alex Schweitzer: Around 1983.

Representative Metcalf: And we already have to replace the sewer system?

Alex Schweitzer: That is correct. There is some work that needs to be done on that for sure. What priority are you looking at?

Representative Metcalf: 6

Alex Schweitzer: Yes. That is going on 30 years old. We are talking 25 years.

Representative Bellew: Is that a septic type system or a city sewer system.

Alex Schweitzer: It is our system that will eventually be tied into the city. That is what we eventually will be doing. That is what part of this work is to do. We are actually going from own system into the city's.

Representative Bellew: Does the committee request any other information from the department at this time?

Brenda Weisz: We do have some requests you have asked for that are coming forward to you. We hope to have those to you Monday. I was going to deliver them to the clerk. That would be the question of yesterday of Representative Nelson on the PAR. We are pulling those numbers together for the ISLA and the inflationary scenarios at 4, 5, and 6. If that is ok with you we will drop them off at the clerk on Monday.

Carol Olson: I would just like to encourage the committee to think hard about the requests of the department's budget have been. If you have any questions please summon any member of us down here to answer them. I think you have seen our priorities. I think you know what is important to the department and what is important to the citizens of the state. I think if you look at the overview testimony that I gave and look at Brenda's you can pretty much understand what we have heard from the citizens, what we have picked up at our stake holder meetings, and what we have prioritized in our funding request for instance the medically needy, the ADRC. I think you still have questions about the ADRC. I'd like to clarify that it isn't redundant it isn't going to duplicate any services that we have out there right now. I would ask you seriously to consider what we are asking for in that pilot. Anything else you have questions about please don't hesitate to ask us to clarify them for you. As you noticed, we are here in 4's. We would like to clarify anything you have. I know you have a lot of work ahead of you and we appreciate it.

Representative Bellew: From my perspective I want to thank you and your staff. Your efforts have done a very, very good job. You need to pat them on the back.

Carol Olson: I will do that and yes they are the best staff in state government. They are super and committed.

Representative Kerzman: Could you put together something to show how much it would cost to get a single entry evaluation or assessment put together in the counties so they could assess all the counties. There seems to be a lot of concern about that.

Brenda Weisz: I'm not picking up on what you are requesting.

Representative Kerzman: They have like 3 or 4 different computer programs that you have to go through.

Brenda Weisz: Yes that is our eligibility system. Can I tell you where to find that information? It's on our OAR listing we do have the costs to replace that eligibility system. It's under the 5th category, 2nd page, and 2nd side of that sheet. I believe it's just over 18 million.

Representative Bellew: I think its $3.6 million total. It's $9.3 general.

Brenda Weisz: It's a 50 50 match. It has an additional FTE associated with it to go through the development.

Representative Ekstrom: How long would it take to implement that?

Brenda Weisz: I think what we are looking for is we were counting on a 24 month implementation to do the work. Right now the difficulty with that system change would be with that ITD and their staffing and the majority of the staffing being associated with the MMIS project. Right now there is a lot of difficulty for ITD themselves to do this kind of work. As far as the staffing for the projects that relate to our department with MMIS being so big and taking up a great deal of their resources.

Representative Ekstrom: Is there a smaller bite of the apple that we can take this time to get this started?

Brenda Weisz: We could look at that to see what pieces we could do. There would be a planning phase that you would have to go through. Similar to what we did with MMIS. Right now, this biennium, the majority of the funding is to do the whole implantation of the system. If I

back you up two biennium's we did actually have a planning phase to that. There is planning involved in that number and there are steps that need to happen before you go forward with the development and looking as to what kind of changes you make, what kind of off the shelf there would be and that sort of thing.

Representative Ekstrom: This sort of goes hand in glove with the single point of entry does it not?

Brenda Weisz: I think it would assist definitely. Anything that would consolidate your eligibility systems and anything that would consolidate and make things easier from a processing standpoint would certainly help. The more we can bring things together the better it is and more efficient it would be.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1012 Amendments

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 2/4/09

Recorder Job Number: 8650

Committee Clerk Signature

Minutes:

Chairman Pollert: Called the meeting to order and took roll call. Every member present. Am handing out information that was given to me by the health care association (Handout A) and from Mr. Cichy (Handout B) about the dental. Before we get started who could talk to me about SB 2074. It is an autism bill. Just so everyone knows we aren't going to be voting on any amendments today. All we are going to do is ask for amendments whatever they may be. That is what we are going to do. I would hope to have a little debate but I don't think it is necessary for us to have a lot of debate. We will be coming back as a committee to vote on the amendments and HB 1012 on Tuesday of next week. We will probably start at 8:30. We will do the amendments on HB 1012 at that time. If I'm correct we are going to have to have time because legislative council has to write them up and we have to come back. We will have to have whole appropriations give us some time. Hopefully we can get to HB 1014 this afternoon also. I know on the green sheet in the DHS budget there is money in for autism from birth to age 5.

Brenda Weisz: Up to age 5.

Chairman Pollert: Do you know what SB 2074 does? That is about a $3 million fiscal note.

Brenda Weisz: I cannot.

Chairman Pollert: Could you find that out?

Brenda Weisz: Yes we could have JoeAnne Hoesel talk to you. She is at a hearing right now.

Chairman Pollert: Ok thank you. That might help make a decision as far as what is on here. If you remember this is a very informal process. We only ask for amendments and no motions. With that I will ask for amendments for HB 1012.

Representative Ekstrom: I'm asking for a study directing the department to report the uncollected arrayed numbers in terms of total as well as interest accrued . As separate numbers and to report on the practices of other states, which ties in with their study, to consider a new model for our system in ND. I have a little bit of whereas language. What I'm trying to get at is that other states are obviously charging interest. It's racking up to about $275,000 a month. We aren't seeing what I consider is a true number what is owed. Obviously they owe the interest. I just want to know if we are making progress with the collections. What have we managed and not managed to collect. And also to look at the uncollectable and whether or not we are writing that off .

Representative Bellew: Uncollectable? What are we talking about?

Representative Ekstrom: If such a low dollar amount, is it worth our time to try to collect it.

Representative Bellew: Where is the money coming from?

Representative Ekstrom: People who haven't paid their child Support. I'd like to add funds to the peer project which is the mentoring project for mentally ill. We would be adding $4.6 million additional of which $2.7 is general and the rest federal. It's on the OAR.

Chairman Pollert: I just want to make sure that I'm tracing through to what you are asking.

Brenda Weisz: It is second from the bottom on the first page of the OAR sheet.

Chairman Pollert: It is peer support. Could you give me a brief explanation about it again.

Representative Ekstrom: If you remember testimony from the public. We had several folks come in that have been mentally ill. This is an employment program. We pay them to mentor and buddy up with other individuals who have recently gone through mental illness. If you will look at the OAR sheet on the back, the last item is in blue. Centers for Independent living was only partially funded in the Governor's budget with $800,000, I would like to fully fund it. That would allow them to do expansion in terms of sites.

Chairman Pollert: Each side of the aisle has met separately the last couple of days. If we have to bring someone forward for an explanation we will do that. With the $800,000 didn't that include them going into Wahpeton and doing some outreach?

Representative Ekstrom: There is a little more going on with outreach that we had.

Chairman Pollert: I have the amendment on my desk but I forgot it up on the house floor. What my amendment is going to do is for the Developmental Center but what it will do is help with the admissions at the Developmental Center. It would tighten up the admissions because we need to be on a schedule to dropping down the clientele. There will be an amendment on that.

Representative Ekstrom: Are you calling for new admissions or talking about the facts that folks are coming back from the community and re-entering.

Chairman Pollert: It would be both. They would go through a more stringent process. We are trying to get the numbers down at the Developmental Center. That is what those amendments would work on.

Representative Nelson: Adding to the Human Service budget, I would like to have an amendment drawn up for a $2.1 million for assisted living rent subsidy.

Chairman Pollert: Was that an OAR?

Representative Nelson: Yes.

Chairman Pollert: Can you tell me where that is at?

Roxanne Woeste: It's on the back page. It's the second one under provider requested enhancements.

Chairman Pollert: Assisted living and board subsidy? Ok.

Representative Kerzman: I would like to offer an amendment to get a comprehensive eligibility system started. I got some information from the department. To get started we would need a couple of temporary positions that would go away after they get the program up. It would be $100,000 on that. We would have six county members to go through the needs with them which would be about $85,000. They figured the contractor would cost about $500,00 for a total of about $685,000 that would be split amongst general funds. It would be $342,500 each way. It would address a lot of concerns out in the counties if we would try to get the single assessment going. They wouldn't have to have individual sessions for every program. It wasn't an OAR but I think to get it fully run would cost about $18 to try to get something going.

Chairman Pollert: I've gotten some emails on the computer eligibility system. Is that what you are talking about?

Representative Kerzman: Yes if you look at the fact sheet of OAR's and the eligibility system replacement, it looks like a total of $18 million. I just want to see to get something going to look at it by next biennium. I know the counties are pretty adamant that we do that.

Chairman Pollert: When we initially start the groundwork on the computer process, is it normal for us to start with the funding to start the process?

Brenda Weisz: Yes. There is usually a component you have to do some planning before you move in to the whole full fledged product. You need to lay out the groundwork as to what you are going to do. We did that with the MMIS project as well. We had money in the budget to do the planning. The next session we came forward with the development costs.

Chairman Pollert: It seems to me that Cytec was number 3 or 5.

Brenda Weisz: it was number 5.

Chairman Pollert : Do you remember how much money we had to put up front to start with MMIS.

Brenda Weisz: The number that sticks in my head is $10 million. We spent $10 million the first biennium. The plan might have been $5 million. We will check. I think it was somewhere near $5-6 million.

Chairman Pollert: Would it be my suspicion that whoever is here in the next biennium that this eligibility computer system is going to be on? I would suspect that it is going to be in your budget probably.

Brenda Weisz: We will come forward with the request.

Chairman Pollert: How fast would this speed up the process?

Brenda Weisz: This would probably give us a good 6 month start on it.

Representative Kreidt: In regards to basic care facilities and their personal needs allowance, I would like to increase their allowance from $60 to $75. I'm thinking this is going to cost $150,000 in general funds.

Chairman Pollert: When we don't have the exact, I take it you will get a hold of DHS and have that conversation?

Roxanne Woeste: Right.

Representative Kreidt: Number 2 is on the nursing facilities asset limits we all realize that nursing homes are beginning to age. There is a lot of new construction going on . We have an asset limit right now that I feel is a little bit on the low side. I would like to increase the nursing limits for nursing facilities of general funds to $324,506. What that amount of money will do is

allow us when you are building the facility to have the dollar amount when you have a private room and semi private room it would be to increase .

Representative Ekstrom : Would this pull in federal funds too?

Representative Kreidt: Yes a little over half a million dollars. Moving on, in regards to basic care facilities and nursing facilities I want to put in a benefit and wage path for those facilities. This will be for individuals in those facilities that are making $15 and less per hour. More or less directed to CNA's, dietary, housekeeping, and your maintenance personal. Broken out it would be about 75% of the individuals now working in those facilities, around 10,000 employees. Using dollars out of the general funds and out of the health care trust fund to do that. I'm going to use a dollar amount in my amendment of $14 million in general fund and $1 million in health care trust fund. If my memory serves me right we have about $1.375 million left in the health care trust fund. We will have to check that. $3 million was used already in the department's budget in regards to long term care.

Chairman Pollert: If Roxanne has a question she will get with you.

Representative Kerzman: What did you say the wage pass was going to be? An hourly figure?

Representative Kreidt: Something along the $2 range.

Representative Metcalf: As I recall you mentioned basic care and long term care, this has nothing to do with the DD facilities?

Representative Kreidt: No it doesn't. I believe there will be further amendments coming forward in regards to DD.

Chairman Pollert: Do you have numbers basis 50 cents an hour or $1 an hour?

Representative Kreidt: I will be getting those. Right now I am using a $2 an hour figure with this dollar amount.

Representative Ekstrom: Will it be at the discretion of the supervisors at the facilities to decide who gets what?

Representative Kreidt: It will be up to the administrator or supervisory staff. I think we would probably have a way to a degree to track that through the cost reports. We should be able to track that because we would see where the increases are. This is what they would have to do. This would be effective July 1, 2009. This is where we are hurting in these facilities in attracting staff. Instead of going through the regular process of where they receive their increases and inflators. We would want to enable these facilities to plug those salary increases in as quickly as they can and be able to maintain the staff they have. A lot of the facilities, the turnover they have would be a big problem.

Chairman Pollert: So you are going to have a statement of intent as far as how this amendment goes?

Representative Kreidt: Correct.

Chairman Pollert: We know we have oil dropping and that the revenues are dropping as well. In your amendments, do we need to ask for amendments on the 50 cent or one dollar? Are you going to bring that forward so we can have a discussion amongst the section?

Representative Kreidt: Yes I will bring it forward.

Chairman Pollert: Will that be ok? We will have the $2 out there but if we have amendments we can substitute them.

Representative Kreidt: In regards of talking with those dollar amounts right now, I don't know how many of you are aware of this. Looking at the nursing home numbers, approximately around 49% of the facilities are doing contract nursing. They are spending about $3.5 million a year in doing this. I'm hoping that with this amendment and being able to plug in those dollar amounts into those pass through for wage and salaries that we are going to see a significant

amount of this contract nursing come down. We are already paying for that. We can see that number come down significantly. This will offset that amount to some degree.

Chairman Pollert: Could you have the amendment to say it would eliminate contracted services?

Representative Kreidt: We can't say we would eliminate it. It would be nice if we could but if you have a facility out there that is in a real spot and needs staffing, they have to go that direction. I'm hoping that we can give them that amount of money to plug into CNA salaries. Some of the facilities that have nursing staff haven't been able to raise their salaries. I hope they can get to a place where they are competitive and not have to contract for those individuals.

Chairman Pollert: Are contract services and wages both involved in the direct cost of formulas? What would to say if the $14 million passes but the contracted services are still out there, is that a way to still raise the rates? I'm not being accusatory just asking the question.

Representative Kreidt: I can't sit here and guarantee that we are going to eliminate all contract nursing. I would hope that we can eliminate a significant amount. You have to realize that under contract nursing if you are paying an in house nurse $20 an hour and you are contracting a nurse outside of the facility you are paying that nurse $60. If they are driving you are probably paying their mileage and their hotel and everything else. It would probably fall into different categories of your cost expense. Still, if I was an administrator facility and I could give my staff that are underpaid $2 an hour I would make every effort I could to eliminate what contract nursing I am doing. These facilities don't want to do it they are forced into doing it because they just aren't able to give those individuals the salaries they need and deserve in those communities to attract those people to come and work for them.

Representative Nelson: I think the last time this was done was after the money was used for the wage increase. This industry has a turnover in excess of 50%. The last time this was added it was $1.50. On the chart, the turnover declined very rapidly. That is the whole thing. If you can attract and retain nurses your contracts are going to go down. There are obviously areas in the state where your employee opportunities are less. To eliminate contract nursing would be hard to guarantee. I'm certain that if something like this would pass you would see a rapid decrease in contract nursing. I know for our facility in Rugby we have had occupancy at 100%. On a monthly basis we are losing money. It's hard to imagine how this could happen. That's an area that is the most likely place this loss occurs because of contract nursing. This just kills facilities.

Chairman Pollert: We know that there is equity in the state employee funds. I know that when we do that it affects the salary ranges for the nursing homes and the long term care industry . I know there are amendments going to be coming forward. Whatever passes we have to be cognizant of the fact that if we do this for long term care we are going to have problems with DD. We have to keep that in mind with our deliberations as well. In all these discussions, I am going to ask for a discussion on the inflator. If we are going to do a wage increase we have to have a discussion on the 7&7.

Representative Metcalf: I just have a question. Unless I misunderstood you, you mentioned that the state employees will get that raise and so will the DD and long term care. Is that what you said?

Chairman Pollert: No I said if we do a 5&5 and do equity, I know that affects high acres manor and all of them in the Jamestown and Valley City area. Then we have a salary discrepancy between the state hospital and long term care facilities. Then we know we have a discrepancy for opportunities. This is an effect that we have to keep in the back of our minds.

Representative Kreidt: I have an amendment that will be attached to HB 1012 in regards to the health care trust fund. My amendment will say any money from the health care trust fund can only be appropriated by the state legislator.

Chairman Pollert: So what you are saying is that the DHS cannot have that as far as a funding source in the Governor's budget?

Representative Kreidt: Yes that is correct. It can only be appropriated when we are in session and directed to that. Nursing homes would generate those funds. It was put into the long term care. I would feel better that whoever is here as the years go forward that they would handle that fund. There is money coming in continuously and it will for the next 15-20 years.

Chairman Pollert: Roxanne, can the legislator hold off limit trust funds from the Governor's budget and from agencies appropriating them?

Roxanne Woeste: I would have to do some further checking.

Representative Kreidt: This one goes to the green sheet, page 6, number 25. This is the compulsive gambling services. Historically, $400,000 of special funds from the lottery is used to do what we do with compulsive gambling. There was a general fund increase of $300,000 that would have increased it to $700,000. My amendment would state that we would include, instead of the $300,000 the $100,000 to bring the amount up to $500,000 for compulsive gambling.

Chairman Pollert: So you are asking for an amendment for $200,000 decrease in the funding?

Representative Kreidt: Yes that is correct.

Representative Ekstrom: Do you have a rationale for why that is?

Representative Kreidt: Personally I don't think it should be in the budget. I think it should be

in the Attorney General's office. That is almost doubling those funds. Let's give them the $500,000 and see where we go in further sessions.

Representative Metcalf: For the Children and Family Services, they have requested an additional $200,000 be added on the CFS.

Chairman Pollert: Is that an OAR? Or is it for a particular service?

Representative Metcalf: It is not for an OAR. It is for an expansion of services that are currently provided.

Chairman Pollert: Are you talking about health families?

Representative Metcalf: Yes Children and family services.

Chairman Pollert: What segment are you talking about? Last session there was $300,000 appropriated for the healthy families to start in the Grand Forks area. Then they expanded through a Bush grant to Burleigh and Morton County to a couple hundred thousand. Then they were asking for a couple hundred thousand to substitute. Is that what you are talking about?

Representative Metcalf: I am talking about the testimony that was provided to us in open testimony day. It was provided by Lutheran Social Services. That is underneath healthy families programs serving the counties of Burleigh and Morton. They want to expand their services. They have basically testified that they could easily pay for the additional costs with the services through the families that can be saved through early intervention.

Chairman Pollert: Yes I think you are talking health families.

Representative Bellew: On the OAR sheet it is the second to last one. Is this the same thing?

Representative Metcalf: It is in addition to that $300,000. It's to add another $200,000.

Chairman Pollert: Are you saying that you want the OAR of $385,000 plus the $200,000. I know health families had asked for about $200,000. You are showing the OAR plus $200,000. The whole appropriation would be $800 and some odd thousand. Currently last biennium we

did $300,000 to start the healthy family's project. If you add the OAR of $385,000 you are looking for a total of $685,000 or $885,000.

Representative Nelson: I'm guessing that the $300,000 is in the base budget. Their OAR is for $385,000. So we are talking about $685,000 with an additional $200,000.

Representative Metcalf: $200,000 additional above what the OAR has requested.

Representative Nelson: From this wouldn't we be using plus $585,000.

Chairman Pollert: That is what I understand is that it is an extra $585,000. We are looking at $885,000. They are at $300,000 at the base budget. There have been emails asking for an additional $200,000. That would raise it to $500,000. Representative Metcalf is asking for the OAR of the $385,000 with the $300,000 plus he wants an extra $200,000 on to the $385,000. Instead of it being the $500,000 that would equate to the emails that I had received, Representative Metcalf is asking for the OAR to be added on to that.

Representative Nelson: I have a couple amendments. At the State Hospital in their capital improvement line item I would take $1 million from their request. I believe that still funds on their priority list, it funds 1-15 or 16.

Chairman Pollert: Wasn't it for $3.2 million of onetime funding? Are you saying you want to fund priorities 1-15? Or are you saying you would leave it up to the discretion of the state hospital and DHS on how they would want to address that?

Representative Nelson: I would like to see the State Hospital have the discretion to use the funding and have the flexibility to use it as they need. It would be a $1 million savings in this area.

Chairman Pollert: Can I bring Brenda up for a question? This pertains to Representative Nelson's amendment but it doesn't. It also pertains to the economic stimulus that might happen. We don't know what that means. With the capital expenditure of the $3.2 million, there

is $3.9 million in the DHS budget of one time expenditures. If there is money coming on the economic stimulus package could those dollars be used for the capital expenditure projects? My concern is with the economic stimulus package is we are going to throw whatever it is going to be, we will fund more ongoing programs causing more of a problem when the federal government figures they can't keep spending money. They are going to reduce those dollars. We are going to have the wrong programs that we are going to have to use general funds. I'm asking for one time funding. Do you have any idea when the economic stimulus package would be allowable for this?

Brenda Weisz: We continue to work with Office of Management and Budget on the economic stimulus package. One of their budget directors is the lead on the package. There are some categories specifically when you look at the categories that pertain directly to DHS there wouldn't money to that. There are some other categories that have improvements that are combined within those categories that we don't dive in to as much. We will be working with Office of Management and Budget to find out if some of those can extend to areas of those budgets. From the funding that directly comes to us or that they are proposing that will effect DHS programs, the answer would be no for that. However, some of the other categories we aren't sure with. We are still trying to unravel what all of that means and what kind of requirements for any of the other improvements that they are talking about in other categories.

Chairman Pollert: We know we have a long ways to go in a short period of time to see how this is going to unfold. This is probably going to unfold in the second half so we have some direction.

Representative Nelson: With that having been said, I will ask for an amendment to be prepared to reduce and take out the resurfacing and paving line on that priority list for $300,000. Then maybe there is some better understanding that will take place .

Chairman Pollert: Are you talking $1.3 million.

Representative Nelson: That would be the total. That line item would be removed completely in this amendment. It does take away some of their flexibility. I have another. At the Developmental Center under the capitol improvement I would move to reduce by $150,000 from their priority list as well from capital expenditures.

Chairman Pollert: Are you saying that it is at the discretion of the head of the developmental center? The one stop center and DHS?

Representative Nelson: Yes it is. I believe it would allow about half of their priority list to be funded.

Chairman Pollert: I think their expenditures were about $700 and some thousand dollars. I know there were some roofing projects in there that we would do if they are leaking.

Representative Nelson: Although they would have the flexibility to choose which projects they go forward with. Certainly it is my understanding that the funding would be available for the major roof projects.

Chairman Pollert: So you are still going on with the priorities they asked for with the listing of Alex.

Representative Ekstrom: We have several stand alone bills. The money is in the DHS budget. All we sent to policy committee was the policy part. When are we going to see those things being plugged back into this? This is certainly going to affect our ability to make a judgment on where we are going with this thing.

Chairman Pollert: If I'm correct, it wouldn't be my intention to ask for the removal of them. Those have already been removed from the DHS budget and put into the policy committees. If the policy committee comes with a do pass it will come to the appropriations. If it comes out with a DNP it will go to the house floor.

Roxanne Woeste: I believe that is correct.

Representative Ekstrom: What I would be asking is that if we have a sense of timing on that right now?

Chairman Pollert: The fiscal notes are all supposed to be out of the committees today. Either Friday or Monday they are supposed to be out by then. If I understand right they are still being pushed to pull the fiscal notes out of the committee's today. By Tuesday we should know. We may have to ask if there are amendments on that or what we need to do with the time. That is what we are trying to do. The money is still in the DHS budget but in a way it isn't. I think it is just going to go to the whole appropriations because we are going to run out of time. Those three we are going to have to keep in the back of my mind. There is a dementia bill out there for about $1.2 million. Since they aren't in the DHS budget right now we don't have to account for that?

Roxanne Woeste: The dementia bill is a separate stand alone bill. I believe it is in the Senate right now. No it is HB 1043 so it is in the house. It might be coming your way. I don't believe it has any tie in to the existing budget.

Chairman Pollert: That is why I'm trying to get a feeling. I want to know what SB 2174 does for the autism. I think it is Sen. Lee's. Is that related to the autism waiver on the green sheet?

Roxanne Woeste: I believe that SB 2174 doesn't directly relate to the autism waiver. It may do so indirectly. It creates an autism spectrum disorder task force. It lays out who should be in that task force. The members are supposed to be appointed by the Governor who gives the task force specific duties and responsibilities. The appropriation that is tied to that bill is $3,000 from the general fund. It goes from the department of human services. It is for expenses relating to the task force itself.

Chairman Pollert: Someone told me it was $3 million.

Brenda Weisz: It was. It started at $3 million. It was amended down to $3,000.

Roxanne Woeste: I think it is introduced at $5,000. It just relates to expenses associated with this task force.

Brenda Weisz: What you are referring to is an individual that worked on the bill did put a budget to it to just under $3 million. That is probably what you saw.

Chairman Pollert: I didn't see it, I was just told. We are trying to find out what is where.

Brenda Weisz: Initially they designated the health department for the oversight of that bill. They then switched the fiscal impact.

Chairman Pollert: The autism waiver is $450,000 some dollars on page 5 of the green sheet. What is the objective of SB 2174. If the objective is to try and figure out what the task force should do, then my question would be why should we do the $450,000 of autism and the FTE if we have a task force trying to figure out which direction we should go.

Brenda Weisz: The purpose of where the department went with their request was actually to provide the services to the children that would be diagnosed with autism and then would qualify under the waiver. Ours is services driven. To provide the services for the individuals that would be impacted. The other bill talks about establishing the task force to oversee that I would imagine. We would work with what the families are bringing forward as to what they are seeing with autism.

Chairman Pollert: I understand that. I know that you are a lot smarter than I am with the services. Are we getting the cart a little before the horse when we have a task force out here? Just for a little further discussion I am going to ask for an amendment.

JoeAnne Hoesel: I will give you some information on how this evolved. The Department of Human Services pulled together a group of stakeholders last spring. That was to provide us some guidance on how we address the autism issues and how it can be dealt with. Out of that

came the request for an autism waiver for 0-5. In addition, Congress provided funding to Minot State University for funding that deals with school age individuals that have disorders on the autism spectrum. The autism task force formalizes a group that is already meeting on how the state of ND needs to address the areas of autism spectrum. These are areas that have already been identified. We have the transition age group that we have not addressed. The 16-24 year old that has autism spectrum disorders. We also have adults that have autism spectrum disorders. We have not really targeted our attention. That task force will not only provide us guidance on how we write the autism waiver. They also provide guidance to Minot State to provide guidance to how they are addressing the school age so all the pieces fit together. I think this is a continuation and making sure we are all on the same wave length and not having a conflicted system.

Chairman Pollert: I'm still going to ask for that. I take it this must be Sen. Gary Lee and not Judy Lee? I'm still going visit with the policy committee. I'm going to have the discussion. I'm still going to ask for that.

Roxanne Woeste: I believe so but I think we got caught midstream. You started your amendment but I don't think you completed it. Do you want all of your funding out for the autism waiver? Is that where you are headed?

Chairman Pollert: On page 5 on the green sheet it is the last paragraph. $450,724 I want a chance to talk to the Senators to see the intent. I just want to have the discussion before I get to there and the talk to Sen. Judy Lee as well.

Representative Nelson: So if I understand you, your amendment is to eliminate that?

Chairman Pollert: We are going to have a discussion. That is what it is going to do, yes. That gives me a chance to talk to the people I need to.

Representative Wieland: It is my understanding that within the department they have some flexibility in how to utilize FTE's. There are two FTE's in here that I would like to take out and then we can have the discussion on it to see whether or not that they can be replaced by existing FTE's that will not be filled. One is on the green sheet under management, Item 1. There is $56,724 in general funds. Total is $129,055. That is the auditing standards. The other one is on page 5, under 16, the waiver for home and community based care. There is an FTE position in there. The general and the federal both are $66,872. I'm not asking to remove any part. I'm just including the FTE.

Chairman Pollert: Are you talking about the autism waiver? I already asked for that one. Your amendment would take out the FTE but keep the autism in?

Representative Wieland: That would take out the FTE but keep the autism in so there is a difference.

Chairman Pollert: You talked about an FTE about grant writing?

Brenda Weisz: That was a .5 FTE

Chairman Pollert: Where do you have that under the section of DHS?

Brenda Weisz: It's not on the green sheet under administration and support.

Chairman Pollert: If we don't ask for that amendment it is still kind of in there then?

Roxanne Woeste: That's not a new .5 FTE. Perhaps they are adding money to an existing position that has been funded.

Brenda Weisz: It's a realignment of staff to meet the priorities of the department.

Chairman Pollert: You haven't gotten the general fund as to what that would do?

Representative Wieland: On the waiver the general fund would be $66,872.

Brenda Weisz: To clear up the confusion between 2174, we mixed it up with 2198. SB 2198 is actually a TBI bill. That bill has an appropriation of $2.6 million to the DHS for TBI services.

The reason that there is additional service dollars in that bill is the result of developing a registry for TBI with the thought process that there would be others that once they saw registry and were on the registry or realized that there would be services available, more would come forward. That was the confusion with the $3 million for 2174 it is actually 2198 and that one has two appropriation sections. That bill 2198 has the two sections and one is for $40,000 and the other is for $2.6 million.

Chairman Pollert: I want to have an amendment drawn up for a discussion. I need to ask a question. Anything with global health whether it's at the state hospital or the human service centers; I think that amount was $4.3 million. We do have some discrepancies on the green sheet with some items and also from what DHS says is an example, the CIL's and the community for independent living services. I can't remember what that number is. All the testimony showed an increase of $800,000 for CIL's. I think the green sheet showed $900,000 some thousand.

Roxanne Woeste: It is $800,000.

Chairman Pollert: What I'm saying is with the $4.3 million that is what is pulled off the green sheet. Anything related to global health initiative, I'm asking to pull it. The whole thing. The Cooper House staffing, because of how it was written in the testimony, is that part of global health or not part of global health?

Brenda Weisz: It is part of global behavioral health. The staffing that we had built in that global health capacity issue OAR was a contracted FTE. It is included within that number. Your number is correct with general funds. It is $4.3 million. That is what it should be. The contracted FTE is all we had related to Cooperhouse.

Chairman Pollert: So there is nothing else for Cooperhouse in the budget? Let's say the staffing stays in for the Cooperhouse. Does there have to be an amendment drawn to make sure that all the contracts are signed before this happens?

Representative Ekstrom: What I would suggest is let's put the Cooperhouse as a standalone. Then we can put that instruction into the language so that they indeed have to have all their money in a row. The local commitment on this has already been done. They have already done demolition work. They are a long way down the road.

Chairman Pollert: So your amendment would be a separate one as far as the Cooperhouse? Then we would want some language as far as that goes for the amendment to make sure that everything is done before we commit ourselves.

Representative Nelson: I'm confused as to what the dollar figure would be for the Cooperhouse contract. I had $279,178 as one. I don't' know if that is right or not.

Brenda Weisz: It is 24/7. I need to check my notes. I have it as $315,360.

Chairman Pollert: Are there further amendments to HB 1012?

Representative Bellew: This pertains to the green sheet again on page 6. This is just a discrepancy I saw between Legislative Council and DHS. Number 23 they have listed $323,921. I think I wrote it down as $308,496.

Roxanne Woeste: The difference could be the compensation package. I've noticed on some of the schedules. Sometimes there is a minor difference. The numbers on the green sheet would include the 5&5. Those numbers were taken right from salary reports.

Representative Bellew: This is the one FTE position with background checks for child care providers.

Brenda Weisz: We get a sheet from Office of Management and Budget that tells us what the Governor's recommendation is for our FTE's and what they add in general funds. The amount

that the Governor's office added for us is $308,496. That is what I would have added for general funds. On top of that they do add the salary package. We get the number from Office of Management and Budget before that and they give us a separate number for the salary package. For the 5&5 on those two half time positions which equate them to a 1.0 FTE that would have been included in the commentary from when Tara Muhlhauser did her overview. It would be within the difference between the green sheet number and my number that the 5&5 would have been reported in a category where we tell you what the 5&5 would be.

Representative Bellew: Is the number on the green sheet right or not?

Brenda Weisz: Both numbers are right. The reason that I will report to you exactly what is added to that position specifically is often times when we go through the legislative session there are adjustments often times to the Governor's salary package. We keep those numbers separate so when you actually go in and do an adjustment. If you would change anything in the 5&5 we know what those numbers are. Let's say it changes to a 7&7 then we know which ones to increase.

Representative Bellew: I'm going to request that $15,921 be taken out of that.

Brenda Weisz: If you take that 15 out you are taking that 5&5 out but you will have enough to cover that.

Representative Bellew: On the medically needy budget levels I would like two amendments to raise the rates to 65 and 75%.

Chairman Pollert: Currently in the DHS budget it was 83% of poverty. You said that was 75% and 65%.

Representative Ekstrom: Do you have any sense of the dollar figure on that?

Representative Bellew: I don't at this time.

Chairman Pollert: We are trying to get the dollar figures. You said that it was 65% and 75%?

Representative Kreidt: I don't have an amendment I just want to make an introduction. Today is National Cancer Awareness day at the capitol. My son and his wife and three of my grandchildren are here. One of them is a cancer survivor who is Anna. They are here for the day from Dickinson.

Representative Bellew: On the OAR, number 2 it says the capacity and DD case management and 4 new employees. I want an amendment to remove that OAR.

Chairman Pollert: On page 7?

Representative Bellew: It is the 2nd one down. That does correlate with page 7 on the green sheet. According to the OAR it is $201,252.

Chairman Pollert: The green sheet shows $235,000.

Roxanne Woeste: I believe the difference is the compensation package. When I remove positions I take all the funding associated with that position.

Chairman Pollert: We have a vacant FTE listing. If you remember the last biennium we asked for an underfunding of salaries of $1 million. I'm going to ask for an under funding of $2 million. If you want to know how I got that figure, basically all I did was I took the vacant FTE's. There was 114 on the list and 40 got filled. All I did was take the remaining 74, took that and divided it by the general funds and did about half of that. It comes out to pretty close to $2 million. Same as always, that money is left up to the discrepancy of DHS how they want to do that. There were 2 $1 million deals.

Representative Ekstrom: In this current budget I know that we made up for underfunding issues. Can you tell me that number?

Brenda Weisz: For management and program policy it was $600,000. Then for everything else it was $2 million with a total of $2.7 million . There was a general reduction made to the

human service centers, anywhere between $800-$100,000. That wasn't said to be a salary underfunding but it was a general fund reduction. Can I ask a question on the vacancy map. With the 40 positions that were filled, did you remove the general funds associated with those filled positions then had a remainder of general funds?

Chairman Pollert: There are 114. I took out the 40. There were 2.136 that I took away from the 6.13 which left 3.970 of the 74 unfilled and I split it in half.

Brenda Weisz: The institutions are already underfunded by $1.3 million so that would double underfund them.

Chairman Pollert: I understand that.

Representative Wieland: This would be on page 7 of the green sheet. It refers to OAR's. It's the young adult transition services. One is for Southeast at $426,844. The other is for Westcentral at $750,000. I'm pretty sure the Westcentral is brand new. I'd like that in two separate amendments to discuss removal.

Chairman Pollert: So you want to have 2 separate amendments?

Representative Wieland: Yes. Those are two OAR's and I don't know why they would be separately listed on the back page of the OAR sheet. The other one is to put a pass through dollar amount for the workers at nursing homes. I would like to do the same things for DD's. I'm hoping we can work it out so the dollar pass through would be the

Chairman Pollert: So are you saying you are looking for the $2 added on?

Representative Wieland: We can put $2 in. I don't know if we can handle that much. We are getting numbers for 0.50, 1.00, 1.50, and 2.0.

Chairman Pollert: So we will have the same discussion with DD as we would for long term care. Do you have the maximum amount it would be?

Brenda Weisz: It's on the backside of the page. There is a DD provider increase. The general funds are $14 million. That is for $2. We are doing work on the other increases as well.

Chairman Pollert: So we don't need to ask for the amendments because we will just have that discussion as we get in and discuss these two amendments?

Representative Wieland: That is fine.

Brenda Weisz: We will still work the numbers.

Chairman Pollert: We will ask for those numbers before we get started. These have got to be separate amendments. We had this study on the reimbursement for hospitals, physicians, ambulances. I am going to ask for a discussion. The hospitals were put at 100% of the costs. Did that get into the Medicare level. What did that do again? It's 100% of the standardized cost reports. I'm going to ask Roxanne to get the information on 80% of that. It would be a 20% reduction, and also a 90%. I could go back to the sheet and tell you how much that would approximately be. That is going to have to come from Brenda, Maggie, and Roxanne to work out. If you take a look we have a good sheet to go off of. It was handed out earlier.

Representative Ekstrom: That's $8.1 million?

Chairman Pollert: Correct. I'm not talking the inflation factor. Beings we are on hospitals I am going to ask for the information on the rebasing of 15% physicians, based off of the 25%. On this report the rebasing was 25% of the costs of what they got. Currently, physicians are at 51% of costs. The Governor's budget put them at 64% of costs. I also want to find out on the same page, I want one at 50% of the report and 75% of the report. I'm saying there is $153,836 of general funds. I want to know what 50 and 75% of that is. I'm going to want an amendment on ambulances. I'm going to do the same thing as the chiropractors 50% of that report and 75%.

Representative Ekstrom: Since you have it in front of you can you give me that dollar amount?

Chairman Pollert: The general fund for ambulances was at $743,710. My notes show that it puts them at the Medicare rate. 50% might be a little strong. It showed that $743,710 general funds. I would want it as a general fund dollar amount. We did that last time. We said here is the money and the DHS has to be in contact with that dollar amount. If you take a look at the reports that were handed out, there were a couple of items at 114% handed out. I want them to stay intact where they are at. I don't want to re-reduce them. We would leave it up to them like what we did the last biennium's.

Representative Bellew: What I would like an amendment to read is put the dentists back to what the OAR request was. The OAR request was 214 general and 365 federal for a total of $580,000. The second part of that amendment says all the other rebasing entities are the 7&7. I'd like to do that at 0 and 7. It is on page 1 of the OAR. If I remember the testimony right it brings dental services to 60% of bill charges. The second part is since all the other rebasing entities were at 0&7, I want the dentists there too. In the bill they are at 0&7.

Chairman Pollert: That is a general fund amount on the ambulances. It would be a schedule thing. Then the dentists would be at 65% of bill charges and 70% of bill charges.

Representative Wieland: I would like to get up to date on those rebasing amendments. Could you run through those one more time?

Chairman Pollert: I'm asking for is the hospitals rebased at 100% of the standardized cost reports. I'm asking for 10% off of that and 20%. So it would be 80 and 90% of the cost reports. On the physicians it was based on 25%. I'm asking for 15% of that cost report and 20% of that cost report. Then on chiropractors they had a different format. I'm asking for 50% and 75%. Then ambulances were 60% of the cost report and 75%. Based on the general fund dollar that

they would be in conjunction with. Everyone was handed out the sheets for the inflators of 7&7 (Attachment C). Does someone want to have an amendment for everything out at 6 or 5%.

Representative Bellew: I would like to call for three amendments. I would like to see the 6&6, 5&5, and 4&4. I know we will have a good discussion.

Chairman Pollert: With what Brenda handed out, the information is on these sheets. I have also asked for information on what they think the CPI is going to be for the next biennium. It is in attachment C. If you did the averages out you could pull it out. There was about 8/10ths of a difference when I did the averages. Over the amounts, the average came out to 2.0 or something like that. I do have that number somewhere. The CPI was 2.8 when you averaged out the years in that form. I'm trying to get information on what the CPI is going to be.

Representative Ekstrom: Over the years we have seen the budgets have increased at particular percentages. I think I'd like to see some historic trend on how we have increased year to year. It is certainly variable depending how much money and revenue we have in terms of what we were able to do each year. I would like to see that perspective. If you are looking at this as a whole, if we do this at the particular rate, it is similar to what we have done in the past. It is reflective of what has been sustainable. I think that's a word that we are going to hear a lot of in the next few years. That is my biggest concern in this entire budget is as we do things, we know what happens when we come back here. We have the cost to continue. We have to make sure of that. I know the oil revenues are variable. I know that oil will go back up but when is the question.

Representative Kreidt: Following along on Representative Bellew's line on the 5&5 and 4&4 we might as well do 6&6.

Chairman Pollert: Yes he requested that.

Representative Kreidt: I thought he missed that one. I thought he only did the other two.

Chairman Pollert: I know some of us have meetings soon, if I'm correct did I say we could finish this in about a half hour, 45 minutes this afternoon?

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 2/4/09

Recorder Job Number: 8660

Committee Clerk Signature Morgan Bennett

Minutes:

Chairman Pollert: Opened meeting for the afternoon. If I'm correct we are asking for amendments for HB 1012. We will finish them today and I sure hope we will get to 1014.

Representative Bellew: This is on our green sheet, page 6. Its number 24. I would like that amendment to pull all of the general funds. I have another one on that same page. This is going to be very controversial but we are going to ask for the amendment anyway. Number 21, the Centers for Independent Living, with the increase of $800,000 general funds, I would like to remove $400,000 of the general funds.

Chairman Pollert: They had the one earlier this morning to add to it, now you are saying you want to go to where?

Representative Bellew: The total amount I would like to go to is $400,000 in the budget. Right now in the Governor's proposed budget there is $800,000. I would just like to remove $400,000 of the total.

Chairman Pollert: It's written at $980,000 on the sheet and you are saying that you are going to reduce that on half.

Representative Bellew: I'm going to request an amendment to reduce that in half.

Chairman Pollert: I know the green sheet says $980,000 but it would reduce the $800,000 to $400,000 in the Governor's Budget.

Representative Bellew: That is correct.

Representative Wieland: I have two proposed amendments that are really an option. One would be to address critical needs with enhanced apting which is OAR priority number 5. I'm not sure how that is worded or set on there. The amount is $3 million, but $1.168.183 is general funds.

Brenda Weisz: I think if you are listing on the OAR listings it is on the back page under provider enhancements. In the middle of that grouping there is one called DD staffing to meet critical needs. That is the OAR that is being referred to. The amount is a little higher on this sheet.

Representative Wieland: That is correct.

Chairman Pollert: You are talking the $2.3 general funds?

Representative Wieland: Actually I'm talking about 50% of that. It is ½ of the OAR. You are just taking 50% of that which is the $1.1 million of general funds. I have extra copies if you want them.

Chairman Pollert: We probably should have that. Its $1.1 general so about $3 million total?

Representative Wieland: Well yes. The total is $3.158,958. As an alternative to that with a connection to that this would represent one year of a loss to the Ann Carlson Center. This would be in connection with that. This would be the other option. To enhance critical needs with the enhanced staffing that would be $438,900 of general funds and a total cost of $1.186,857.

Chairman Pollert: We will discuss both amendments.

Representative Wieland: It would be one or the other.

Chairman Pollert: Brenda could you come up to the front? This is more of a discussion than anything else. On the green sheet ,the $3.5 million Bank of ND loan that was put in there in case we needed to access those funds, didn't have to happen? I notice on the green sheet it shows and addition of the $3.5 million for general funds. Then it shows a reduction. Its number 5 on page 5. It's 16 about halfway in the middle. I just want to have a discussion a little bit why would it be in the base budget?

Brenda Weisz:

So are you saying that we didn't have to access that. You are saying that we had to have to continue the costs for the DD. Because you have the authority to float between line items that is what you were doing. The case loads didn't go over but the costs did.

Brenda Weisz: When you prepare a budget you have to start and say what the total costs to total costs are. This time the

Representative Wieland: Explain to me that when you borrow money and pay it back, so you aren't paying it back with general fund dollars?

Brenda Weisz: We aren't borrowing any money, we don't need to.

Chairman Pollert: I thought we only needed the $3.5 million in case the DD didn't need the $3.5 million. My question deals with the language we put in the DHS budget bill last session dealing with the DD providers.

Brenda Weisz: This is a rough example. If we are talking current biennium and let's pretend for the DD program there is $100,000 cost to run the whole program. To fund it would cost $97,000 of federal funds. It would really need $3,000 of general funds but we took those general funds away and put a bank loan in its place. That is why it should say total, federal, general, and other. Now we are in to the next biennium. We have costs to continue of $3,000 which is a continuation of the year 2 inflation. Now when we develop the DD budget it costs

$103,000 for the DD budget. Let's say nothing changed with the federal funding. That is $97,000 of federal funding. Since we don't have a bank loan available, the rest would come from general funds. That is why you have the funding shift on the green sheet. It costs $103,000 to do the program. You only have $97,000 of federal. The remaining 6 has to come from somewhere and if we don't have a bank loan it comes from general funds.

Chairman Pollert:. You are saying that we had to have the $3.5 million to continue the costs for the DD and because you have the authority to float between line items that is what you are doing? If I'm correct the case loads didn't go over what we thought but the costs did.

Brenda Weisz: Right. For DD we won't actually need the full appropriation either because we didn't have to replace that $3.5 with general funds. That is attributed to the case load comment that you made. When you prepare a budget you have to start and say what the total costs for total costs are and you have to fund it with your funding sources available. This time the funding source that was depicted to be used for the match was the bank money for this biennium we are working on for 09-11. There is no bank money so you have to fill the difference that the federal government won't pay with general funds.

Representative Wieland: Explain to me that when you borrow money and have to pay it back, you aren't paying it back with general fund dollars?

Brenda Weisz: We aren't borrowing any money. We will not borrow money. We do not need to borrow money.

Chairman Pollert: They don't need to borrow the money. I'm questioning why the green sheet needed to have the $3.5 of general funds and the $3.5 out.

Brenda Weisz: It's a funding shift. That's all it is.

Chairman Pollert: I'm probably missing something. You didn't need it because of the case load but you still use the general funds from that $3.5 million to fund the DD because of the

increased costs?

Brenda Weisz: We are mixing apples and oranges. It's more of an authority issue. Right now for the DD loan fund, when we left the session last time we replaced general funds to the tune or $3.5 million. It was a replacement of general funds.

Chairman Pollert: I thought we only needed the $3.5 million in case the DD didn't need the $3.5 million.

Brenda Weisz: What happened in conference committee was that there was a disagreement on the case load and what the cost would be for DD. Instead of cutting the federal and general and taking both pieces out, there was a funding shift to say that we are going to take the general funds out and replace it with a bank loan if indeed that case load reaches your level. It wasn't a total reduction to the DD program it was a funding shift for the general fund part. In total for authority that was anticipated to be needed was $100,000. We broke down and did it whatever way was improved. We still need $103,000 of appropriation authority to fund our DD grants. This is how it breaks down. When you go from budget to budget you have 0 general funds making up authority but you need general funds for next year it is going to be an increase. If you have $3.5 million of other authority and to go forward it is a reduction. That is why it's showing up. We were both right last session. We didn't need the $3.5 but we needed a little. If you wouldn't have put the loan in we would need up to $1 million of that loan. Since we have turn back in other areas that is why we won't access the loan.

Chairman Pollert: So the case load is right but we did have some?

Brenda Weisz: We were down on the case load but it was pretty close.

Chairman Pollert: We still had some costs in there.

Representative Kreidt: We are using that $6,000 moving forward figure. To me it looks like we didn't access the $3.5 last time. We are going to access it this time?

Brenda Weisz: There is nothing in the other line that is a zero. We aren't accessing it.

Representative Wieland: My question remains then why do we need to keep it in the budget. If we aren't going to access it and not going to use it then why does it need to be in the part of the overall general? This to me is still general funds. It isn't called special funds.

Brenda Weisz: It was this biennium.

Representative Wieland: You have it listed on the green sheet under general funds.

Brenda Weisz: Right it was other funds this biennium.

Representative Wieland: In this coming biennium you have it listed under general funds but you aren't going to access it?

Brenda Weisz: I'm going to access general funds I'm not going to access the loan.

Chairman Pollert: You are going to access the $3.5 million because you need that because of the increase costs of the DD. It has nothing to do with case load utilization because that came out to what we thought. The costs were still higher. So did the authority for the bank of ND sunset at the end of June 30, 2009? Did we have that in statute that we could do that?

Roxanne Woeste: It does. The section that allows for the authority to get the bank loan is for the biennium in 2007-2009.

Chairman Pollert: Ok. Thank you.

Representative Kreidt: The way that it stands if you really wanted to tomorrow you could still access the $3.5 million?

Brenda Weisz: No I can't. I would have to go to the budget section.

Chairman Pollert: They are expecting turn back of $22 million of which a little over half is the Medicaid. They wouldn't need to do that.

Representative Bellew: On page 7 on the green sheet, I would like an amendment to remove the FTE for the program coordinator position for the Partnership Program at the Southeast Human Service Center. Its number 4. I don't think I have asked for that one yet.

Chairman Pollert: What does it pertain to?

Representative Bellew: It was an OAR, the 3rd on the sheet.

Chairman Pollert: Can someone explain to me what that is about?

Brenda Weisz: That was an addition because of the partnership case load at the Human Service Center at Southeast. It was in excessive of how the staff can handle that. We had to bring temporary on to handle children with serious emotional disturbances. It was to accommodate a case load issue at the center.

Representative Bellew: On the same page number 6 on the other FTE I would like to remove the position with the related operating expenses. I just have a few more. Also on the OAR list they have the option for personal care tier 3 for $1.21 million general funds. I would like the amendment to remove that.

Chairman Pollert: That is the one that I'm just going to say goes from 8 hours to 10 hours.

Representative Bellew: Right, that is my understanding too.

Representative Ekstrom: They had a specific number for how many individuals that would be able to come back out of a nursing home and back into their own homes, can someone answer that at all? What is the specific number?

Brenda Weisz: What we have in the budget is 27 individuals would qualify for the third tier. I think we talked about some of those would avoid nursing home placement but I don't know if we said how many would come out of a nursing home per se.

Representative Ekstrom: I will research that a little further. I remember specific testimony that said there was some number of people that would avoid nursing home care and the potential of some people coming back to the community.

Chairman Pollert: Would you have taken into consideration on the nursing home bed numbers tier 3 for personal care. If they were going to go under this program, would that have reduced the beds in the utilization case load numbers?

Brenda Weisz: Based on the timing of when the Oar is submitted and when the budget is submitted, we will check with Maggie as far as how many would come out of the nursing home. The OAR was added after the nursing home budget was submitted.

Representative Bellew: During the presentation I noticed the travel expenses have increased significantly, a total of $772,00 department wide. I want to allow half of the travel to $386,256. I know it is not all general funds either. To me that is an excessive amount of increase in travel.

Representative Ekstrom: There are a number of them where their travel costs actually went down. I have been doing some research on this as well. Do you only want to apply it to them ones that have increased?

Representative Bellew: Yes.

Chairman Pollert: Could it be said that instead of traveling expense that there is reductions in $386,000 somewhere else even though it will also hit. We will have the discussion because you asked for the amendment. When we talked about vacant FTE's they automatically look at the department's and how they want to spread that out.

Representative Bellew: In the administration overview they said they were going to give blackberry's to their employees. I'm not sure the state taxpayers should be funding blackberry's at this point. They didn't convince me that if we gave them their blackberry's that

they would reduce costs in any form or fashion. If I got the figure right the 16 blackberries would be $64,732.

Chairman Pollert: I'm not bringing this up to argue with you but we will have to have them come forward. Maybe we need to have them give us a discussion. I thought I heard them say that they aren't charging for the use of them or they have some that are per shared cost or something. We will have Brenda come explain that again. Are there any other amendments? I want to bring up case load utilization. We will get into explaining it. I don't know what your side looked at. We took a look at it. What we went through on the case load, what we are going to ask for on Medical Services when we look at case utilization it came out to about $9.6 million. I'm talking about inpatient hospitals, outpatient physicians, we did not touch drugs or SCHIP or dentists. Most of it we found. We are going to have to have a discussion on inpatient hospital and outpatient and physicians when you look at the case load numbers.

Representative Ekstrom: In that discussion as we move forward, they do have a review process in terms of utilization. There is an audit mechanism that allows them to say that this was an appropriate use of medical services or not an appropriate use. I want to have that discussion as well. We may need to hear from Chip Thomas or some of the others.

Chairman Pollert: On the whole long term care, case load utilization, if I have these figures off because I know they are going to change, I show about $5.6 million of case load utilization on nursing homes when looking at beds.

Representative Bellew: That's not just nursing homes but the whole long term care.

Chairman Pollert: Nursing homes, personal care, beds, basic care, age disabled, TBI waiver, TCM, and PACE. There will be one more amendment coming I just have to get my notes caught up. Representative Ekstrom are you going to want to have the same discussion on long term care?

Representative Ekstrom: Yes. It said the department has strict guidelines as far as eligibility for these services and how they proceed. I don't believe that we necessarily have many folks that are getting services that they should not. I think we have to see what the department has done to try to contain costs.

Chairman Pollert: Correct me if I'm wrong. We did not touch their increase in costs of the continuation of the 4&5. We did not touch the 7&7. On very few items did we touch their growth. It's perspective and very subjective when you look at the detailed of services. They knocked it down by the months. They had in highlighted areas which ones to use. We went and went through 12 months. We went through 9 months. Depending on which 9 month or 12 month those numbers are drastically different. I want to have a discussion. It has nothing to do with the 7&7. It has nothing to do with the 4&5. It has nothing to do with the growth you put in there. It is a discussion of how at the end of the last 9 months in patient hospital, their numbers have dropped drastically. We should have that discussion to see if that is correct or not. That is why it's there. It's not about the costs that you are asking about. Basically the numbers were given to us off the charts. On the DD grants line item, that is ISLA's, ICFMR's, day support's, MISLA's, Infant development, in home support, $2.746 million. It's all on case load utilization. The same thing, we didn't look at that. We honored the 7&7, we honored the 5 on most of the growth. We did look at the growth on the few of them. On the long term care and DD. We did not look at the growth or if there was anything as far as the medical services if I'm correct. Why those amendments are going to be brought forward, I know it's subjective as well. When we look at the turn back we have to have the discussion as far as how much the turn back is on Medicaid. When you look at the whole total budget it wasn't that much. When you look at the millions of dollars they go through but it's still a discussion we need to have. Having said that, any other amendments to HB 1012?

Representative Kreidt: Starting out as some information and an amendment to follow up, something that has come to my attention in regards to child support.

Chairman Pollert: Mike's not here so Brenda that will fall on you. Can you come forward on a question of Child Support?

Representative Kreidt: We are doing the amendments today. If I can't get the answer can I bring this amendment forward after we receive the information we need?

Chairman Pollert: You have every right to bring whatever amendment you want to bring forward.

Representative Kreidt: In regards to child support and over payments, it's my understanding that an individual makes a substantial overpayment on a child support situation due to some circumstance or through documentation or fact finding. It is identified that he has made an overpayment. My understanding is that the state is unable to pay that individual back that amount of dollars. That is my first question. If that is fact, that is where my amendment would follow up in regards to my question that we would be able to refund that individual that overpayment on his child support.

Brenda Weisz: I don't know the exact answer or circumstance. If they owed that might have some say as if it is overpayment.

Representative Kreidt: The understanding I have is that this person is owed this money. They know they owe him a considerable amount of money that he has overpaid. The system does not allow them to pay him back. They can take the money in but they can't spend it out.

Brenda Weisz: I will find out for you. It doesn't sound quite right.

Chairman Pollert: If you can get Mike Schwin to get a hold of Representative Kreidt to find out of there is a mechanism in place. He is being told by someone that it is not in place.

Brenda Weisz: Would you be able to talk specific to him. Maybe he knows something about the case itself.

Chairman Pollert: Is there any child support bills out there? I hate talking policy when we are dealing with money but this is kind of a policy thing too. If there is a problem, of course it would always be good to throw it on an amendment on a bill somewhere.

Brenda Weisz: Are you asking if there is any policy child support bills this session? There is. HB 1175 is a department bill. Can I ask a question about travel. You didn't state a general fund amount. A lot of the travel is federally funded, the increase is federal funds. Were you going to state a specific general fund amount or pro-rate it based on the percentage that is actually federal?

Representative Bellew: Pro-rate it. I don't know the specific general fund because I don't know what it is.

Brenda Weisz: For example, if 75% of that increase is federal, which predominately most of it is federal dollars. The increase then your reduction is 25% general, 75% federal.

Representative Bellew: Correct.

Brenda Weisz: We will look at the ratio.

Chairman Pollert: Any other amendments to HB 1012?

Representative Bellew: Hopefully this is the last question. The $900,000 increase for senior service providers, where exactly does that money go? That goes to the providers and the providers dish it out? It's not specifically for food though is it?

Brenda Weisz: It is actually specifically for food that goes to a provider. It's in our aging services budget area. We work with 8 regional contracts for the meal delivery across the state in the 8 regions. That money passes through to them to cover their costs for delivering their

meals, home delivered meals or congregate meals at the meal site. It goes directly to the cost of the meals.

Chairman Pollert: Some of them are for senior citizen centers and stuff like that?

Brenda Weisz: They are all basically through the senior centers except for some areas. I do know they contract with the restaurants that provide those meals without a center.

Chairman Pollert: Any other amendments for HB 1012? Committee I want to switch gears if these are all the amendments. We can still ask for more. We are going to have a long discussion. I show 46 amendments. Besides a discussion on the inflationary that we are going to have when we get on the wage and salary issue.

Representative Ekstrom: Just one question. This sheet that was provided to us as far as what the numbers are for the 5&6. That includes all services. In other words, it would also include long term care unless we decide specifically to leave long term care out of it.

Chairman Pollert: I would think that your assumption is correct. I have some questions as far as the 7&7 that go into some of these in human service centers. Some of it's not to brick and mortar.

Representative Ekstrom: All I'm saying is when this sheet was prepared it said that the numbers would sort of be applied equally across all of the places that we had the inflationary increase unless we specifically say?

Brenda Weisz: The way it is calculated is the assumption that everybody is at 7&7 and here is the scenario with everybody at 6&6, 5&5, 4&4, all across the board.

Chairman Pollert: Not that we would do that but we have the discretion to say that we might look at 5&5 and 6&6. We might say that we don't want to do anything. We could say that we are going to change rebasing and keep this 7&7 in place or whatever we want to do about what we could pick and choose if that's what we so desire.

Brenda Weisz: That is accurate.

Chairman Pollert: Are there any more amendments to HB 1012? If there are going to be further amendments showing up before we meet on Tuesday, I would ask that if they are going to come forward that it has be in writing because we are going to run into a time problem.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 2/10/09

Recorder Job Number: 9101, 9102

Committee Clerk Signature

Minutes:

Representative Bellew: Called meeting to order. Took roll and will stand in recess until Chairman Pollert gets back. Roxanne passed out amendments. : 30-2:27 blank

Chairman Pollert: Called the meeting back to order. This is going to be a slow process. I myself have two different copies that I'm going off of for amendments. I thought we would do the same as we did in the past and start with the Management Division. We will start on the top and go through. We will go page to page. We will not be talking on the inflators. I may decide when that becomes appropriate. The way it is there right now we will not talk to it in that agenda. What I plan to do instead of us asking for firsts and seconds. We will just take the papers, open the discussion and then take votes. We have to be out of committee this morning at 11:25. Some of us have a meeting today that we weren't aware of. Then we will come in shortly after floor session, 15 minutes after it's done. With that we will start on amendments. Are there any questions before we start? Starting on the first page where it says management subdivision. Right off the bat it comes with remove one new FTE add an executive budget to perform additional duties required by statement on auditing standards No. 112 regarding internal control matters which is amendment 1. If we want to bring DHS up to talk I have no problem doing that if we need a clarification. I do not want it opened up to public hearings so

we have this all over again. If there is something that DHS can't answer then I will permit that in a short time period. Is there discussion for the one FTE?

Representative Ekstrom: That was Representative Wieland's amendment. This person for managing the auditing standards would directly report to Brenda. The feeling from the department standpoint is this really is for internal controls. It is recommended by the state auditor. It is to comply with the accountancy board recommendations. This rose out of the Enron scandal where there were loose practices in regards to auditing. I think all of us recognize the hard work that Brenda and her department do. To short staff them in this area, I don't feel like we need to do that.

Representative Wieland: The reason I asked to have it removed was within the budget of DHS they have flexibility and they have so many vacant FTE's and they don't really need to have this position added because they can move one position over to another.

Representative Ekstrom: Indeed they have many vacant FTE's but we have another amendment to under fund to the tune of about $2 million. We have addressed that issue.

Chairman Pollert: Took voice vote. First amendment passed 5-3. Move on to second amendment which is reducing funding for salaries and wages department wide for anticipated savings from vacant positions and employee turnover in addition to the $1,917,041 reduction included in the executive budget. It has a general fund of $2 million.

Representative Ekstrom: These people have really worked hard. The department and all the people who work in human services have done a tremendous job. I don't think any of this is a reflection on anything they have done or not done. One of the things I wanted to mention in regards to this underfunding is that I asked for the deficiency appropriation that we had to come up with for the department this time through. In management it was $200,000 program policy, the state hospital was a little over $1 million, the development center was a little over $1

million. If you recall last time we underfunded the human services center $100,000 each which made it $800,000 total. We can go ahead and take this $10 million out and underfund because we have vacant FTE's. Please remember that we will come back next year and put the $2 billion back in.

Representative Bellew: The department is going to have a roughly $22 million turn back. This might be a little steep. Right now I think its ok. I would like it to stay the same for now.

Chairman Pollert: Any other comments? If I remember on the sheet that was handed out, it seemed to me it was around $22 million dollars. $12 million was on the Medicaid turn back and the other was distributed amongst basically the state hospital and human service centers. What that kind of tells me is we took a good hard look at the caseload utilization numbers the last session. It appears to me that maybe we should have looked at them a little harder.

Representative Ekstrom: I agree. We have the ups and downs in this budget all over the place. $2.6 billion is our budget so you are going to have that in a budget this size. One thing I would remind the committee about is last time the SCHIP program was changed substantially to allow children to come in and be qualified for the entire 12 month instead of on a month by month basis. That was done through Medicaid. In any event, we did see a shift of children away from the traditional healthy steps or SCHIP toward that Medicaid program and that did account for quite a bit of the money.

Chairman Pollert: Any other discussion? We all realize that this is the first period in a hockey game. I appreciate the work of the DHS. These discussions will continue into the second period. For now I am willing to except this for now. This is a revolving process this biennium. Took roll call vote on 2nd amendment. The amendment passes 5-3-0. Next is the 3rd amendment which removes funding for the handheld communication devices. Representative Bellew requested to take out his third amendment. I agree with your assumption especially

with the last amendment we passed because they are going to be looking for items in the budget and transferring them around. We will move on to the 4th amendment.

Representative Kerzman: This is my amendment to get the uniform eligibility assessment program started. I believe this would put on a couple of temporary people to start with and bring in about five people from the counties and help them organize the program. I would like to see this get started because it would be beneficial for our counties.

Representative Ekstrom: I received an email from the Mountrail county social services. Out of all the different programs she deals with, each process is a start over. This would create more efficiency in the department. We have to start some place. It's a very large item on the OAR's. This would let us get started.

Representative Wieland: I'm trying to remember what the total estimated cost of this project will be.

Chairman Pollert: It was on the OAR. I think it's about $18 million. I agree with you. I think the computer system needs to be done. Of course it was highly ranked on sytec. If I'm correct Brenda came up and said that this would speed up the project by 6 months. I sit back and look to the increases to the budget and yes I agree with you. I can fully support this to the next biennium for them to come forward with it in the budget. Right now I'm going to avoid the amendment.

Representative Kerzman: I think it would create so many efficiencies out there in the counties. It would pay for itself over and over. It would be easier for them to use and easier for them to trace back and get the programs on the correct page. I think for a little bit of money, $342,000 is not an awful lot. We may be able to slip some stimulus money in something like this as a new system starting up. Maybe one of the areas we might be able to utilize that.

Chairman Pollert: Brenda not only would be talk about this particular system but let's say that we know there is some sort of economic stimulus package going to happen we just don't know what it is going to be. My personal concern is that we can't depend on ongoing from the federal government, it's going to be one time. Could this be considered one of those one time projects that if this came through the whole computer system could be funded through to work on.

Brenda Weisz: The only thing really relative to technology systems and economic stimulus that I'm aware of is the Health IT. This in itself doesn't directly relate to Health IT in the manner that they are discussing it in economic stimulus. I think what it would do is help with some of the general funds which would free up general funds for this present.

Chairman Pollert: I agree that we need to do the project. I just have the time table problem.

Representative Kerzman: Just in response to the time table problem I think anytime we can start something we are going to save money. If you put it off two more years it will cost more money because of the way technology and construction have been going. If you take that $18 million times 20%.

Chairman Pollert: Is there any other discussion? If not we will take roll. The fourth amendment fails 4-4. We will move onto the 5th amendment which is to add a section to provide for a Legislative Council study of DHS child support enforcement program. Is there any discussion?

Representative Ekstrom: If you look at the other packet that was handed out this morning (handout A). What I was trying to get at is how other child support enforcement is done in other states and how they calculate interest. The other item that didn't get in the amendment has to do with the cost effectiveness of going after some of these. We have no mechanism to write off an arrearage that is uncollectable.

Chairman Pollert: Has there been any other of these studies done? Has this ever been studied before?

Allan Knduson: I can do checking but I don't recall any specific of what this study is looking at in the recent years.

Representative Ekstrom: The other thing that I recall is that Mr. Schwintz said that the department is really doing long term ongoing study. This is to direct that study even more in terms of what other states are doing.

Representative Wieland: I think the last study that was done on child support was whether to have the state take over the entire child support enforcement and remove the counties from their responsibility in regards to that. That was either two or three sessions ago.

Chairman Pollert: And that didn't include anything on arrearages?

Representative Wieland: Not that I recall.

Representative Metcalf: For some reason or other the DHS has a hard time letting go of any hold they have on many people even though it is long gone and a minute amount. . We carry things on the books that basically should have been dropped a long time ago. To me it makes a lot more sense when we are hearing the budget. When they say we have $10 million coming in. We know that they have $10 million coming in. Not only $17 million and $10 is collectable.

Representative Ekstrom: The arrearage now totals some $280 million. This figure has alarmed me for all the years I have been in the legislator. The other fact is that $275,000 per month is occurring in terms of interest. It is very difficult for us to see progress. That interest just keeps clicking away.

Chairman Pollert: It sounds like we need a bad debt write down because we are never going to collect that.

Representative Bellew: Is there money involved? Do we require an appropriation?

Representative Ekstrom: When I talked to child support they said that they are pursuing this. This is to direct the study that they are already planning to do. It's already in there.

Chairman Pollert: We will take a voice vote. The 5th amendment passes 8-0-0. We will move onto the 6th amendment which is decreasing funding for department travel.

Representative Bellew: That was my amendment. In their total budget it was like $760,000 total travel increase. The budget was prepared back in July or August when gas prices were very high. I just think the increase is a little excessive.

Representative Ekstrom: During committee discussion I asked if this would also apply to divisions that have seen a decrease in travel. I suggest that we don't decrease their travel further than what it is now.

Representative Bellew: That was my intent. I hope that can be ironed out.

Chairman Pollert: Any other discussion? We will take roll call on the 6th amendment. That passed 7-1. As we are going through the segments, is there anything on economic assistance? We will move onto the 7th amendment. The executive budget adds money to the medically needing. Everyone knows what that was in the budget. There are two alternatives, a and b. We are going to have a few of these especially in the medical services dealing with alternatives. What I will do is decide which way we are going to go. We will look at alternative B first. Does everyone understand the medical need in the medical needs program that deals with recipient s? Initially we talked about the SSI levels and found out if we did the SSI levels that this wasn't going to work. That is why that amendment wasn't brought forward. Is there any discussion?

Representative Kerzman: I will resist alternative B for sure. I think what is going to happen is we are basically going to force people to spend on the money faster and you don't allow them to have services like homemakers and things like that coming into their home quite as quick.

Basically you are going to move them faster towards long term care. I'm not sure the figures of what that would do but right now we are at about $500 and going to 83% would bring it to $720. I don't know what 65% would bring it to. I would sure prefer the Governor's recommendation on this one.

Representative Ekstrom: The income level was last changed in 2003. Food, clothing, rent and all the necessities have gone up by what is in the Governor's proposal. This is truly a catch up number. The increase translates to $33.95 a week. I don't know what you could do with $4.85 a day. I can barely pay for my lunch with that.

Chairman Pollert: Are you stating the increase would be in the Governor's budget and not the 65% you are talking about. Any other discussion? I agree partially about the Governor's budget proposal. I don't support alternative B but I do support A. We will take a voice vote on alternative B. It failed 0-8-0. Let's move on to alternative A.

Representative Ekstrom: Could we ask Brenda to tell us what this would take it from. In other words we know where we are right now but in terms of a monthly increase how much we would be talking about?

Brenda Weisz: 75% would bring the one family household to $650 . And the two family size to $875.

Representative Wieland: Concurrently?

Brenda Weisz: Yes the Governor's budget has a household budget of 1 at $720. The household size of 1 is $500. The household size of 2 is $516.

Chairman Pollert: We will take a roll call vote on the 7th amendment, alternative A. It passes 5-3. We will move to the 8th amendment. There were physicians, chiropractors, ambulances, and dentists all on one page. This might take just a little while. We will go to the rebasing of physicians. The question I have is on 80-90%, I understand that at 90% one of the hospitals

would receive less reimbursement. Under the 80% it was like 4 hospitals. I asked Legislative Council to have it as a hold harmless. Is that in these amendments? I mean as a hold harmless that I don't want to see them receiving less reimbursement then they did the year before. We all realize it is based off of standardized cost reports. We could have the argument but actually the hospital costs could be as much as 30% over these cost reports.

Maggie Anderson: You are correct. When we prepared the estimates with this amendment, it was done with holding those facilities harmless so that they would not go backwards. They would receive a no increase the first year and then receive the 7% inflation the second year.

Chairman Pollert: Yes because we haven't talked about the inflators and that is a discussion for later. With the rebasing of hospital rates, which hospitals do these work with? Is it all the critical access? Is it the big 5?

Maggie Anderson: The rebasing affected the non-critical access hospitals which would be the large facilities in Bismarck, Fargo, Grand Forks, and Minot.

Representative Nelson: I thought PPS hospitals were down quite low in the percentage of costs. Give me an example of how this one hospital of 90% is being paid over 90% of cost.

Maggie Anderson: Each facility is different in terms of what their cost structure is and how their facility is made up if they are integrated or stand alone. Costs are different. Those costs are relative to each facility. When we collected the information for the hospitals through the cost reports and did calculations, and when the amendment was requested that we look at 90% of that. There was one facility. It has to do with what is included in their cost and how they staff and run their facility.

Representative Metcalf: I only have one statement I would like to make. I think we all have to look at if we want the quality of service that we have been receiving from our hospitals. Knowing that they have in the past, cut back on staff to do what they have to do to come within

the reimbursement schedules. I think it is important for us to pay them to maintain the staff that we feel is necessary. If we don't want the MRI's and different things like that which they give at hospitals or any other expense, then I guess we should give them a lower level. I personally feel that we need the best medical service we can get. I'm going to resist both alternatives.

Representative Ekstrom: I'm having a little difficulty looking at this as a standalone rebasing. We aren't looking at the inflation factors as well. When we looked at hospitals we rebased their funding to 100%. The inflation factor was going to be 0 the first year and 7% the second year. I know we have terrible uncertainty with regard to the stimulus package but the point of fact is we know there is some money in there in terms of FMAP. How much it is, and it is one time. What I'm trying to do is get my arms around the whole thing. I think we should leave that base funding where it is and as far as the Governor's package for the rebasing. Leave it at 0 for that first year then come up with a number for the second year so that we insulate ourselves. Once that one time FMAP money drops off then we are insulated a little bit in the out years.

Chairman Pollert: I understand what you are saying but there are so many questions on the horizon of what is going to be what, where, and why. I don't want to say my opinion but I'll say it anyways. I don't support alternative b. I don't agree with that. I think that is too hard. I will support alternative A. I'm not bringing the inflator into this discussion at all. I understand we have to but I don't know how we bring the inflator discussion into this without bringing in everybody under the whole package that way. That is my opinion.

Representative Esktrom: The question I have is wondering if there will be any inflationary increase the first year. That is really where my difficulty lies.

Chairman Pollert: When we get on the inflators the 4,5, and 6's. We can vote as a section to whichever way we want to go. It would be a horrible thing to do but to look at that whole 7&7 or

whatever. I myself have a problem with the human service centers getting a 7&7. A lot of these places don't need that if they don't have brick and mortar.

Brenda Weisz: Some of the human service center providers are brick and mortar. They are residential facilities. As a policy branch you do have the ability to make a decision on what you want to offer.

Chairman Pollert: So depending on how the vote on alternative A goes can decide what you want to bring forward just because we don't have the amendment forward. We can have the discussion later on the inflator.

Representative Kreidt: As we go through the debate today and the numbers we are working with, I don't think we should be talking about the stimulus package now. That is far down the road and it looks like they may have something done by the middle of March. I don't think that should even enter into it. As we deal with these numbers today, we are in round 1. This hasn't gone to the Senate or conference committee. Lots of things could change as we go forward with this.

Representative Kerzman: In light of what Representative Kreidt said if we look at what we have today we have a Governor's budget that left a surplus in here yet. We have an economic forecast that is pretty healthy. I don't know why we should be cutting at a big budget as much as we are. When we look at human services and one party decides to take quite a bit of money out of there but leave the other budgets alone.

Representative Kreidt: I would agree with your statement to a point. The economic forecast that we heard yesterday, I feel that I'm a realist. Even sometimes what our Governor tells us in regards to the future and the economy of our state, I don't always agree with.

Representative Bellew: We aren't cutting anything. We are reducing the increases.

Chairman Pollert: I think the higher education budget is way overstated. I agree with you too that if the reductions in the DHS budget the way we are proposing, I have no problem with that. It's not fair that we in this section have to look at this budget like this and that higher education gets a free pass which I thought they did the last biennium. Is there any other discussion. We will call the roll on alternative B. It fails 0-8-0. We will now take the roll on alternative A. That passes 5-3-0. We will move on to amendment 9 which is the rebasing of physician rates. There are two alternatives to this amendment also. Is there any discussion?

Representative Ekstrom: I feel like I have a large family here that is doing their job every day. We aren't treating them equally. I think the department, and Governor tried very hard to be as fair as possible. I think we will have some that do considerably better than others. I think it is inherently unfair.

Chairman Pollert: Any other discussion? We will take the roll call vote on the 9th amendment alternative B. It fails 3-5-0. We will move on to alternative A.

Representative Nelson: If I remember right the last time physician rebasing took place was back in 1995. It was probably the same as hospitals.

Maggie Anderson: The physician rates have never been rebased. It was the hospitals that were rebased in 1994-1995.

Representative Nelson: If we treated everyone with a fair handle we wouldn't have to be here. This is an area where out in the field there is a critical need for physicians. There is a shortage in every part of the state. There is something like 400 physician openings. Probably half of them are family practice situations which get into this population as well as anybody. We aren't talking big money. It's $1 million. This is an area that I was hoping that we had some years like this where there were expectations and we had money that we could kind of do something for the priority items. This is one of mine. I'm voting no on this alternative a as well.

Chairman Pollert: We will take the roll call on the 9th amendment alternative A. That amendment passes 5-3-0.

Representative Bellew: I just want to remind the committee that what we do in subsection is to make recommendation to the full appropriations committee. If you do want to bring another amendment forward when we go to full committee you sure can do that.

Chairman Pollert: We will move on to the 10th amendment which is rebasing of the chiropractors. There are two alternatives to this one also. We will take the roll call on the 10th amendment Alternative B. That amendment fails 3-5-0. We will take the roll call on the 10th amendment Alternative A. That amendment passes 6-2-0. We will now move on to amendment 11, the ambulance payments.

Representative Ekstrom: I talked to some of the rural ambulance services. They were in dire need last biennium. Literally they are having bake sales to put oxygen and stuff into the bus. This is the first line of medical service that most people see when there is an accident or some other tragedy. A lot of these people are volunteers. The least we can do is to provide funding for them to make them as whole as we can. I'm going to resist both A and B.

Representative Wieland: Maybe I'm wrong but isn't there another bill out there that deals with first responders and ambulances. I know we had a bill in last session where were we provided $1.5 million. I thought there was a bill coming in this session but I haven't seen it.

Chairman Pollert: I know there is a bill. I think human services policy committee has it. I think it was 4 FTE's and 4 region and I think they reduced it down to 2. It's Rep. Uglem's bill. I know we had a sheet of paper that showed the different rates of amounts billed. Some of them are over 100% already. I think there is one or two items. I want to know if those one or two items were held harmless in that amendment. That was probably our thought.

Brenda Weisz: How the amendment was written up or how it was discussed was to do dollars and just work with ambulance providers.

Roxanne Woeste: I haven't found Rep. Uglem's bill but there is SB 2049 which does expand that current EMS operations grant program that is currently run through the state department of health. There is a bill in the senate that is expanding that program. It currently is at $1.25. The bill does expand it to $4.5. Many of the grants went to providing funding for on call, and that sort of thing.

Representative Wieland: Are ambulances included in that?

Roxanne Woeste: That is all ambulances, EMS.

Representative Wieland: First responders aren't really necessarily ambulance but that is why I'm wondering if it's first responders and ambulance.

Roxanne Woeste: It is worded EMS so I'm not sure if quick responder units would be included or not. I know the health department has rules established for the grant program. I believe it was targeted at what they considered critical access ambulances.

Chairman Pollert: It's not Rep. Uglem's bill but it was probably brought through public safety or one of the interim committees. That was a continuation from the last biennium of all the dollars and the programs that were brought forward by EMS last session. That is through one of the interim programs. That sets up FTE's for coordinating program or something of other. I do have the policy committee bills.

Roxanne Woeste: Perhaps it's HB 1571 that provides an appropriation to the state department of health for providing regional assistance to the EMS operations.

Chairman Pollert: Was that an interim committee?

Roxanne Woeste: No. Currently the bill is engrossed and it has a $273,428 general fund appropriation for 2 FTE's.

Chairman Pollert: Is there any questions? If not we are going to take a vote on the 11th amendment, alternative B. That fails -0-8-0. We are going to go right to alternative a and take a roll call. This one passes 5-3-0. We will move on to amendment 12 which is rebasing the dentist rates. When I first read this one I had some questions about it so if it rises up questions let's get them answered. We are rebasing rates to 75% of average bill charges and funding of $1.7 of which $641,000 is from the general fund. There are three alternatives for this bill also.

Representative Bellew: That says no change to inflation which means if they adopt that, it is a 7&7 inflation, is that correct?

Chairman Pollert: Right now if we change the 7&7.

Representative Bellew: I just wanted that understanding.

Chairman Pollert: If we need further explanation we will do that. The last session there was one for 75% of bill charges. The bill was amended down at the end of session to 65% of bill charges. Then it was amended further in the conference committee. Then it was at 75% of children's coverage. I don't have the wording correct but I do think it was something like that. What this is doing is 75% of bill charges straight across. We have all the alternatives here. Representative Bellew were you the one who asked about the 60% with the 0&7. Do you have figures for the other ones at 65 and 70% of bill charges?

Representative Bellew: I have some figures but I don't think I have those unless I am reading my sheet wrong.

Chairman Pollert: I have a number here. I thought you were asking about that information but maybe I didn't get that to you. We are actually going to have 5 alternatives to this particular part of rebasing the dentists. The sheet that was handed out (handout B) is that it is rebased on 65% of average bill charges and inflation of 0&7. The sheet below that is a rebase at the amount of 70% of bill charges and inflation of 0&7. Is it because the hospitals were at 0&7?

Representative Bellew: That is exactly why I requested that. The other rebasing services were all at 0&7 except when we get to long term care.

Chairman Pollert: I think this is what you were looking for. Is there any questions because we didn't have this information before.

Representative Bellew: I think we should have the discussion.

Representative Wieland: I still see the 7%. It may be 7% but in the event that it is changed I'm assuming that it can change whatever motion we pass but it can be adjusted with any motion we pass. It shows in here for the 65% and 0&7 inflation, if we are adjusting the inflators and we are going to make them equal would this reduce to 6 as well?

Chairman Pollert: It depends on what we do. If we look at all the inflators and move the inflators from 7&7 to 8&8 or 6&6. Unless we specifically say that the dentists would not be hurt by that that is what we would do. Anybody with the 0&7 we would have to have this specific language stated that it would not have effect.

Roxanne Woeste: That is correct. At the time which it is appropriate to discuss inflators you can decide at that time if you want it to be straight across the board or if there is going to be different numbers for different categories.

Chairman Pollert: to complicate the matter to move it to whatever, if we specifically don't' bring up the 0&7's they will go to 6&6 or 8&8.

Roxanne Woeste: At the time you want to discuss inflators and currently it is at 7&7 except for the rebased which are at 0&7. When you discuss inflators you can decide where you want to go.

Chairman Pollert: If we don't make that motion wouldn't it go to the motion to go from 0&7 to 0&6 then it has got to be stated. Otherwise wouldn't it go to the motion of a 6&6 or am I getting too technical?

Representative Nelson: It is pretty plain where this is going. When we ask for that study last session to create a level playing field, the results did that. Here is a situation where the last two issues that we have covered, we have gone to 75% of funding. Whether it is cost based or charged base. You can argue that all day. The one option that I would like to see if we are going down this path is the 75% of bill charges and then the 0&7. That is the only one that isn't offered. That would keep us on a level playing field of providers.

Representative Bellew: If you read those last two amendments it says 75% of which was proposed in the Governor's budget. That is something that we could talk about when we talk about the dentists going to 75% of what is proposed in the Governor's budget. I would be open to that discussion.

Chairman Pollert: You are talking about 75% of bill charges and 0&7. We don't have that alternative in front of us right? Do you have any numbers on 75% of bill charges and a 0&7?

Brenda Weisz: I would have to check upstairs. We may have run that back in the Governor's budget.

Chairman Pollert: Could you have that to us in 10-15 minutes?

Brenda Weisz: If it exists but if it doesn't it will take awhile.

Chairman Pollert: Since we are on this topic I don't want to go back. Would you be able to look that up if we take a break?

Brenda Weisz: Yes. If we don't have it run we will have someone bring it down when it's ready.

Deb McDermott: (Handout C) I set this up like your other spreadsheet. There is $4.2 million roughly in the executive budget. The rebasing amount at 75% is $2.4 million. The inflation at 0 is another $600,000. That brings a total to $3 million. The difference would be $1.2 million total to go to 75% with a 0&7 versus 75% with a 7&7.

Chairman Pollert: These two sheets would go hand in hand. We are going to stay on dentists. Is there any discussion? Took roll call vote on 12th amendment alternative A which failed 2-6-0. We are down to five amendments. We have in front of us alternative B that is 65% no change in inflator which would be 7&7. Alternative C is no change in the inflator and 70%. Then you can go to the new pages that are out there on the 65% of an 0&7 and a 70% of an 0&7 and 75% of an 0&7.

Representative Nelson: Are you looking for one we should choose and speed this up or how do we do this? If that is your wish I'll pick 75% and 0&7.

Chairman Pollert: That is the new sheet that was handed out by the department. We will take a roll call vote on the 12th amendment, alternative d with the 75, 0&7. It failed 3-5-0. We are down to the 65% amendment.

Representative Bellew: I would like to take a vote on the sheet the department gave to us. The rebased on 75% of bill charges.

Chairman Pollert: I'm trying to guess what the committee is thinking on which one they support. I'm trying to get some kind of a feeling of what alternative to look at. I will ask for a show of hands on who is in support of 7&7? (Noone). So I do this accordingly I am going to ask for a vote. I'm assuming from this vote that you are in support of the 0&7.

Representative Metcalf: But we do have the original bill too so we have three choices.

Chairman Pollert: You are right. If these both fail we are back to 75, 7&7. I am going to withdraw alternative B and C with the 65 & 70 and the 7&7. Do you want to vote on the 65, 0&7? We will vote on this. It fails 4-4-0. I will ask for the 70% 0&7 now. This one also fails 4-4-0. We are back to the Governor's budget. We will talk about the 14th amendment which is decreased funding for medical services projected caseload/utilization rates.

Representative Kerzman: I think that is a pretty heavy cut. I can't support that because of several reasons. I think we are going to be bumping up against our maintenance of effort and we are going to be leaving some federal dollars lay if you take the match at a 63% or whatever. It's a pretty good size hit to the department. I also hope that we aren't affecting any of the entitlements to the Medicaid program.

Representative Bellew: Something similar on that same line, we have a reduction of 9.6. Shouldn't there be a reduction of federal funds on those same lines? We went through utilization rates last biennium. We were fairly close. We did the same thing this biennium. Some of us believe we are fairly close again. I just wanted to bring that forward.

Chairman Pollert: I would remind the committee on the turn back. The last biennium we could have actually hit those numbers a little harder but we didn't. Any other discussion?

Representative Ekstrom: This is across the board. I think that if you look at things like the state hospital and the human service center which is being hit pretty hard with returning veterans with traumatic brain injuries and so forth, this is an awfully severe cut.

Representative Kerzman: Just a little bit on case load. I know out in the west we have difficulty providing some of the services because they are bumping up the oil filed rate salary. There were a lot of unfilled needs out there. That might be why utilization is down a little bit in some areas.

Chairman Pollert: I don't know if you guys looked at the utilization numbers and went through them. That is what we did and what we came up with. When we had the detailed reports the shaded areas, we went through the 9 months of the last year. Those numbers seemed awful similar. That is how we come up with the number as far as case load utilization.

Representative Kerzman: We realized that too and we looked at those. That is kind of surprising to me because of the aging population. I think we might experience a good spike. I would like to see us prepared for something like that.

Chairman Pollert: We were discussing the case load utilization.

Representative Bellew: If we come up with a specific spreadsheet then I think the department will have to follow that .If we just pick a number like this they still have the option of moving in between line items so they can work their budget to the best of their ability. I don't have a problem with this.

Chairman Pollert: I'm going to do all utilizations at the same time and hopefully everybody is going to be here. We will take a roll call vote on the 14th amendment. The 14th amendment passed 5-3-0. Now we will go to long term care. We will start on 15th amendment. Could you give us some breakdown of that?

Maggie Anderson: The OAR was built on an estimated number of Medicaid eligible individuals that would be living in assisted living. It was based on $1000 a month rent subsidy. It would be 100% general funds because CMS does not participate in room and board for anything other than their specifically identified institutions. The people would need to be Medicaid eligible and receiving personal care services. Then they could apply for this and it would be up to $1000 a month per person. It would be 100% general funds very much like the room and board that they provide for basic care.

Representative Nelson: I will give you an example. In assisted living is where the bar is being moved to. It is a great alternative for the residents who utilize that. I know the numbers in basic care have decreased because of the assisted living option being available. It is a less expensive alternative. I guarantee that we will do this. It may not be this year. It is good for the people who utilize that. I think its worthwhile exploring.

Chairman Pollert: We will take a roll call vote on amendment 15. It fails 4-4-0. We will move on to the16th amendment which adds funding to increase the personal allowance for individuals in the basic care facilities.

Representative Kreidt: That was my amendment. We will increase from $60-$75 a month. $60 doesn't go very far. The $75 would give another $15 a month to buy personal items to make life easier.

Representative Bellew: There would be no federal funds involved?

Representative Kreidt: Correct.

Representative Ekstrom: I'm sure you recall on public testimony where we saw the budgets of these folks down to the penny. I remember one individual in particular after getting the ride to church and giving a little donation to church she has $0.26 left at the end of the month. That's not dignity. For her to be watching pennies like that seems to be wrong.

Chairman Pollert: We will take a roll call vote on the 16th amendment. It passes 8-0-0. We will move on to the 17th which adds funding to nursing facility bed limits.

Representative Kreidt: This is my amendment. Many of you realize that our nursing facilities were mainly constructed in the late 50's, early 60's. We have a lot of construction going on with a number of new facilities being built. We continue to see increased costs as we move forward with these projects. This would allow the property costs for a single room to be $138. For most construction projects that are out there, this would allow them to stay under the limits. If you remember we are using the in general funds out of the healthcare trust fund to enable us to go ahead and do this. This will this attract over half a million in federal funds. I think we need to enable these facilities to move ahead with these products.

Started new job. Recorder quit.

Representative Kreidt: Most of the remodeling is going to fall along the lines because most of these facilities right now have single rooms. Most of the people out there don't want a double room they want to go to a single room. They want privacy and a better quality of life instead of having a roommate. Most of the remodeling and a new construction allows those facilities to have mainly single rooms for those facilities. That is the trend we are in. Even speaking for myself if I had to go to a facility I wouldn't want a roommate unless it was my wife.

Chairman Pollert: Let me ask you this question. In their rate structure aren't they able to do that with the proposed Governor's budget anyway?

Representative Kreidt: No. You have your cost categories that have limits set on those. There is a limit you can reach. If the construction project exceeds that then you ahead those costs.

Representative Bellew: This is a question for Roxanne. Do we need to have this specifically stated that it is coming out of the health care trust fund? It looks like to me that it is coming out of the general fund right now.

Roxanne Woeste: When you vote on the motion you can have it be that the funding can come from the healthcare trust fund and then it will be adopted there. The motion would be adopted and rejected in such a manner.

Chairman Pollert: I think that was your intention?

Representative Kreidt; That was in the amendment that I provided when we brought forth those amendments. I did state that the amount would come out of the healthcare trust fund.

Chairman Pollert: This is a huge budget. The amendment is that the money is to come out of the health care trust fund. We will take a vote on the 17th amendment. It passes 8-0-0. We will move on to the 18th amendment with basic care and nursing home facilities. We will move on to the 18th amendment. This is a breakdown because you are going to need these for the next

few items (Attachment D). It was asked for in the amendments about the $2 wage enhancements. Then it incremental down. You can see it is broken down between nursing homes, basic care, and the DD. That would be part of that particular amendment.

Representative Kreidt: There would be a division. Number one would be for individuals making $15 an hour or less. The other one would increase $2 an hour for everybody.

Chairman Pollert: On the next page if you look at the bottom it has to add a section of legislative intent regarding the funding for basic care and nursing home facilities, salary, and benefit increases. That would have to be put in when you are trying to work for the $15 an hour or less if I'm correct.

Roxanne Woeste: That is correct. There is just an accompanying language on your second set that kind of specifies that.

Chairman Pollert: It is on the next page under programs affecting program and policy.

Roxanne Woeste: It is the second paragraph in your second language packet of amendments.

Representative Kerzman: I guess I would prefer alternative B. My concern with Alternative A is when we talk about the $15 or less, out in the rural areas we have a little trouble attracting nurses. If we approve that attraction at all we need to raise it up a little bit. We basically are giving this to the lower services. They need that but I think we also need an adjustment to nurses.

Representative Metcalf: I guess it's a matter of who we pay and when. Do we pay that now based on the fact that contract nurses are at such a rate that it is going to kick this cost up way beyond whatever is in here. That is a personal feeling that is not a documented feeling. The fact is that if they can't get the nurses they need the first thing they need is to offer the wages there to go overtime. Many of them accept that overtime and will work whatever it takes. That

overtime costs money too and a lot of money. If they have to go into contract nursing then we will really know what the costs are. This will make this little bit here shrink down to nothing. In my opinion we have no alternative but to offer alternative B there for $2 an hour salary and benefits for the nurses and everyone on the staff.

Representative Kreidt: I think we realize where our real problem is. I do realize that there are outlying facilities that do have problems attracting nurses and keeping them on staff. Again, my feelings in regards to this using the $15 an hour and under is good. The situation is really the CNA's and where it comes into place. If we can get those people up to what I feel is a fair living wage to attract those individuals to come work at the facilities. That is where it really lays. We have a 7% inflator that is on the table. That 7% can also be used to increase nursing salaries .most of those individuals are at a higher rate than your other personal. If you are inflating a $20 salary at 7%, it is quite more substantial. If you are inflating a $9 salary at 70 cents. There is quite a difference if you are looking at that and putting that percentage inflator into effect. I thought this was a fair way to go and still be able to save about $4 million to use towards the inflator. That is kind of the reasoning that I use with the $15 and under and the $14 million figure.

Chairman Pollert: If the $2 passes for the $17 million then we have to take a long, hard look at the inflator. That is my opinion.

Representative Kreidt: I think you would be correct.

Chairman Pollert: Let's say we pass the $14 or $17 million. If this $2 passes you are advocating for a 4&4 on the inflator? I think this is a legitimate argument. I don't care if you are talking about long term care or DD. If this passes we have to have a long hard look about the inflator for everybody. When I say 7&7 I mean everybody, not just one segment.

Representative Metcalf: I understand exactly what you are saying. I'm not in favor of spending any more money then we have to. I'm going to talk about the nursing homes that are basically within 50-60 miles of Fargo, ND who are paying Fargo wages and still can't get the nurses that they need and have to hire contract nurses, this is going to go out. It's not going to be staying in there. It's going to be in our cost. We have got to be able to provide that service. I really feel that it would be nice to look at both of these individually but I think we need to look at them as a package. The 7&7 and the $2 inflator is the minimum of what we need to keep our nursing homes viable and by that I mean with the staff that they need to operate that home. I realize that economics say that we can take this out of the nursing staff and we don't have to pay them what they are worth or what the private industry thinks that they are worth. I really stand up against that philosophy and I would hope that we could support this amendment.

Representative Nelson: I think the bigger picture is what we do. There are some realities that we have to live with. In this case you look at the $15 an hour, there was a $3.6 million cost savings there. It was my feeling that whatever we do in this regard we have to be on the same level with the DD providers. There is a $3.6 is the number here. The DD providers, does everybody have a ball park figure for the people that are over $15 an hour. Are there any that would be affected in this regard?

Barb Murray: 10% are above that. 90% are under $15 an hour.

Representative Nelson: If we go down this road with nursing homes with the raise. The wage pass through is important. It gets to the employees sooner. It does raise the floor for the workers that are working at the lowest rate. The inflator will pick up the higher level employees. I don't have a problem doing this but I think we should do the same for DD providers as well.

Chairman Pollert: Does anyone know what the increase per cost of bed is in the Governor's budget. I know I'm just wondering if anyone else does. It is $8,139 per year increase per bed.

What I did was take the increase between the nursing homes and basic care of $55 million divided by $3,388 beds and divided that by 2. I come up with an increase per bed of $8,139. I myself find that a huge figure. I sit there and ask if we add $2 an hour and add $2,508 towards the cost of a bed per year, meaning each bed will go to $10,600 and some odd dollars. Now you know where I stand. To me, a lot of our costs are getting out of control. I fully understand that salaries need to be paid. When I see the $8,139 you just kind of go wow. I know there was information passed out that showed the average cost when we were looking at the inflator of 7&7. I think the average cost total for the nursing homes was 5.8% increase. This budget is showing a 14.1% increase for the nursing homes. That is why I'm bringing that forward. That's all I'm saying.

Representative Metcalf: I have one thing to say about that. I do not feel that we should provide salaries for our staff that leave them in the poverty level. I see that happening time after time. When 65% of your CNA's are being turned over every year because they are getting poverty level wages. I'm not saying that we should pay them a CEO's wages or anyone that is on a career path. I do believe that they are entitled to a living wage and get them out of the poverty level.

Chairman Pollert: We will take the roll call on the 18th amendment, alternative B. That fails 3-5-0. We will take the roll call for the 18th amendment, alternative A. That passes 6-2-0. We will move on to the 19th amendment.

Representative Nelson: I will further amend that to add the language after providers under $15 an hour.

Chairman Pollert: Does anyone have the numbers for under $15 an hour?

Representative Kreidt: If we are talking 90% you would get a pretty close figure by knocking 10% off with the figure we have there. That would get you a ballpark figure. It would reduce that by $150,000 or somewhere in that area.

Chairman Pollert: Can we get that further figure sometime today? Is that a possibility?

Brenda Weisz: We don't know how we would get that information. We don't do the rate setting that way. You could put intent language into your amendment that says that is forced to go and then we would have to work with the DD providers to find out that information.

Chairman Pollert: Ok.

Roxanne Woeste: I do believe Representative Kreidt is correct. For the purpose of this committee work I think the best thing would be to take 90% of that number. The general fund would be $12,775,059 which would be close. That is the general fund number.

Chairman Pollert: Is there any other discussion? If not we will take a roll call vote. That motion passes 6-2-0.

Representative Wieland: The reason I supported these last two increases in the budget. We have a $127 million increase and a $22 million turn back in the Governor's budget. I realize that the turn back isn't from everybody. Those kinds of numbers really aren't sustainable. We are going to run into trouble. I know everybody thinks that the report from yesterday from the forecast was rosy. That expelled caution to us. That is part of the reason that I have voted against new programs. That is the point I want to make. I feel that it is far more important to take care of the people we already have than start creating new programs. That is why I voted against new programs and I intend to continue to vote that way.

Chairman Pollert: I'm keeping a running tally as we are going here. I know we haven't talked about the inflator yet. Currently we are $10 million over the Governor's budget right now. When

you look at a 21.6% increase over the previous biennium I have a hard time with that. That is my opinion. We will move on to the 20th amendment.

JoeAnne Hoesel: The autism waiver is focusing on children from birth to five. It would have several tiers of services that would be directed by the parents but there would be a menu. It is intended to have a team of professionals that have enhanced training in this area so that the methods that we can impact their autism can be minimized. It is really based on the research your ability to impact and reverse the negative results of this kind of disorder have a better chance at this age instead of identifying this as an adult . This is identified for 30 individuals. There is a cap per individual. They do need to be screened to the ICFMR level of care. We are looking at children that need intervention. However, they do not need to have a mental retardation. It is focusing on a group of children that we currently do not service in the DD waiver.

Representative Ekstrom: I think it is fairly clear that if we can intervene with these children at an early age, we produce kids that are functioning and that's the difference between whether someone is going to be in a regular classroom or if we are going to have them in some other more intense situation. It's an investment just like vaccinations. If you put the money in right now you don't have to spend it later.

Chairman Pollert: I would love to support this. I look what we have done with the $2 an hour on the last two budgets and wonder where we stop. If we would have had $1 hour talk instead of $2 right away and ran it through, I could have understood he discussion. When I look at this I understand the long term care people. I understand the DD people. These people are living, working, and making a living. We are talking about kids who need our help. I think we lost focus. Any other discussion? We will take a roll call vote on alternative A. It fails 4-4-0. We will

move on to alternative B. All of these amendments can come forward again. This passes 5-3-0. We will be in recess until 15 minutes after floor session.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 2/10/09

Recorder Job Number: 9144

Committee Clerk Signature Morgan Pennell

Minutes:

Chairman Pollert: We will call the committee back to order. I don't have the title page but it is DD critical needs, alternative A and B.

Representative Wieland: I have a correction to make on alternative B. This would just change the one. The other one was OK. I'm going to pass these out right away.

Chairman Pollert: Before you start, this morning we did the personal use. We went from $60-$75. That is actually in the Century Code. It takes a statutory change. Roxanne is going to get the amendment ready. That one is one of the few that is in the statute. We do have to have that done. That is going to be coming forward. For some reason that one is in the statute.

Representative Nelson: That having been said, that was the personal needs. That is for basic care residents? We didn't discuss any amendments as far as personal needs allowance for ICFMR residents did we?

Chairman Pollert: We have not discussed that yet, if there is one coming. I thought there was one more coming but I don't remember for sure.

Representative Wieland: Again you had proposal A and proposal B. Proposal A does not change any when you come from the consideration. Proposal B has been changed because what it does is it corrects it so that it would be to the Ann Carlson Center and any other DD

facilities that need to be included. I wanted to make sure that the change would be noted in B. I plan on supporting B. You can do it how you wish. I don't have any suggested way in which to do this.

Chairman Pollert: We will take the roll call vote on the 21st amendment alternative B. That passes 8-0-0. We will take the roll call vote on the 21st amendment alternative A. If it passes would alternative a take precedence over alternative B? Is that correct? What I will do is take the vote and ask that it would be a substitute for the other. We will take the roll call vote on alternative A. That fails 3-5-0. We will move on to the 22nd amendment which is to remove funding included in the executive budget for the addition of a third tier of personal care that would allow a maximum of 1,200 unites of care per month. Everybody knows the fiscal? Any discussion?

Representative Ekstrom: I went about looking at this from the standpoint of how many folks we could conceivably bring back out of the nursing home. When I asked that of the department they estimated about 10 individuals could come back from a nursing facility back into their homes with the addition of these two hours more a day which would come up to 10 hours a week. If you take the number of $912,500 in the biennium, 10 individuals of approximately $125 a day times 365 days a year. That total is the $912,500 in the biennium. That is the savings to the state of ND. There are costs involved so you would have to offset the costs. Every individual that we keep out really does ultimately save us.

Chairman Pollert: Is there any more discussion? I think this dealt with going from the 8 hours to 10 hours. We will take the roll call. The vote fails 3-5-0. I'm going to reconsider. I did mean to vote yes. I have to ask for a reconsideration. The roll call vote is 5-3-0.

Representative Ekstrom: Again I want to say that taking those 10 people out gives us the $1 million that we would be spending in general fund dollars in this biennium.

Chairman Pollert: Is there any other discussion? We will take the roll. This passes 5-3-0. Moving down the line to decrease funding for long-term care projected case load/utilization rates. What I will say is that we went through the detailed reports again and that is what the amendment called for if I'm correct. We will call the roll. This passes 5-3-0. Going down again, the decrease funding for DD grants. Any discussion?

Representative Ekstrom: I'd like to hear the rationale in terms because there seems to be push in this committee to reduce the population at Grafton. These are the folks that would be coming out into the community and would add to the case load. They are the most severely disabled. They are the ones who are the most difficult to take care of. They are the most challenging cases. I would submit that we need this money. I would agree to a decrease but not this big of a decrease.

Representative Nelson: I can assure you that when we went through these numbers that they are specific as to the new residents coming out of Grafton. They were considered in the decrease utilization. They were added in. That wasn't part of the greater number.

Representative Kerzman: How many did you figure would come out of Grafton? 30?

Chairman Pollert: 115 to 97 I thought was their projection. You have to remember the discussion the last biennium when we had the same discussion on case load utilization. I remember it. You would have sworn we were kicking everyone out in the streets. When you see the turn back on the DHS budget, the Medicaid budget showed about a $12 million turn back. That tells me that the case load utilizations that we looked at actually were correct and we could have went a little further. If it's specific, I don't have the figures in front of me. Those are the numbers our side came up with. I will remind the committee that DHS does have the flexibility of moving around which they did. The last biennium, a lot of our case loads came out long or short. They came out what we thought except for SPED. Those numbers did increase.

You will see that we aren't doing anything with SPED. We are agreeing with those numbers. Those increases I agree with.

Representative Ekstrom: The $22.4 million turn back, $2 million was human service centers because of staff turnover and difficulty filling the position. State hospital was $2.7 including the $1.3 million unspent one time capital project. Long term care was $4 million primarily from nursing facilities. Medical drug was an estimated $1.6 million and Healthy Steps, because we changed the eligibility requirement for SCHIP or whatever we are calling that now is half a million. There is a traditional grants turn back of $12.6 which was in the November reports that generated from the old MMIS indicate a utilization and cost data that needed further analysis. It goes on. This is page 2 of Brenda's testimony.

Chairman Pollert: You are talking about the discussion of the turn back sheet that was given to us. If I'm on our side of the table, we did not touch the turn back in any of our figures we did not touch SCHIP. Please correct me if I'm wrong. We definitely did not touch the nursing facilities to the extent that we did last session. We could have touched them a lot harder but we didn't. We didn't get close to that number. It was 40 or 50 beds I think. We will take the roll call on the DD grant utilization. That passes 5-3-0. On the next page on the aging services program, I'm withdrawing that amendment. Moving over to our Children and Family Services program. This increases funding by $200,000 from general funds to $300,000. Representative Metcalf you asked for that, is that correct?

Representative Metcalf: I dropped it down by $385,000. You should be happy with that so now we should just put a yes on what we requested. This program is one that is being run by Lutheran Social Services. It is basically working with our children up to age 3. They have seen a considerable improvement in the children that they have worked with. To this point not only will that $200,000 be brought back in my opinion but they are expanding this facility into

Burleigh and Morton Counties which they feel are right for the use of this program. I really feel that the request is justifiable and I hope this committee will approve it.

Representative Wieland: Is that an OAR?

Representative Metcalf: It is an OAR. It is the second to the last one.

Chairman Pollert: It's a different figure from the original figure that Representative Metcalf was asking for. If no further discussion we will take a roll call vote. It fails 3-5-0. The next line is to decrease funding for a new FTE position and adding a budget for background checks. If I'm correct isn't that just a difference of opinion between Office of Management and Budget and the green sheet. That is just a straightening out?

Roxanne Woeste: The executive budget did add $323,921 for this activity. The amount reported by the department is the $308,000. We are talking about the same funding. The higher number includes the 5&5. The $308 reported by the department would be the base salary for that new position. For all the agencies that we do green sheets for, when the Governor's budget adds positions we include the total funding including for that position including whatever the compensation package is. If a committee so chooses to remove one of those positions we would agree to move all that funding. I don't think you would want to include extra salary dollars for a position that is not funded.

Representative Wieland: I don't understand. If you hire someone at a figure you give them a raise immediately? That is what we are talking about. They would get a raise then or on the first of August. I assume that they are going to be hired about the first of July or August. You are saying that they immediately get a 5% increase in pay?

Roxanne Woeste: The way the budgets are built when they add a position, the position is added whatever the base salary is. When the Governor's compensation package runs, it will increase the salary for that position. They will get the increased funding so the department can

work with whatever the dollar provided is for that position. I'm not saying the department is going to hire someone then give them a raise that first day. They will look at the money available for that position and decide what the appropriated starting salary is for that position, knowing that they have to fund that position for 24 months. If that person is showing favorable performance they would have to give them an increase on July 1 of the next fiscal year. The committee can decide if they want to keep all of the funding in or part of the funding out.

Chairman Pollert: Basically we are just talking about removing $15,921. That is what this would do .It's not removing the FTE.

Roxanne Woeste: This does not remove the FTE just part of the funding.

Representative Nelson: It would help me to know is the $15,921 is that the increase in the second year of the biennium? The performance increase or is that a 5% on each year?

Roxanne Woeste: I believe it's a 5% on each year in health insurance package.

Representative Nelson: So the health insurance isn't part of the base salary?

Roxanne Woeste: Do you want the position in or out? You could always decide to partially fund it.

Representative Kreidt: You've got $308,000 you can work with that number. You can delete the $15,921 and use that $308,000 for that position.

Representative Bellew: My concern is that I'm not sure what this person is doing in the human services budget. I think it should be in the Attorney Generals budget.

Chairman Pollert: Is there any other discussion? Would we rather just remove it? Let's eliminate the 27th amendment. We will move on to the next amendment.

Representative Ekstrom: That was my amendment. I think we heard in public testimony from a number of individuals that have had mental health issues. I just can't get over the fact that you would stand up and be willing to publicly testify. The stigma of mental illness is often great

in this society. This would create jobs for people who have had mental issues. They would partner with other people who are not so far along in their treatment. These folks make a difference in terms of making sure that these folks are getting up in the morning, going out, shopping, getting a job, and being productive members of society. I know it's a lot of money and I'm as hesitant as anyone else to add money where we have not had it before. I do think it's an important program and I put it in there.

Chairman Pollert: Was that on an OAR? I was just looking for it.

Representative Ekstrom: Yes it was a partially funded OAR and what I suggested is that we would fully fund it.

Chairman Pollert: Is there any other discussion? If not we will call the roll. The amendment fails 3-5-0. We will move on to compulsive gambling. The Governor's budget had an increase of $300,000. This amendment would reduce that to an increase of $100,000. Currently there is $400,000 in the Attorney General's. I won't go to that specific part. This comes out of DHS.

Representative Kreidt: That is my amendment. My amendment was that there was $300,000 from general funds. I did reduce that to $200,000.

Chairman Pollert: You reduced it to $100,000 increase over the Governor's Budget.

Representative Kreidt: Yes so they would have $500,000 to go forward. I feel that is a fair amount. I'm sure we will be looking at this again in two years. Let's see what kind of results we get out of this.

Representative Metcalf: I guess this particular aspect is something that I have been very concerned about over my years in service here at the legislature. Since we added lottery and other gambling services into our state processes, which I don't think should be in here as far as gambling is concerned. When you see the damage that is being done to families because of gambling. We don't realize it. The problem is for the people that will not admit they have a

gambling problem and before they know it have lost everything they have had in their careers. We don't want to spend a few hundred dollars that we make off the profits that the state makes to ensure that we can minimize the losses that these people are incurring. I feel that we should leave it the way it was. What is more important, to have an extra $200,000 in the surplus that the state will carry forward or is it more important to take care of our people who are being injured during this process. I hope we can kill this amendment and give these people a chance of living a good life.

Representative Nelson: Although I don't disagree with much of what Representative Metcalf said about the addiction of gambling, I'm guessing we are still over the Governor's budget. This money isn't going to the state treasury. We are still on the plus side of the ledger. That seems so unfair to me is that much of this comes from casino gambling. The state of ND is making an effort to decrease gambling. The tribes of the state are not. They have a voluntary contribution that hasn't grown as I can tell since the original compact. They should be partners in this as well. That is where much of the addiction comes from. We certainly contribute to it but this should be a partnership. I think that is one of the faults of the gaming compact with the tribes of the state.

Representative Metcalf: I don't think it's fair to consider the tribes versus what we would say the white people or the other people. To me we are all people and we all deserve that. I cannot change the agreements that have been made between the Governor and the tribes. I can change what we can do for our people who need this service. When you hear what people say and how they have had this problem for years, they fight it continuously. They will say that if they didn't have the help that they did that they would succumb to it again. It is a constant pressure. It's the same as if you would have an alcohol problem. If you don't have the help it is difficult to overcome. I would hope that we could leave that $200,000 in there. It won't be that

much of a cost to the state. They will end up making money because of the continued employment of the individuals.

Chairman Pollert: What if I made a substitute motion instead of the $200,000 to reduce it $150,000. The Governor's budget was $300,000.

Representative Metcalf: I would like you to make that motion. Whether I support it or not is something else. There are certain things that we don't know. I would bet that there are families in this room that someone in their family has had a gambling addiction. I know I have in my family.

Representative Wieland: I'm going to support doing this. I'm going to tell you why. One of the most successful addiction programs that we have anywhere is AA. The State of ND contributes nothing to AA. They do it all on their own. They have their own program and did their own thing. They didn't ask for any dollars from the state. We are giving them $400,000, now we are trying to go higher? I just don't see why we need to increase that program that much. I just can't support that.

Representative Metcalf: I just want to bring to mind the fact that the state of ND doesn't sell booze but we are selling lottery tickets.

Representative Kerzman: AA is merely a support group and doesn't get into a lot of the addiction problems. Treatment is a different thing.

Chairman Pollert: I'm going to ask the clerk to vote on the $200,000. It fails 4-4-0.

Representative Nelson: I would move to the motion that you were going to make. The removal of $150,000.

Representative Ekstrom: I second that.

Chairman Pollert: Basically we are reducing the increase in spending by 50%. We will take a roll call vote. That motion passes 7-1-0. We will move on to amendment 30 which removes funding for Governor's Prevention and Advisory Council grants. Is there any discussion?

Representative Ekstrom: This goes directly to the voice of the people and what they said they wanted. I don't know exactly what removing this funding would do to that council. I would need some clarification.

JoeAnne Hoesel: The council was formed in the last legislative session. It was given $100,000. In our current biennium is located in the Governor's office. This council is represented in all of the agencies in the state that have any prevention funding. It also has some local representation from some treatment providers and from the higher education and also from a school prevention officer. What their task is, is to take a look at prevention programs in the state of ND and make sure that there isn't duplication of services, and also put in place a prevention plan. It is prevention of substance abuse and prevention of also high risk behaviors. This currently funded $100,000 went 100% out to 6 grants in the state. We issued a request for proposal. From that, we received proposals from around the state and ultimately funded 6 of them. All of them are at the local level providing prevention services to the group that was identified. They were 5-8 years old. We took a look at the prevention data in the state which shows that children in ND are starting to use alcohol younger and younger. The plan was to put money targeting it toward that age group.

Representative Ekstrom: This has nothing to do with Measure 3.

Chairman Pollert: When information came out there was like $97 million between alcohol, drugs, and tobacco rehabilitation programs. I'm just wondering if there wasn't a double up there. I would have to believe in the DHS budgets that you must have some prevention programs going on. I would have to believe that. I'm just wondering if this is a double.

JoeAnne Hoesel: The task of this council is to assure that there isn't a duplication of efforts. You can take a look at the other departments. They all target different areas. These grants are not duplicated. That's one of the tasks of this council is to assure that it is the case. The funding that you are referring to is federal funding. This is general funds. I believe the general fund is like $199,000 total in general fund versus the $9 million that would be federal.

Representative Wieland: You said this was funded in the Governor's budget in the last biennium? Why didn't it stay there?

JoeAnne Hoesel: My understanding is that this reflects the fact that the division of mental health and substance abuse was reviewing all of the information anyways since the Governor's office typically doesn't fund and operate grants. The division of mental health and substance abuse does .My understanding is that they just put the money there because we were managing the grants anyways .

Chairman Pollert: Any further discussion? The amendment passes 5-3-0. We will move on to the 31st amendment. Alternative A increases funding by $1.09 million and alternative B is to decrease the funding for centers for independent living by $400,000.

Representative Ekstrom: Later on this afternoon, I know we are going to talk about the ADRC and we know what is pretty much going to happen. The centers for independent living could be an ideal vehicle for us if we were serious about doing single point of entry. They have established centers around the state. What this additional funding would do would allow them to have more sites. I don't know where this committee came down. The discussion on the floor with regard to the dementia bill mainly does not address single point of entry. When I ask the other committee members from human services policy division that was never discussed during that testimony. They had no rebuttal. They had no one coming in and saying that they

didn't want single point of entry. Everyone who testified was in favor of it. I think that is a discussion we should have here.

Chairman Pollert: I know one of your amendments is coming up when we go down further on program and policy. They could also be related.

Representative Bellew: Policy committee doesn't like it when we add stuff back in that they killed on the floor. They really don't like it.

Chairman Pollert: That discussion is going to happen anyways.

Representative Ekstrom: I am aware of that and I know how angry they get when we do that. I think we have a unique situation this year. I don't know how many bills were stripped away. From policy appropriations, I agree that the policy needs to be debated. I also know that our responsibility is the money. I have watched almost every one of those bills that became stand alone go on to die. I'm not saying that there is a conspiracy or anything else, I just know that there is an urging coming from the other side of the aisle to reduce this budget. I can be in agreement with a lot of that. I really have a lot of difficulty with the way the process was worked.

Chairman Pollert: I have to correct myself. The increase in the Governor's budget was $980,000. I am wrong on that it was $800,000.

Representative Ekstrom: I think from a philosophical standpoint that there is a place for nursing homes but there is also a great place for community based services. I think that we did hear a debate on the floor where very intelligent people that said their family went through a great deal of grief trying to find services. I have heard this from my constituents. I think we have an ideal vehicle to get this up and running.

Representative Nelson: I wish we would have had the opportunity. The county social service directors have been left out of this discussion. I really would like to hear from them and let

them defend what they do. I'm not so sure that they don't do a better job. I think that some point in time in this session, in the Senate, or in the interim that it should be part of the discussion to see where the bar is at. We can see if that is the appropriate place before we start going to a different direction. Their voice has not been heard in my opinion.

Representative Wieland: I have talked to several social service directors and they have indicated to me that they do provide that information. You had one person who said to go to the yellow pages. I would have fired that individual in a minute. That is total incompetence for them to do that. I have some experience here because my mother is 97 years old. She lived in an independent apartment until she was about 95. We could see some problems. We went to the social services in Cass County and we got terrific help from them. They gave us all kinds of options. It was our decision. If they expect that someone is going to make the decision for them and the ADRC that is not what they are going to do. They are just going to tell them that this is what they have and this is what their options are. There is assisted living and other things that you can do. There are options that they told us about. I agree with Representative Nelson that the social service directors are getting a bad rap here. I think we have 53 of those facilities out there. If we are going to do a single point of entry maybe there is some training that needs to be done to allow them to do that and for us to set up an additional 2 now and who knows how many later just doesn't work. I think we are barking up the wrong tree.

Representative Kreidt: Just going back we heard on the floor today and now Representative Ekstrom said something. Single point of entry wasn't established to keep people out of nursing homes. That isn't the intent of that. The majority of residents coming into nursing homes usually come from the hospital. They aren't looking for additional services.

Chairman Pollert: Is there any further discussion on alternative A? If not we will take roll. It fails 3-5-0. Is there any further discussion on alternative b?

Representative Ekstrom: Is there a rationale for the decrease?

Chairman Pollert: In the last biennium wasn't there $250,000 or $280,000 put in the communities of independent living. What this would be doing is half of the $800,000 in the Governor's budget. This motion passes 5-3-0. We will move on to amendment 32 that relates to the health care trust fund that provides moneys in the fund will not be included in drafts and appropriation bills introduces as part of the executive budget.

Representative Kreidt: That is my amendment. This is the health care trust fund. This is money that is generated on an annual basis by interest and repayment of loans to health care facilities that receive money out of the health care trust fund a number of years ago. This money will keep coming in probably for another 15-20 years with the repayment of those loans. This is money that is generated by nursing homes, basic care facilities, some assisted living facilities were also involved with those loans. My personal feeling is and has been that the money should e used for ongoing basis for a healthcare facilities either in salary incentives or an inflator usage and that it should be appropriated by the legislator when we are in session. That is what the amendment would do.

Representative Ekstrom: This is tying the hands of the Governor and any future Governor. I don't know the process is broken so why do we need to fix it.

Representative Bellew: It is the legislature that does the appropriations, not the governor. That is in the constitution.

Representative Ekstrom: All I'm suggesting is that as the executive branch puts forward a budget that the money is available to play into the budget.

Chairman Pollert: Any other discussion? We will call the roll. This passes 6-2-0. We will move on to the 33rd amendment. Is there any further debate?

Representative Metcalf: Basically you will be surprised that I understand where Representative Wieland is coming from. One of the problems that we have as far as our county social services is the name that they are social services. People attribute to that name as being welfare. This is one of the reasons why they don't like to go that way. If there was some way that they can change that name and I'm sure they could provide all the services that we need. As citizens of this state. It is that stigma that goes along with that name that is hurting the whole program. That is my opinion.

Representative Ekstrom: Just one other piece. I think you all know that I work at a funeral home. At a daily basis I do pre-planning services for folks that are mostly well over 70. They talk to me often about the process of trying to decide how to get services. It is very confusing and there is a stigma about going to the county. They perceive it as being welfare.

Chairman Pollert: Any more discussion? If not, we will take the roll. This amendment fails 2-6-0. We will move onto SCHiP which is the 33rd amendment.

Representative Bellew: I believe we have to have an amendment to take this out.

Roxanne Woeste: That is correct and now might be a good time to do that. HB 1012 does include as it stands $600,000 as it stands for aging and disability resource. It may be a good time to proceed with an amendment.

Representative Bellew: I will make that motion to remove that $600,000.

Representative Wieland: I second that.

Roxanne Woeste: I believe the funding is in the aging services program. The policy has already been removed.

Chairman Pollert: We will vote on this motion. It passes 6-2-0. The SCHIP bill authorization and funeral set aside have not hit the floor.

Representative Ekstrom: For purposes of time saving I will withdraw those amendments but I would like to have in the record that I have serious problems with the way this process was carried out in terms of taking these out and making them stand alone. I understand the changes in policy but there were plenty of other things that were within HB 1012 that were policy changes that never went to a policy committee.

Representative Bellew: Another clarification from Legislative Council that is if it's changed on the policy committee we have to remove the funding.

Roxanne Woeste: That is true. We do need to wait to finalize this budget 1012 to marry it with the two policy bills.

Chairman Pollert: That is correct and I'm sure hoping that the votes on the floor come up. The SCHIP bill hasn't been on the 6th order yet and the funeral bill is going to go in front of the whole appropriations.

Roxanne Woeste: We have a couple issues we need to clear up before we can finalize 1012.

Chairman Pollert: Moving on to the bottom of that page to the 36th amendment. I need a little explanation on that.

Representative Nelson: If you remember the overview this was the monitoring systems that were sent. This is currently used in Cass County. That is one area that I remember. Quite honestly there are variable to monitor whether it is blood pressure, heart, or that type of things from homes. It would actually save money with mileage. There is no need for an appropriation as I see. This might be something that would become very useful in rural areas as well, rather than having a nurse come and visit or the patient go to the clinical setting. I think its one good use of technology and it provides healthcare delivery in the home.

Chairman Pollert: What would this legislative intent mean?

Roxanne Woeste: This is the best language we could come up with. What the legislative intent would be is that the department should consider any changes they need necessary to implement reimbursing for home tele-monitoring visits at the same rate as inpatient visits. I didn't have the pleasure or time to discuss with the department if there are current practices for reimbursing at different rates for these visits.

Maggie Anderson: Off the top of my head I do not know what the difference in our reimbursement rates are. I do know with the tale-monitoring sometimes it is the equipment piece as well. The initial equipment that they need in the home to actually do the monitoring. If I understand this intent it would require us to pay the same for a tale-monitoring visit as we do for a home health visit. I don't have those rates with me off the top of my head. We have not done any kind of fiscal analysis or impact for this.

Chairman Pollert: Any other discussion? If not we will call the role. It fails 3-4-1. The next page is the state hospital. The top of the page has amendment 37.

Representative Nelson: That was mine. We funded about half of the extraordinary repairs. If we want to do both of them in one we can. We had no intention of taking the resurfacing and paving out. The reason that is included in a separate motion is with the uncertainty of the economic stimulus money. We thought that it may qualify for that. That is the reason. If it doesn't qualify for that we would be more than prepared to put that back in.

Chairman Pollert: Is there any other discussion?

Representative Ekstrom: I showed you an amendment that I had, I don't know if we plan to bring that up this afternoon? Can I make a suggestion that we will hold that one for full committee until we get our ducks in a row? The one that deals with more than just the $300,000.

Chairman Pollert: I haven't had time. I know our discussion on the $300,000 which is a small figure as to what might happen with the federal stimulus package. The million dollar was just a priority list. I'm trying to justify the $300,000. I know it's needed. We did half last biennium. I'm just trying to get a comfort level of what we are doing here. Do we put the $300,000 or leave it out, or wait and make that decision when we have a better idea from the Senate. The way it sounds to me is that the $1 million won't make any difference. The $300,000 might. Maybe it's all mute .

Brenda Weisz: We won't know with the economic stimulus. We don't know if that can pave the road. Last year during appropriations you did remove money for resurfacing. I'm not sure that we got half of it done with that change. I don't know when we will know if the economic stimulus will allow for resurfacing work or will the economic stimulus package call for roads that are unsurfaced on this point and those are the ones that are actually included in the roadwork of economic stimulus or what.

Chairman Pollert: It's kind of strange because we are trying to work with this budget and keep it in line.

Representative Nelson: I would just say that at the end of the day that this biennium is going to be a good time to resurface that project and get it done because of the economic situation. I don't really think it hurts to pull that money out now. By the time the senate gets this bill, it is certainly one that could be flagged. There might be answers. If not we can put it back in then.

Chairman Pollert: Any other discussion? We will take a roll call vote on the 37th amendment. It passes 5-3-0. We will move on to amendment 38. I have one more question for Brenda. If you throw something out thinking you are going to throw it back in, we don't even know what the economic stimulus package is going to say. If we say we are going to do something that is what I'm struggling with.

Brenda Weisz: Alex clarified as well that we did no resurfacing this biennium.

Chairman Pollert: I think it was $600,000 and we approved half of it.

Alex Schweitzer: We didn't do any resurfacing at all during this biennium.

Chairman Pollert: Would we have put it in as one time and you would have decided where you would have needed it at maybe?

Alex Schweitzer: In my recollection it was pulled out completely. It was basically using chip asphalt.

Chairman Pollert: How much would that have been?

Alex Schweitzer: We didn't deal with any parking lots or anything. We used what we had in dealing with chipped asphalt and did some work with the gravel in one of the parking lots. We were asked not to do any asphalt.

Chairman Pollert: Yes last year says reduce capital improvements from $3.362 million to $3.062 million in reduction of $300,000.

Alex Schweitzer: Right. That was in general. It was basically a general reduction in capital. We didn't have the additional money to do the resurfacing.

Chairman Pollert: Was that number one on your priority?

Alex Schweitzer: It is a high priority because the fact is that we have the prison. It is number one if you look at the capital improvement list by the way.

Representative Nelson: Does that hamper you if this is held over until the senate hears the bill? I know it's a long shot but we don't want to hamper you either.

Alex Schweitzer: I don't have an issue because we won't be bidding on this until the middle of summer. The important thing is that it was listed as the number one priority. That is a key thing.

Brenda Weisz: The economic stimulus package is very clear from the federal government that

you can't replace general fund dollars with stimulus dollars. They are putting their piece on that too.

Chairman Pollert: We will call the question. Amendment 38 fails 1-7-0. Do we want to have the discussion on global health initiative all the way through or do you want to do it in one swoop.

Representative Metcalf: We want one swoop.

Chairman Pollert: I'm the one who asked for the amendment. It gets split down with the divisions all the way through. I'm going off of memory. It is like $4 point some million dollars and 11 FTE's. It's not that I don't like it. There is some of it that I could probably take but there is some I can't. I don't know if that means that the discussion goes on further which it will in the Senate.

Representative Bellew: It is 11 FTE's. The general funds are $4,324,776.

Representative Ekstrom: My amendment is under the Southeast human service centers. There is a separate amendment dealing with Cooperhouse.

Roxanne Woeste: It would work if you take it in one removal. If it would be ok with the committee members you could address Representative Ekstrom's whose would be an add back for the Cooperhouse contract staffing.

Chairman Pollert: Representative Ekstrom is that ok with you?

Representative Ekstrom: Yes.

Chairman Pollert: Any other discussion? We will take a roll call. It passes 5-3-0. We will move to the next page and the Developmental Center. The 40th amendment is to decrease one time funding for extraordinary repairs.

Representative Nelson: Again that was about one half of extraordinary repairs with the

highest priority given to the completion of any roof projects. That is kind of where we left at is that all those roof projects would be completed with this funding.

Chairman Pollert: Any more discussion? If not we will call the roll. It passes 5-3-0.

Roxanne Woeste: If you have your packet that deals with language changes, I believe it is the third page in which is the copy of the statutory changes that we are looking at here.

Alex Schweitzer: The amendment is pretty simply. It changes statute to require that anyone admitted or readmitted to the developmental center requires a screening and approval by the center for them to be admitted. We use our cares team for that purpose. The reason for that is that I heard pretty clearly from that committee that they would like to see the population reduced then. We cannot do that if we continue to have readmissions and admissions to the facility. It is similar to what we do in the state hospital. It is one of the key reasons why we have been able to place people in appropriate settings. That is a part of it too. People want to be places in appropriate settings. That is a higher cost facility. It has been an effect of the state hospital that we hope will be very effective at the developmental center. The screening process, if we felt that the individual needed to be served at the developmental center we would admit them. It is to make sure we wouldn't be admitting people that would be inappropriate.

Chairman Pollert: Any further discussion? If not we will call the role on the 41st amendment. It passes 5-3-0. If I'm correct there are no changes on the Northwest Human Service Center. The next items would be the North Central Human Service Center. The first one on that we would have taken in one swoop with the global health initiative. The one item on that page is to remove funding in the executive budget for providing additional oversight and monitoring of DD cases. Is there discussion?

Roxanne Woeste: To assist with the committee work there are 4 of these positions spread amongst the human service centers, north central, northeast, southeast, Westcentral. This is also one if you care to do all in one motion instead of.

Chairman Pollert: You are talking about page 7 on the green sheet, right? That would be the numbers that I would have figured

Roxanne Woeste: That is correct.

Chairman Pollert: There is 4 positions of $58,793. If we want we can do it as one swoop or keep it. There is 4 FTE's in here. You heard it from Northcentral, Northeast, Southeast, and Westcentral. If there isn't discussion we will take the roll on amendment 43. It passes 5-3-0. We would move on to the Southeast human service center. Alternative A is out and now we need to talk about alternative b which is Representative Ekstrom's amendment.

Roxanne Woeste: I believe Representative Ekstrom's amendment would be to maintain the contract staffing at the Cooperhouse for 24/7 coverage. It is different than how it looks in the paper amendment. It is $236,520 from the general fund with a total of $315,360 total funds.

Chairman Pollert: That is down on the amendment sheet.

Representative Ekstrom: If the committee remembers as we were discussing this initially one of the questions that the chairman and several others had was the commitment of other funds that have already been brought to bear on this project. If you look at page 2 you will see that there is $4.1 million that has been committed. I've got letters verifying those facts that are behind that first sheet. The city of Fargo has made a significant commitment to this project. Demolition has already taken place on the site. We have heard from our chief of police as well as state's attorney's and others that indicate that this would begin to stop the chronic homelessness. We cannot put these folks into one of Ann Carlson's' buildings. We have talked to Rep. Carlsen about that. This is not a Fargo bill. The folks that we are dealing with, most

have come from out of state coming to Fargo in search of their programs. Sometimes they are looking for work and they are not getting it. We all know where homelessness comes from. I would ask the committee to give us a yes on this one.

Representative Wieland: I'm not sure exactly what to do about this particular thing. I had a discussion with a member of the city and asked him some pretty pointed questions about this facility. I got some things that kind of concerned me a little bit. One of them is that a lot of the people would be residents here and would not accept residency and halfway houses or other existing facilities. The second thing is that this reminds me an awful lot of a onetime proposed wet house. I know there is not supposed to be any drinking done in this facility but they expect the individual that is hired through this fund to do something about that. The only thing that this individual would be able to do is call the police department who would respond to that. I'm kind of concerned. We don't have any idea what the FTE's requirements will be. We are just told that it is someone that is supposed to check people in and out. I'm not so sure that it is all they are being asked to do here. I have some concerns. I don't know that it's a bad program. They said that over half of the homeless are in Fargo. That indicates to me that there is going to be someone else that is going to come in and ask for funding of a particular thing. I realize that they have gone a long ways here. I wish they provided us with a little more information about what this individual that would be hired would really be doing. This kind of concerns me. If you are going to deal with a drunk, sometimes those people are hard to handle. They get awnry sometimes.

Representative Nelson: There has been no ground breaking yet?

Representative Ekstrom: That is correct. All I'm suggesting is to say to remove the structure that is down there. Demolition has happened.

Representative Nelson: So we are sitting here. They have the letters of support to build the building. If we don't fund this position is that a deal breaker for the whole project?

Representative Ekstrom: They have indicated to me that without state support that it is going to put it in severe jeopardy. That is as far as I can give you assurance many of the folks that have committed money have said that we need to see some state support on this.

Representative Wieland: Is the amendment in this packet here?

Chairman Pollert: It is but I'm going to get a clarification here so that I get the right vote for everybody. Roxanne, if we want to fill this back in with what Representative Ekstrom wants to do we vote yes. Am I correct?

Roxanne Woeste: Perhaps we will just reword B to say add funding for contract staffing at Cooperhouse of $315,360 on which $236,520 is general fund. A yes vote will be to add the funding and a no vote would be to not add the funding.

Chairman Pollert: So the general funds would be a positive $236,520. The total funds would be a positive $315,360.

Roxanne Woeste: Correct.

Chairman Pollert: So does the committee understand this? We will call the role for the 46th amendment. It passes 5-3-0. That amendment adds back in $236,520. The next amendment was removed in the swoop. The next one is removing funding for young adult transition services. I also think there is another amendment in the west central human service center that deals with that as well. If you look at west central a couple pages in, that is for $650,000 for the young adult transition services. If I'm correct the dollars are different but they are a similar program. Do you want to do them separately or both?

Representative Ekstrom: These are the young adult crisis beds. The beds would keep these kids out of more expensive crisis beds, emergency rooms, and inpatient hospitals. This is a

less expensive approach to transitioning these young adults into the community. I think we heard that they aren't ready for Primetime. They need this additional support to ease them into the community so that they are workers and taxpayers.

Chairman Pollert: Is there any other discussion. I'm asking for this for one vote on the 48th and 54th amendment. This motion passes 5-3-0. We will move to the 49th amendment which is to remove funding and FTE position added in the executive budget for the partnership program. Is there discussion? If not we will call the roll. It passes 5-3-0. On the next page the Southcentral human service center, remove funding and FTE position added in the executive budget to complete vulnerable adult protection services. Any discussion? If not we will take the roll. This passes 5-3-0. The rest of the amendments were the global health which were struck out in one swoop. We had our discussion on hospitals and a hold harmless on that rebasing of the hospitals. On that particular hospital what would it take to get the inflationary. There is a 0&7 the first year of the biennium. With the rebasing I think one of the hospitals got affected by the 90%. Is there any way to get what that figure would be at 7&7 or 3&7?

Maggie Anderson: Are you just asking for the one that is being held harmless or the other ones? For example just because they aren't held harmless at 90% they might be sitting right at 91%. Would you just want the one that is held harmless?

Chairman Pollert: Would the 0&7, do we have that figure?

Maggie Anderson: For the hospitals? At 90%.

Chairman Pollert: If we did the first year at 7%, and of course the 7 is already in the second year. Do you have what that figure would be?

Maggie Anderson: We should be able to get that to you.

Chairman Pollert: While you are at it, why don't you just give me what the 7&7 would be for

that one hospital. With that we will be in recess until 7:30 tomorrow morning. (114:30 done),

the recorder was kept on after that but no recordings after 114:30.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 2/11/09

Recorder Job Number: 9150

Committee Clerk Signature Meghan Pollert

Minutes:

Chairman Pollert: Called the meeting to order and took roll. Every member was present. We are going to continue working on HB 1012. I want to talk the inflators this morning. When you look on the revised sheet, page 3 on the amendments that we looked at yesterday, you will see it says alternative A, B, and C. Of course the Governor's budget is at 7&7. Looking at the sheet, if there is a call to go to 5&5 or 6&6, if I'm correct does that mean that the hospitals would go to 0&6 and the nursing homes would too? Long term care also has an effect on hospitals, am I correct?

Maggie Anderson: The way the sheet was comprised was 7&7 is the way the Governor's budget was built, or 0&7 for those providers. When you go to 6 the same assumptions apply. That it is 6&6 across the board except for those that were singled out for 0&7, now become 0&6. The same goes for 5. That is how that methodology was carried forward in the inflation scenarios.

Chairman Pollert: I want to talk the inflators.

Representative Bellew: If we do anything with the inflators and this is just me talking, the ones that were rebased and are at 0&7, I would like to leave them at 0&7 if that is acceptable

with the committee. I'm just bringing that up for discussion to see what you think. If we go 6&6 or 5&5, leave them at 0&7.

Chairman Pollert: The reason I bring that up is because of what inspired yesterday with the $2 increase with long term care and DD. My feeling is that the inflators have to change and not go up. At the same time if you remember what we did with the amendments on hospitals and standardized cost reports, hospitals were put at 90 of that cost report instead of 100. Because of what happened with the long term care, I don't think that should be that way for the hospitals. My feeling is that they shouldn't be affected by going down to 6&6, is that what you are talking about, and ambulances, chiropractors, and the other three.

Representative Bellew: That what I was talking about, except for the dentists because they remain the same as the Governor's budget. The four I was talking about was hospitals, physicians, chiropractors, and ambulances.

Chairman Pollert: Is the committee comfortable with the $2 raise to long term care and DD?

Representative Kreidt: I did a little recalculating last night and had some long thoughts about our action yesterday. My personal feeling is that I don't want to jeopardize the inflators for nursing facilities. If we move ahead with the $2 we are going to lower the inflators. I want to reconsider the amendment I made yesterday.

Chairman Pollert: You are talking about the $2 for nursing homes?

Representative Kreidt: Correct. We were handed out a sheet yesterday. It was a little late to take a look at, not saying I couldn't have figured this out before that. You can see on there that $0.50, $1.5, and the $2 salary increase using dollar amounts there. I don't know how to get rid of the $2? I have to reconsider it and plug in a new number.

Chairman Pollert: Your amendment yesterday was $2 an hour.

Representative Kreidt; We used a dollar number.

Chairman Pollert: You talked about $10-$15 but someone who is making $15.02 they get nothing.

Representative Kreidt: You have to remember that with the salary increase we are looking at July 1 that would go into effect. Those individuals that are above that probably would have seen some increase when the facility gives salary increases when they receive the 5% inflator. Those individuals would have probably moved up %5. It depends because it is up to the facilities discretion. Again as I mentioned yesterday if we have high end people who got a 5%, if they were making $20 they got $1 raise. If you had a $9 person they got a 45 cent raise at 5%. I still think we are inflating those with the bottom people July 1. That is where the critical need is that we see some significant turnaround in the number of people leaving their employment or trying to attract more people at the lower level. That is the critical area.

Chairman Pollert: I don't disagree with that. When I look at this sheet, the $2 at $17.6 million, your amendment was at $14 million.

Representative Kreidt: That is correct. We are looking at the lower 75% of that pay scale.

Chairman Pollert: When I look at this then, what are you thinking about doing?

Representative Kreidt: What I was looking at doing is using the dollar range. There are general funds of $5,950,451. Again, subtracting $1 million out of the Health Care Trust Fund. We would be expending not quite $5 million to cover about $1 raise. If the committee has problems with using the $15 and under and want to open it up, let them all scramble for it. I'm just trying to maintain as much money as I can for those lower level people.

Chairman Pollert: I'm not arguing that at all. Yesterday you were at $17.6 but the amendment was at $14. I'm trying to get the $5.95, are you trying to have that read the same? Do you see what I'm getting at, the correlation between the $17.6 and the $14? Are you doing that correlation or are you just saying it is going to be $1 increase at the $5.9.

Representative Kreidt: I would like to use a dollar amount. Let's not say $1 an hour let's just use a figure to give to the facilities.

Chairman Pollert: So they will just have the leverage of how they are going to do it?

Representative Kreidt: Right. They get the dollar amount. They could give the raises.

Chairman Pollert: It's not that I'm disagreeing with you. I'm just saying that the amendment was for $14 million which is different than the $17.6 I didn't know if you were trying to do the same ratio.

Representative Kreidt: If the facility wanted to do a $1 raise, I just assume give them a dollar amount.

Chairman Pollert: We would have to reconsider our action.

Representative Kreidt: I'm moving that we reconsider our action of yesterday of the $15 million figure with $1 million coming out of the Health Care Trust Fund.

Representative Nelson: I second that.

Representative Kerzman: I resist that. I have a little bit of a problem of just putting the money to the facilities. I think we want to give it directly to the people who need it. The main reason I'm voicing my opposition is because do we want to reconsider all of our action we did yesterday or are we just picking parts of it? I came here this morning with the understanding that we are just going to work on the inflators. I have a couple things that I would reconsider too.

Chairman Pollert: Well if you are going to bring it forward then we will bring it forward. If I do it for one I'll have to do it for all. If that is what you want that is what I'll do. I don't have a problem with that.

Representative Kreidt: I would like to see the nursing homes have this dollar amount. I realize that the inflators are very critical. We are talking salaries here. Would this enable the

low end people to still get some money? The cost of nursing facilities, regardless of the economy, seem to go up. To be able to cover the cost categories with the higher inflator, I can see if we pass the $2 out which we did. I see that going down in flames. I am also taking the chance on the inflators going with it. I'm trying to protect the inflators. As I said yesterday I am kind of a realist and I know where this would go in full appropriations.

Representative Ekstrom: I have the inflationary increase compared to the consumer price index.

Chairman Pollert: We have that. Did you want to discuss that?

Representative Ekstrom: I could. I know we aren't talking about the inflators at the moment. If you look at that chart in regard to that hospital and related services, with fiscal year July 1, 2008 their increase was 6.8%. Now the overall CPI for that same period was 5.6%. I think it is relevant to the discussion as we move forward with this.

Chairman Pollert: If you look at the average of the 12, the average was 2.78. The average on what the legislator has done is about 2.07, 2.08. There was a discussion that CPI could be 2.1. I went through the numbers and it would show you the 7&7 would be more if we added to what we were told. We would be paying on an average for the last 14 years if we go 7&7. If we go 6&6 it is pretty close to the CPI. I looked at them and did some simple math.

Representative Ekstrom: I'm a business manager for a company that employs very few people. We just took a 17% hit on BCBS. We have been told to expect that again.

Chairman Pollert: We will take a roll call vote to reconsider the motion. It passes 5-3-0.

Representative Kreidt: Then I would like to come forward with a new amendment using the dollar amount. If the committee feels more comfortable saying they have to give $1 to these individuals then I could include that in the motion. I would just assume to leave it as a dollar figure.

Chairman Pollert: Roxanne, are we going to have to have language to go to the full appropriations. We sure aren't going to have that here this morning. Do we need it as a whole committee before we approve the budget?

Roxanne Woeste: Yes.

Chairman Pollert: Basically what you want to do is give the authority to the nursing homes. The problem I have is that it might go to the executives.

Representative Kreidt: Using $4,950,451 out of the general fund, $1 million out of the Health Care Trust Fund to be provided for salary increases for the lower 75% of individuals working in nursing facilities or whatever language we need to get that properly put together, I would so move.

Representative Bellew: I second that.

Chairman Pollert: Is there discussion? I would assume this also includes the appropriate federal dollars to move forward? The motion passes 6-2.

Representative Wieland: Yesterday we also passed a motion allowing $2 salary benefit increase for DD providers. It had been my hope under $15. It had been my hope that the inflators is where we would find some of those dollars. From what I'm sensing is that the inflators are not going to be reduced much, if any at all. Certainly not down to the level that I had hoped for. With that in mind, I was on the prevailing side. I would like to bring back that motion for the $2 salary on the DD providers. I will make a motion to do so.

Representative Kreidt: I second that.

Representative Metcalf: I understand your need to bring this back. I would hope that we can somehow keep these two married together so we aren't having these continuous fights within the town that is tearing them apart. We don't want employees moving from one place to

another. I don't favor any reduction in this $2. We have to make sure we keep it at the same level.

Chairman Pollert: I understand your concern as well. It is going to be different in everybody's district. We have the state hospital in our district. With the $2 increase we were going to have a huge discrepancy. They would be moving from the state hospital to long term care and DD. It just would happen. It all depends on what the state employee raises are going to be too. That is a legitimate point.

Representative Nelson: I would just like to add something to that discussion. You are using a gross comparison as far as the inflator. Understand that if I was a state employee versus a DD provider, you have to realize that those two people have to pay their fringe packages out of their pockets. The health insurance had a 28% increase for the state worker. That is an added benefit. That comes out of the pocket of the nursing home or DD provider. That would very likely take the difference of that inflator increase.

Chairman Pollert: I will ask for the motion for reconsideration. We will take a roll call vote. It passes 5-3-0.

Representative Wieland: In light of that I would like to amend or make a new motion to resend the previous action on which we had $2 per hour salary or benefit increase and change that to $7 million general funds and whatever federal funds are involved. That is approximately the $1 an hour area.

Representative Kreidt: I second that.

Chairman Pollert: Is there discussion?

Representative Ekstrom: The sheet we have has some $8 million. Where did the $1 million go?

Representative Wieland: It is $15 an hour or less so there is actually only $90%. It is $14 million for the $2. I don't know why it wouldn't be half of that.

Chairman Pollert: We will take a roll call vote on this motion. It passes 6-2-0. Representative Kerzman would you like to bring any back for reconsideration?

Representative Kerzman: I would like to reconsider our action where we inadvertently left out the DD clients and going from $60 a month that they can retain to $75. We did it for the long term care people and I think we should also include the DD people in there.

Chairman Pollert: Is that on the revised sheet? Could you tell me what page?

Representative Kerzman: I'm on the third page.

Chairman Pollert: We passed that yesterday. We have to have statutory language to put that in the budget. For some reason that is one allowance that is in the century code and we don't know why. We just found that out so we have to have that put in. That is at 75.

Representative Bellew: Isn't Rep. Kerzman talking about the DD?

Chairman Pollert: I'm sorry this is basic care. Do you have what that amount is by any chance?

Representative Kerzman: No I don't. I just assume that they were included in there.

Representative Bellew: On page 3 of our green sheet, about ¾ of the way down. It says add funds to increase the personal needs allowance from $30-$50 a month for individuals in an institutional setting who are SSI only and receive their personal needs allowance from social security. It has $148,000 general fund increase there. I thought that was what Rep. Kerzman was talking about.

Maggie Anderson: There are a couple personal needs allowance in the Governor's budget. One of them is for all individuals that are in an institutional setting. That could be a nursing home or an ICFMR or even a psychiatric residential treatment facility for children. Those are

the three institutional levels that CMS recognizes. What you just read about the SSI is for everyone in the facilities. They are currently getting $30 from SSI and the Governor's budget would increase that to $50. Also in the Governor's budget is an increase specifically for individuals that are in an intermediate care facility going from $50 to $60. Currently what Rep. Kerzman is asking for does not exist in the Governor's budget or in any of the amendment action that you have taken.

Brenda Weisz: The amount to do the increase would be $155,520 in total.

Chairman Pollert: Could you tell me what that's for again?

Brenda Weisz: General funds would be $57,511. That would be for the DD providers and ICFMR's to go from the Governor's budget from $60-$75 to be equal with basic care according to the request of Rep. Kerzman.

Chairman Pollert: Rep. Kerzman is that what you are asking for?

Representative Kerzman: Yes. I will make that into a motion that we include the DD clientele in there.

Chairman Pollert: For the $57,511 total $155,520?

Representative Ekstrom: I second that.

Representative Kerzman: I don't think $60 is enough for the needs nowadays to buy a little bit of the personal things. It would give these people a little self esteem and it would allow them to have a little more. We should keep them fair with the rest of the people out there.

Representative Kreidt: I thought we had done that. I wasn't aware that we had left them out. I am in favor of that.

Chairman Pollert: Is there any other discussion? We will take a roll call vote. It passes 8-0.

Representative Kreidt: I have one last reconsideration. If you remember yesterday we kind of got going on the dentists. In the end we went nowhere. I would like to bring forward a motion in

regards to the dentists to rebase at 70% of the average bill charges with an inflation at 0 and 7. That would be my motion.

Representative Bellew: I second that.

Chairman Pollert: I'm going to just state the figures. It's the bottom of the 2 on the handout that is done. It would show the executive budget was at 75, 7&7, which would be $4.1 million, $1.5 general. This would reduce the total funds by $1,955,935 and reduce the general funds by $722,547. That was handed out yesterday. We will take a roll call vote. It passes 8-0-0.

Representative Bellew: I will bring this up. I still think the 7&7 is way too high. I'm afraid this budget at 7&7 is just not sustainable into the future. I would personally like to see a 5&5. I don't think I would get that passed so with that I am going to make a motion that we go to a 6&6 inflator and we keep all the rebased services that were at 0&7 at 0&7. That does include the dentists in this motion.

Chairman Pollert: I will ask for a second or do you want the information first?

Representative Wieland: I will second the motion for purposes of discussion.

Chairman Pollert: There is a motion and a second from dropping the inflators from all the long term care continuum basically to 6&6. Everybody except for the hospitals, physicians, chiropractors, and ambulances but the dentists would have to be in there with the actions we just did. The trouble I have is that we need information. This sheet is based off of 7&7. If we go to 6&6 that drops the five down to 0&6. You are trying to go 0&7.

Brenda Weisz: Handout A. What this is, is the first number is the savings when you go from what you said from a 7&7 and the rebase of 0 to 7. The savings on that sheet you held up was the top row of numbers. If you keep those that were rebased and keep them at the level of the Governor's budget at 0&7 and 7&7 for the dentists, your net savings to go from what the

Executive Budget is right now would be a savings of $5,484,000 from the general fund. For the dentists going from 70% of bill charge from 75%, the inflation will be minimal.

Chairman Pollert: But we went to 0&7 instead of 7&7.

Brenda Weisz: That will take me another half hour if you want that.

Chairman Pollert: We reduced off of a sheet that was handed out previously. When it shows that you have the inflator of 0&7, it showed it would reduce the general fund $722,547. It shows a rebasing at the 70% and an inflation of 0&7 would have been a reduction of $197,704. Would you take the $197,704 of general funds and take it off of the $5.4 or add it on to the $5.4 making it about $5.2 or something. Do you see where I'm getting that figure?

Representative Nelson: You probably don't want to complicate this even more. It has come to my attention that the hospitals at the 0&7, there is one facility that won't see any increase quite possibly in the next biennium. I don't know if there is a method that we can address that issue. I want to make you aware that it is a probability.

Chairman Pollert: I got here at 6:15 this morning and have been having discussions on that. You are probably going to see something happen in full appropriations. I don't know that for sure but I wouldn't be surprised. I have no idea right now. All I know is that I can't get the information for you in that short of time frame.

Brenda Weisz: With the sheet in front of you to go with the amendment you just adopted with dentists at 70% of bill charges, 0&7, you would have an additional savings of 4$42,214, from this sheet from the Executive Budget.

Chairman Pollert: Tell me the number. From the $5,484,468 million. That is what you are saying when we go to 6&6. If we do the 0&7, that number is going to change?

Brenda Weisz: Add to it the change that you had with the dentists. 70% of average bill charges at 0&7. Then you need to add additional savings to the sheet I handed to you of $280,333. These are general funds. You should have a total savings of $5,764,801.

Chairman Pollert: What that does, 6&6 on everything but the hospitals, physicians, ambulances, chiropractors, and dentists. Those stay at 0&7. That is the motion. We will now take a roll call vote. The motion passes 8-0-0. Is there anything else?

Representative Ekstrom: I had an amendment, did you get a chance to talk about that? It doesn't matter because we can deal with that on the Senate.

Chairman Pollert: I'm sorry let me talk to the chairman so we are ready for whole appropriations. Are there any other amendments to HB 1012? We will be in adjournment until the call of the chair.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☐ Check here for Conference Committee

Hearing Date: 2/13/09

Recorder Job Number: 9431

Committee Clerk Signature

Minutes:

Chairman Pollert: Called the meeting to order and took roll. Every member present. Handed out Attachment A. We should go through and compare the two. If there are questions we will discuss them.

Representative Ekstrom: Just procedurally how do we SCHIP and the funeral set aside out there?

Chairman Pollert: SCHIP and the funeral set aside are still out there.

Representative Ekstrom: How do we melt those back?

Chairman Pollert: If you take a look on page 2 of the amendments, page 4 replaces line 10 through 30. That is the ADRC's. This language is replacing that. Of the amendments that were adopted. If I'm correct Representative Kreidt is going to bring amendments forward about the language on the dollar for long term care and the DD's. They have talked to Legislative Council about that. There will be paper amendments coming forward. They aren't changing the dollar figures just wanting a little better language. As far as the funeral set aside, until something happens those stay in the bill. Chairman Svedjan might wait with this budget until we find out the action on the floor. Is that how that would be done?

Allan Knudson: Those other two bills are out there still with the funeral. The money is still in the budget. I would think you want to hold this before taking action in full committee until you know what happens on the floor. You could certainly send it out of the subcommittee.

Representative Bellew: Could we not remove the funding and if it passes out the floor put it back in at that time? Would that be ok or how would you recommend.

Allan Knudson: You can do it either way. You can take the money out and add it back once they pass it or they could leave the money in and take it out if they don't pass.

Chairman Pollert: I will have that discussion with Chairman Svedjan. If he is trying to push this thing out of here by Tuesday so it is on the floor by Thursday then we will have to ask for the paper amendments at that time. It is a little quick for us to ask for that right now at the moment .We should wait a couple of days.

Representative Metcalf: Looking on page 5 for the compulsive gambling, it was $200,000 and it dropped down to $150,000. The wording on here does not indicate that it is $150,000.

Allan Knudson: We will have to check on that. It looks like it should be $200,000 instead of $150,000.

Representative Metcalf: No it should be $150,000 but the language is wrong.

Representative Nelson: On page 4 of that same area, the second to last column under the Ann Carlson center with the definition of, I was asked to add after the second line after "medically fragile" to add "and behavioral challenged".

Chairman Pollert: For the paragraph? You are talking just in the language portion. Or do we have our amendment?

Representative Nelson: On page 4 it says "provide funding for increase the payment rates for children who are severally medically fragile". They would like to see "and behaviorally challenged" added there too.

Chairman Pollert: Is that needed? With what you are asking for, this isn't language in the bill. If I'm correct don't you have language coming in HB 1012?

Allan Knudson: This is the only area where that is referred to. I don't know if that definition makes any difference for the department as far as the reimbursement levels and those kinds of things whether it says medically fragile alone or medically fragile and behaviorally challenged. That makes a difference then you might want to adjust it.

Representative Metcalf: My question is if the changing in the word has any effects on the benefits provided. That is my concern.

Representative Nelson: I don't think it does. It just clarifies the types of individuals.

Chairman Pollert: You have to make a correction in wording for the other part as far as the $150,000 for compulsive gambling. Is that a problem?

Representative Bellew: Is this only about the Ann Carlson?

Chairman Pollert: No it goes to all facilities. If you remember the language Representative Wieland brought forward that is all facilities.

Representative Wieland: I think we should add that language.

Chairman Pollert :Do we need to have that as an official motion?

Representative Nelson: I will make that motion.

Representative Wieland: I second that.

Chairman Pollert: So in that particular portion it would say medically fragile and behaviorally challenged. We will take a voice vote. It passes 5-2-1. Do we have to have the same thing done about the compulsive gambling?

Allan Knudson: No that was just an error in the amendment. We will just fix that.

Representative Metcalf: The only reason I opposed that is because I don't know what it means. Does this give the Ann Carlson center more advantage over the other ones?

Representative Nelson: I would also like to add in that same area after children, add "and adults". I would move to do that.

Chairman Pollert: I want to get it all in one motion so we have to rescind what we just did. Is there a motion on the floor?

Representative Metcalf: I second that.

Representative Bellew: Why do you want to add adults too?

Representative Nelson: That is the clientele that they are serving. There are children and people over 18 years old that are classified as adults. That is their mix of patients. It just represents the people that they are serving.

Representative Wieland: I understand if we are talking between the ages of 18-20. I think over the ages of 21 there are different programs. I'm not so sure of the wording. I don't have a problem extending it up to add some of the adults. I'm just wondering if we are including 64 year old adults in this too.

Chairman Pollert: I need to have a better definition.

Brenda Weisz: The reason for the request to add the adults is because there are children in the facilities who are medically fragile or behaviorally challenged. What happens is those two types stay in those facilities and don't generally leave. If you don't add adults, when they turn 18 then money shuts off for that facility. They still are medically fragile but the money would shut off. If you add adults it will stay with that facility as long as that individual is with that facility no matter if they are 18, 19, and 32. It travels with the client.

Chairman Pollert: All those in favor raise your hand and it is unanimous. Now it is going to read medically fragile and behaviorally challenged residing at the Ann Carlson center for children and adults.

Representative Nelson: I think you would want to add and adults in the first line after children. That would read better.

Representative Bellew: The total reduction is on page 2 of the explanation. What we did was $26,711,414 in general funds . That is still a 19.7% increase over last biennium. I took the figures from the bill and not the green sheet.

Chairman Pollert: Is that number on the green sheet correct? The general fund is off on the green sheet compared to the bill budget.

Allan Knudson: That is correct. On the bill the one time funding is backed out. On the green sheet we show two separate amounts. The top number includes the one time. If you look down below it is the ongoing and one time broken out separately.

Chairman Pollert: Can you give me those figures? On the green sheet as the $721,512 that is the figure I've been using whenever I talk about a 21.5% increase in spending.

Allan Knudson: That is the amount of general fund appropriation.

Chairman Pollert: So if I take the $721,512,545 deduct off the $26,711,414 that gets to $694,801 just like it says. If I take that figure and divide by $593 it says it's a 17% increase.

Allan Knudson: That would be correct. The reason that Representative Bellew's would be higher is that the number in the bill does not include the one time funding from last biennium so that would be a lower figure. One time funding is backed out of the 07-09 amounts in the bill. That is why his amount would be higher. Then you are comparing the ongoing funding from last biennium to the total funding of this biennium.

Chairman Pollert: Are there any other questions or discussions about the amendments? We need to have a motion if we are accepting these amendments. There has to be a motion for accepting the amendments to HB 1012.

Representative Kreidt: I move that motion

Representative Wieland: I second that.

Chairman Pollert: If there is no discussion we need to vote on the amendments. These pass 5-2-1.

Representative Bellew: I move HB 1012 as amended.

Representative Wieland: I second that.

Chairman Pollert: Is there any discussion? I still have repercussions about the bill too. There are things I like about the bill and things I hate and things that I am neutral. We have to get it out of the committee. Whatever happens in full appropriations happens. I'm the same way but I still plan on voting for it.

Representative Nelson: I think we are all in that boat. I think we have done some very good things. In this whole process the department brought forward some very good programs that would help people in the field. We were charged with doing some efficiencies and I'm always frustrated in this committee because we end up having to be the brunt of the full committee's work. Yesterday was a good example of that frustration. I think again the human services have taken a much bigger portion of the efficiencies that we are expecting to get.

Chairman Pollert: I understand your frustrations. There are certain items I like and don't like. That is my opinion. We will all have those discussions amongst ourselves again before the conference committee. Any other discussion? HB 1012 passes as amended 5-2-1. I will carry this bill to full appropriations.

2009 HOUSE STANDING COMMITTEE MINUTES

HB 1012

House Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: February 17, 2009

Recorder Job Number: 9649

Committee Clerk Signature Holly N. Stanek

Minutes:

Chm. Svedjan turned the discussion to HB 1012.

Rep. Pollert distributed and reviewed amendment .0105 (Attachment A). Rep. Pollert asked another Section member to discuss the nursing facility bed limits. (Page 4, Attachment A)

Rep. Kreidt: This amendment was to increase the asset limit for facilities under construction and we did not use any federal funds. We used the Healthcare Trust Fund using $324,506 and $553,012 of federal dollars to come up with that amount. When facilities are under construction we have an asset limit that sets the rate and develops the property cost. With costs going up we felt it was necessary to raise those limits for a private room and a single room additional asset limit under construction and there will still be some projects that are going to go over these limits. When that happens, they're going to be eating that cost in their rate. This is going to help them a little. (16:04)

Rep. Kempenich: Does this include the cost of the beds? (17:36)

Rep. Kreidt: No.

Rep. Pollert continued his testimony on p. 4, Attachment A. (17:47)

Rep. Berg: What was the rationale for that reduction? I think we had some of that discussion in our interim and I think we are spending about $400,000 or $500,000 on advertising for the lottery.

Rep. Pollert: If I had had my way all $300,000 would have been in the Attorney General's budget because it should not be a DHS problem. I think it's an Attorney General issue through the lottery but I know that it all goes to the general fund. We felt that $300,000 was too high – not unanimous. That's why we put it at $150,000. I have not heard any complaints.

Rep. Metcalf: I was one who didn't want to change that. I wanted to leave it at $300,000 plus the $400,000 because of exactly what was brought up. We are advertising. The state of North Dakota is advertising and enticing people to gamble and here we're not willing to help change their needs as they go along. (22:42)

Rep. Pollert continued on p. 5, Attachment A. (2317)

There are 17 FTEs that have to do with the Global Health Initiative. We removed almost every reference to GHI and removed the funding for the FTEs and the programs. (See footnotes at the bottom of p. 6, Attachment A)

Rep. Ekstrom: On this point with regard to the State Hospital. They came in with statistics that were showing they were at 104 percent of capacity and they were at 85 percent staffing. These particular FTEs were to address that critical shortage. They have a very serious situation because they all have the civilly committed. I think the Committee should seriously look at this. (25:44)

Rep. Pollert continued his review of amendment .0105 on p. 7, Attachment A. As was done with the State Hospital, the Section asked them to rank their priorities of one-time spending. (26:30) Rep. Pollert moved on to p. 8, Attachment A and explained that in the North Central Human Service Center House changes, they removed four FTEs spread through the Human Service Centers dealing with the Developmental Disabilities caseload. On page 9, Attachment A, Southeast Human Service Center, Fargo has remodeled an apartment building and they are

trying to take care of the homeless. This provides staffing for the Cooper House for $236,520.

Rep. Pollert continued on p. 10.

Rep. Pollert moved amendment .0105. Rep. Bellew seconded the motion.

Rep. Ekstrom: Regarding the Global Health Initiatives at the various Human Service Centers, there are two factors as we move toward the Senate, that we need to consider. We have returning veterans returning with traumatic brain injuries who are hitting our Human Service Centers all across the state. That is creating the need for these positions that the Department was asking for. The other factor I think we continually forget is that the Human Service Centers are the next step in the road for folks coming out of prison and the best way to keep folks out of prison is to provide community-based care. The other amendment that did not make it into play was an additional OAR that Jim Kerzman put forward. That amendment dealt with an eligibility computer system. That wasn't OAR (30:51)

Rep. Pollert: $685,000 general fund dollars.

Rep. Ekstrom: Right. That's what we were proposing. No. We had I think we had $343,000 general fund, $343,000 federal funds, but I might be wrong.

Rep. Pollert: The SITAC (State Information Technology Advisory Committee) rating for the computer eligibility was number five on the SITAC. I had a discussion with the agency asking them why it was not put in the Governor's budget and they said basically that because of the work they are doing on MMIS, they want to continue that project before they go on to the next one. The eligibility would cost about $18 million for the OAR. Rep. Kerzman brought forward an amendment for $685,000 to start the planning process. That was not approved by the

Section as well. That would have upped the completion date of the eligibility system by about six months.

Rep. Ekstrom: And the reasoning behind this really had to do with the conversations we've been having with the counties. The counties are seeing that as folks are being processed in with needing various services there is a great redundancy in terms of forms. It's creating a lot of extra work for folks coming into the system. On the medic needy, the Governor had this at 83 percent of poverty and it was reduced to 75 percent. It's been a very long time since these folks were increased. They have been running at a very low level and we really need to do some adjustment upward. Also, there was a personal care tier 3 which deals with basic care. Right now there is a limit of 8 hours per day that are allowable. In the Governor's budget we've taken it to ten hours per day. We were told this would bring as many as ten people back out of the nursing homes back into community care. The savings on that for the biennium would be $912,000. By increasing that Tier 3 to ten hours we could save money.

Rep. Wald: Can you expand on the supplemental payments of Developmental Disabilities? (p. 4 of Statement of Purpose of Amendment, 4th item from the bottom) (34:41)

Rep. Pollert: The $7 million? It's for people making under $15 per hour. That costs $7 million of General Funds for all DD providers. It was felt by the Section, and this wasn't unanimous. The first motion was a $2 per hour increases for all long-term care and all DD providers and it was intended to keep it at 7 and 7. Then it was reconsidered the next day and put at a $1 increase for all long-term care and all DD providers with the intent language that when we did that we moved the inflators from 7 and 7 to 6 and 6. The $2 per hour would have cost $27 million General Fund over the Governor's budget. What this did with the $1 is it increased – I'll say $5.9 million for $12 million. The 6 and 6 was about $5.5 million so the net increase was

$6.5 million increase over the Executive Budget for long-term care for wage pass-throughs (net). (35:00)

Rep. Nelson: The reason that we made that a priority was that basic care and DD providers probably lead the state in turnover. I think it's over 50 percent. By passing a wage pass-through that money can now get to the employees faster than the inflator. (36:53)

Rep. Kreidt: This would not be for all employees. We're looking at the lower $15 per hour and under because that's where the problem is in this situation. I went by a fast food place the other day and they had a sign up that they were paying $14 an hour to hire people to flip burgers. We've got a critical situation now. (37:26)

Rep. Hawken: I've gotten the most mail on that $15. These people are so nice and work so hard and we pay them so little. Every year we say we're going to do better and now when we could do better we're still not. I mean, we are. But we're not doing what we maybe could. What do we do with the person who makes $15.05 and works next to the person making $15 per hour? (38:10)

Rep. Kreidt: The way the formula works, what will happen here, and we have an amendment coming forward that's probably going to take a little bit of that situation off, but we also have the six percent inflator that also can inflate salary line items so if you've got a CNA making $9 per hour and we can move her to $10 per hour but you've got a nurse making $20 per hour and she gets a 7 percent raise, she's going to get a $1.40 per hour increase where the CAN making $9 per hour is going to get a $.60 raise. The facilities will have to use the percent to compensate those salaries.

Rep. Nelson: This is a different industry. When you look at a 6 and 6 inflator you have to realize the operations of the facility have to be considered in this too. It's not like state workers

or some of the other salary lines where it all goes to salary. This goes into operations as well. The 6 and 6 won't equate to a 6 percent increase in salaries. (39:46)

Rep. Pollert: Just so the Committee doesn't think we just went and slashed everything out of the budget. The congregate mills in the Executive Budget had a $900,000 increase plus the from the Senior Citizen mill levy payment they're going to get another $300,000. We did not touch that. What we found out in caseload utilizations from the last biennium, basically what we as a Section last on DD on long-term care beds, we were right. We were about right on on DD. If you remember the loan for the $3.5 million. They said the world was basically going to come to an end. The caseloads came in pretty close to what we thought. And on the long-term care beds we were correct. We were even correct on the inpatient hospital. We take a good look at them. We did not play with SPED. There was an increase in the sliding fee schedule to SPED. There was an increase in the ISLAs. We did not touch that because the caseload utilizations from the last biennium did increase. That we were off on. We fully funded that in the Executive Budget. (40:16)

The motion to adopt amendment .0105 carried by voice vote and the amendment was adopted.

Rep. Bellew distributed and reviewed amendment .0107 (Attachment B). This amendment decreases the funding related to the funeral set aside. In the Governor's Budget there was a $2,000 increase. This amendment reduces that by $1,000 to what was passed on the House floor today. (41:57)

Chm. Svedjan: It reduces it?

Rep. Bellew: By $1,000.

Chm. Svedjan: So it brings it back to $5,000?

Rep. Bellew: No. It brings it back to $6,000. In the Governor's Budget it's at $7,000. We have to have this amendment to lower that to $6,000 because that's what was passed on the House floor.

Rep. Delzer: Rep. Pollert, what is the spending level on TANF? How are we doing compared to . . .

Rep. Pollert: It's going to come down to in the 09-11 biennium; we'll have $1 million left on the TANF. We will be deficit spending and have to go to General Funds to fund TANF in the next biennium. So we've got to avoid spending any money out of TANF.

Rep. Bellew reviewed the Statement of Purpose of Amendment to .0107. (43:47)

Rep. Bellew moved amendment .0107. Rep. Pollert seconded the motion.

Rep. Ekstrom: Does procedurally that bill have to come back to Appropriations or will the money just automatically go to it? (44:37)

Chm. Svedjan: No. That bill doesn't have to come down here.

Rep. Ekstrom: O.K. But the money is matched up with it?

Chm. Svedjan: Yes. It will be matched up.

The motion to adopt amendment .0107 carried by voice vote and the amendment was adopted.

Rep. Metcalf distributed amendment .0106 (Attachment C).

Rep. Metcalf moved amendment .0106. Rep. Ekstrom seconded the motion.

Rep. Metcalf explained that amendment .0106 is nothing but a Legislative Council Study of Long-Term Care costs. There has been a concern of the prices and the inspection services from the Department of Health.

The motion to adopt amendment .0106 carried by voice vote and the amendment was adopted.

Rep. Pollert distributed amendment .0109 (Attachment D).

Rep. Pollert explained .0109. The Executive Budget had it at 200 percent of net. The bill today on the floor was passed at 160 percent of net. When we did that it we have to pass this amendment. It decreases the funding by $725,025. It also removes 1.5 FTEs.

Rep. Pollert moved amendment .0109. Rep. Bellew seconded the motion. The motion carried by voice vote and the amendment was adopted.

Rep. Pollert distributed amendment .0111 (Attachment E). Rep. Pollert explained that this amendment takes out $4,090, 893 of Special Funds to correlate with the General Funds on the vacant FTEs. I was reminded of this from Legislative Council yesterday, that after our work done yesterday about the vacant FTEs, it's going to affect the DHS budget. (50:34)

Rep. Pollert moved amendment .0111. Rep. Kreidt seconded the motion.

Rep. Ekstrom: How does this relate to the critical funding pool in terms of percentage? Obviously DHS is . . . is this a 4 percent? (51:34)

Rep. Pollert: I think it's 4 percent. Actually DHS is a lot better off doing it this way than they are the other way because you look at $600 million, you take 4 percent it would be $24 million.

The motion to adopt amendment .0111 carried by voice vote and the amendment was adopted. (52:24)

Rep. Hawken: The amendment .0107 where we changed the money, the HB number is wrong. It's 1477, not HB 1377. (52:34)

Rep. Pollert: You're right.

Roxanne Woeste: That will be taken care of once we roll all these amendments into one. No need for the Committee to worry.

Rep. Pollert distributed amendment .0112 (Attachment F) and amendment .0103 (Attachment G).

Rep. Pollert explained amendment .0112. With the floor action on the Childhood Services Advisory Board that was passed on the House floor yesterday for $20,776, that's what this amendment is for. It's bookkeeping.

Rep. Pollert moved amendment .0112. Rep. Berg seconded the motion. The motion carried by a voice vote and the amendment was adopted.

Rep. Pollert explained amendment .0103. This amendment deals with the economic stimulus package. This language was drawn up. Rep. Ekstrom had an amendment and I took that with Legislative Council's amendment and these are put together to make .0103.

Rep. Pollert moved amendment .0103. Rep. Ekstrom seconded the motion.

Rep. Kaldor: I'm curious if the department in the past has had authority to receive federal funds without our appropriation process. Do we in every case appropriate every federal dollar that the Department of Human Services receives? (56:12)

Chm. Svedjan: This in effect is an appropriation. It addresses the authority to receive.

Rep. Kaldor repeated his question to Rep. Pollert.

Chm. Svedjan: I really doubt it. We have seen language like this before. This is intended to handle that situation when we're expecting to receive federal funds. There are instances also when we receive federal funds that we didn't know were coming. Then we have the Emergency Commission and the Budget Section to handle that process. In all cases the appropriation is there. (57:10)

Rep. Kaldor: The title of the section does not speak to an appropriation. It speaks to the acceptance of and limitation on expenditure. My point is instead of going through the budget section, because we don't exactly know what's coming and when it might come, will it require all of us to assemble?

Rep. Pollert: I think there have been bills or motions already made about that if I'm correct.

Chm. Svedjan: Yes, there have been. This will all be reconciled. We got a good read on the stimulus package today. I think in the second half we're going to see all this reconciled.

Rep. Ekstrom: One of the things I was specifically concerned about was FMAP and that is definitely in the stimulus package.

The motion to adopt amendment .0103 carried by voice vote and the amendment was adopted.

Rep. Pollert distributed document 99714 (Attachment H). In the discussion about the amendments I was going through with the Human Service Centers, I mentioned that the apartment complex called Cooper House was the only part of the Global Health Initiative that had made it through the section. This removes the staffing. It deals with Fargo and the homeless. (60:29)

Rep. Pollert moved to adopt 99714 as an amendment to HB 1012. Rep. Bellew seconded the motion.

Rep. Ekstrom: Cooper House is part of a ten-year initiative by the Governor to try to eliminate homelessness in the state of North Dakota. The city of Fargo has put together a consortium of folks both private and public to provide funding to build this shelter. It will be at the old Cooper Tire building. They have gotten commitments from grants, the city and the one part they needed was a commitment from the state to help with the staffing. We can either do this here or we can do this in the Senate, but I would ask for a roll call vote on this one. (61:31)

Rep. Berg: We put this in in the amendments, right? (62:27)

Chm. Svedjan: This is being moved as an amendment.

Rep. Berg: This was part of the main amendments that we adopted.

Chm. Svedjan: The main amendments included this funding.

Rep. Pollert: In the section we attempted to remove all Global Health. This is the one that was removed. The persuasive discussions from Rep. Ekstrom brought it back in.

The motion to adopt 99714 as an amendment to HB 1012 failed by a roll call vote of 9 yeas, 14 nays and 2 absent and not voting.

Rep. Kreidt distributed and explained amendment .0110 (Attachment I). This addresses the $15 increases for the DD and LTC and Basic Care facilities. We are using the same dollar amount that we did to accomplish the $15 and less for those entities but we're changing the $15 to a percentage. This will give the facilities more flexibility. We are not increasing funding. We'll be using the 80th percentile of the salary range at each facility for the biennium beginning July 1. For the DD we'll be using a 90th percentile beginning July 1. I think this is a better way to handle this. (65:30)

Rep. Kreidt moved amendment .0110. Rep. Wieland seconded the motion. The motion carried by a voice vote and the amendment was adopted.

Chm. Svedjan distributed document 99719 (Attachment J).

Chm. Svedjan: I am requesting your favorable consideration of restoring some of what was reduced from HB 1012. This would restore the hospital rebasing back to 100 percent. To help pay for part of that it would be to decrease from the Executive Budget the inflationary increase that was granted to hospitals, physicians, ambulances and chiropractors in the second year of the biennium – to decrease it from 7 percent to 6 percent. Over the years I know we have

rebased nursing homes more than once. That's good. It helps keep their reimbursement more current. We have done quite a lot for Developmental Disabilities (DD). In HB 1012, a case could be made that to help do some of what we're doing for DD might have been taken from what was in the Governor's budget to bring hospital payment rates up to 100 percent of cost. It has been many years since rebasing has been done for hospitals. It is the major hospitals in the state that handle the bulk of Medicaid patients, with a couple of exceptions. With the major hospitals, in 2007, their operating margin was in the negative. In 2008, it's in the negative to an even greater extent. With the funds we have available, my hope was we could help shore up some of those programs that we have avoided in the past biennia and one of those is hospitals. We have to be very concerned about our hospitals. Very few are not struggling. I would guess that most are. Hospitals are doing many things to address the situations. Given the fact that there hasn't been a rebasing for hospitals for many years and hospitals are paid about 42 percent of cost, we need to bring them up to 100 percent of cost so we don't have to run the risk of hospitals ever turning Medicaid patients away. Not that I think that is going to happen, but it's getting to the point that selectivity could become a part of that picture.

Rep. Kempenich moved document 99719 as an amendment to HB 1012. Rep. Berg seconded the motion.

Rep. Bellew: If we do this for hospitals should we not do it for the others that were reduced? If you look in the Human Services budget, if you count the rebasing of hospitals and the other services there are actually three increases in the HS budget. They have a new contract cost, rebasing increase and they have an inflationary increase. In the budget they are getting treated very well as far as I'm concerned. I will resist this motion. (73:02)

Chm. Svedjan: I hear what you're saying, but there was a reason why the last legislative session authorized a rebasing study of hospitals and those results came in and we're in a position now where I think it's time to shore these up.

Rep. Nelson: This is exactly what you talked about. The study done during the interim was meant to rebase at a level playing field. We are not doing that in this budget. I have concern with the inflator going down for the other providers, but the one group being left out of this that wasn't rebased at what the Governor put forward either was physicians. That's an important link too. If we start down this road, it would only be appropriate that physicians would get some consideration too because through all the stuff we talk about nobody gets well unless there is a doctor. (74:08)

Chm. Svedjan: This is not in deference to physicians. My understanding is that 80 percent of our physicians are employed by hospitals. It's a very high percentage. For us to do something to help the hospitals will in effect help physicians as well. Going from 7 percent to 6 percent, I don't like doing that either because I think that inflationary increase is probably more as well. What you've seen in the rest of the budget is that the inflationary increases were adjusted to 6 percent. I did that to try and keep some consistency.

The motion to adopt document 99719 as an amendment to HB 1012 carried by a voice vote and the amendment was adopted.

Rep. Pollert moved a Do Pass as Amended to HB 1012. Rep. Kreidt seconded the motion. (76:24)

Rep. Bellew: If this bill passes the cost to continue is going to be in the $60 to $70 million General Fund range. (76:38)

Chm. Svedjan: $65 million.

The Do Pass as Amended motion carried by a roll call vote of 17 yeas, 6 nays and 2 absent and not voting. Rep. Pollert will carry the bill.

Chm. Svedjan thanked the Committee for their work and adjourned the meeting until the call of the Chair.

FISCAL NOTE

Requested by Legislative Council
01/06/2009

Bill/Resolution No.: HB 1012

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2007-2009 Biennium		2009-2011 Biennium		2011-2013 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$3,626,268		$3,800,613
Expenditures			$1,950,909	$5,577,177	$2,039,188	$3,800,613
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2007-2009 Biennium			2009-2011 Biennium			2011-2013 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This is the appropriation bill for the Department of Human Services. Sections 5, 6 and 7 contain statutory changes and only the impact of those changes are contained in this fiscal note.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 5 directs the Department to plan and implement an Aging and Disability Resource Center (ADRC) for the State.
Section 6 increases the pre-need funeral set aside for Medicaid eligible clients from $5,000 to $7,000.
Section 7 - changes eligibility for the State Children's Health Insurance Program. Currently the Department provides health insurance coverage for children up to 150% net of poverty. This bill increases coverage to 200% net of poverty. It is estimated that an additional 1,158 children will receive coverage. It is also estimated that an additional 1.5 FTE will be needed to process the increase in applications.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The Other funds revenues are attribute as follows:

Section 6 will result in an increase in federal revenue of $356,703 from the Centers for Medicare and Medicaid.

Section 7 will result in an increase in federal revenue of $3,269,565 from the Centers for Medicare and Medicaid.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Section 5 - Estimated cost of $600,000 to establish an ADRC as a pilot. All funds from the general fund.

Section 6 - Estimated expenditures of $566,000 with $209,297 from the general fund and $356,703 from federal funds.

Section 7 - Estimated expenditures of $4,411,177 with $1,141,612 from the general fund and $3,269,565 from federal funds.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

House Bill 1012 contains funding for all three sections. No additional appropriation authority is needed.

Name:	Brenda M. Weisz	**Agency:**	DHS
Phone Number:	328-2397	**Date Prepared:**	01/08/2009

FISCAL NOTE

Requested by Legislative Council
01/09/2009

REVISION

Bill/Resolution No.: HB 1012

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2007-2009 Biennium		2009-2011 Biennium		2011-2013 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$3,626,268		$3,800,613
Expenditures			$1,950,909	$3,626,268	$2,039,188	$3,800,613
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2007-2009 Biennium			2009-2011 Biennium			2011-2013 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This is the appropriation bill for the Department of Human Services. Sections 5, 6 and 7 contain statutory changes and only the impact of those changes are contained in this fiscal note.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 5 directs the Department to plan and implement an Aging and Disability Resource Center (ADRC) for the State.
Section 6 increases the pre-need funeral set aside for Medicaid eligible clients from $5,000 to $7,000.
Section 7 - changes eligibility for the State Children's Health Insurance Program. Currently the Department provides health insurance coverage for children up to 150% net of poverty. This bill increases coverage to 200% net of poverty. It is estimated that an additional 1,158 children will receive coverage. It is also estimated that an additional 1.5 FTE will be needed to process the increase in applications.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The Other funds revenues are attribute as follows:

Section 6 will result in an increase in federal revenue of $356,703 from the Centers for Medicare and Medicaid.

Section 7 will result in an increase in federal revenue of $3,269,565 from the Centers for Medicare and Medicaid.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Section 5 - Estimated cost of $600,000 to establish an ADRC as a pilot. All funds from the general fund.

Section 6 - Estimated expenditures of $566,000 with $209,297 from the general fund and $356,703 from federal funds.

Section 7 - Estimated expenditures of $4,411,177 with $1,141,612 from the general fund and $3,269,565 from federal

funds.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

House Bill 1012 contains funding for all three sections. No additional appropriation authority is needed.

Name:	Brenda M. Weisz	**Agency:**	DHS
Phone Number:	328-2397	**Date Prepared:**	01/09/2009

FISCAL NOTE

Requested by Legislative Council
02/20/2009

Amendment to: HB 1012

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2007-2009 Biennium		2009-2011 Biennium		2011-2013 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2007-2009 Biennium			2009-2011 Biennium			2011-2013 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This is the appropriation bill for the Department of Human Services. The sections that previously required a fiscal impact were removed and included in separate bills, thus no fiscal impact from those statutory changes.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Name:	Brenda M. Weisz	**Agency:**	DHS
Phone Number:	328-2397	**Date Prepared:**	02/23/2009

FISCAL NOTE

Requested by Legislative Council
04/16/2009

Amendment to: Engrossed HB 1012

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2007-2009 Biennium		2009-2011 Biennium		2011-2013 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2007-2009 Biennium			2009-2011 Biennium			2011-2013 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

Appropriation bill for the Department of Human Services containing statutory changes or Legislative intent language to support the STATEMENT OF PURPOSE OF AMENDMENT - LC 98013.0209 FN 4. There is no fiscal impact beyond what is included in the appropriation bill with Senate amendments.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Name:	Brenda M. Weisz	**Agency:**	DHS
Phone Number:	328-2397	**Date Prepared:**	04/16/2009

General Discussion 1-19-09 Attachment A

98013.0101
Title.

Prepared by the Legislative Council staff for
Representative Carlson
January 14, 2009

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 1, line 2, remove "; and to amend and reenact sections 50-06-29, 50-24.1-02.3, and 50-29-04 of"

Page 1, remove lines 3 through 5

Page 1, line 6, remove "insurance program"

Page 4, remove lines 10 through 30

Page 5, remove lines 1 through 31

Page 6, remove lines 1 through 10

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment removes Sections 5, 6, and 7 relating to the establishment of an aging and disability resource center, the exempt amount of designated preneed funeral service contracts in considering eligibility for medical assistance, and eligibility under the state children's health insurance program.

Prepared by the North Dakota Legislative Council
staff for Representative Pollert
February 2009

PROPOSED MOTION TO FURTHER AMEND HOUSE BILL NO. 1012

It was moved by _____ and seconded by _____ to further amend House Bill No. 1012 as follows:

	General Fund	Other Funds	Total
Basic care and nursing care facilities - Salary and benefit supplemental payment			
Remove funding for a salary and benefit supplemental payment for individuals employed by basic care and nursing care facilities currently making $15 per hour or less. (Of the $14,739,128, $4,950,451 is from the general fund, $1,000,000 is from the health care trust fund, and $8,788,677 is from federal funds.)	($4,950,451)	($9,788,677)	($14,739,128)
Provide funding for a salary and benefit supplemental payment of $1 per hour for individuals currently making less than $10 per hour and a payment of $0.75 per hour for individuals currently making between $10 and $15 per hour. (Of the $14,166,699, $4,552,546 is from the general fund, $1,000,000 is from the health care trust fund, and $8,614,153 is from federal funds.)	4,552,546	9,614,153	14,166,699
Increase (decrease)	($397,905)	($174,524)	($572,429)
Developmental disabilities providers - Salary and benefit supplemental payment			
Remove funding for a salary and benefit supplemental payment for developmental disabilities providers currently making $15 per hour or less	($7,000,000)	($11,929,151)	($18,929,151)
Provide funding for a salary and benefit supplemental payment of $1 per hour for individuals currently making less than $10 per hour and a payment of $0.75 per hour for individuals currently making between $10 and $15 per hour	5,901,579	10,057,258	15,958,837
Increase (decrease)	($1,098,421)	($1,871,893)	($2,970,314)
Total increase (decrease)	($1,496,326)	($2,046,417)	($3,542,743)

Prepared by the North Dakota Legislative Council
staff for Representative Pollert
February 2009

PROPOSED MOTION TO FURTHER AMEND HOUSE BILL NO. 1012

It was moved by _____ and seconded by _____ to further amend House Bill No. 1012 to remove the following change:

	General Fund	Other Funds	Total
Southeast Human Service Center			
Provide funding for contract staffing at the Cooper House	$236,520	$78,840	$315,360

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 1st amendment.

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 2nd amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 4th amendment

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom	X	
Vice Chairman Bellew	X		Representative Kerzman	X	
Representative Kreidt		X	Representative Metcalf	X	
Representative Nelson		X			
Representative Wieland		X			

Total (Yes) 4 No 4

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 5th amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom	X	
Vice Chairman Bellew	X		Representative Kerzman	X	
Representative Kreidt	X		Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 8 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 6th amendment.

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom	X	
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf	V	
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 7 No 1

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 7 amendment alternative A

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number alternative B

Action Taken 7th amendment (FAIL)

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom		X
Vice Chairman Bellew		X	Representative Kerzman		X
Representative Kreidt		X	Representative Metcalf		X
Representative Nelson		X			
Representative Wieland		X			

Total (Yes) 0 No 8

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 8th amendment alternative A

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 8th amendment alternative b

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom		X
Vice Chairman Bellew		X	Representative Kerzman		X
Representative Kreidt		X	Representative Metcalf		X
Representative Nelson		X			
Representative Wieland		X			

Total (Yes) 0 No 8

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 9th amendment alternative A

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman	X	
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson		X			
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 9th amendment alternative B

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman	X	
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson		X			
Representative Wieland		X			

Total (Yes) 3 No 5

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 10th amendment alternative A

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 10 No 2

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 10th amendment alternative B

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson		X			
Representative Wieland	X				

Total (Yes) 3 No 5

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 11th amendment alternative A

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 11th amendment + Alternative B

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom		X
Vice Chairman Bellew		X	Representative Kerzman		X
Representative Kreidt		X	Representative Metcalf		X
Representative Nelson		X			
Representative Wieland		X			

Total (Yes) 0 No 8

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 12th amendment alternative A

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson		X			
Representative Wieland		X			

Total (Yes) 2 No 6

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number alternative d.

Action Taken 12th amendment -7S, 0, 7

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom	X	
Vice Chairman Bellew		X	Representative Kerzman		X
Representative Kreidt		X	Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland		X			

Total (Yes) 3 No 5

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 12th amendment 6S, 0, 7

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson		X			
Representative Wieland	X				

Total (Yes) 4 No 4

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 12th amendment 7090, 0, 7

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt		X	Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 4 No 4

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 14th amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 15th amendment

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom	X	
Vice Chairman Bellew		X	Representative Kerzman	X	
Representative Kreidt		X	Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland		X			

Total (Yes) 4 No 4

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 16th amendment

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom	X	
Vice Chairman Bellew	X		Representative Kerzman	X	
Representative Kreidt	X		Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 8 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 17th amendment

Motion Made By money come out of healthcare trust fund Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom	X	
Vice Chairman Bellew	X		Representative Kerzman	X	
Representative Kreidt	X		Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 8 No 0

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 18th amendment alternative A

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom	X	
Vice Chairman Bellew		X	Representative Kerzman	X	
Representative Kreidt	X		Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 6 No 2

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 18th amendment alternative B

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom	X	
Vice Chairman Bellew		X	Representative Kerzman	X	
Representative Kreidt		X	Representative Metcalf	X	
Representative Nelson		X			
Representative Wieland		X			

Total (Yes) 3 No 5

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 19th Amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom	X	
Vice Chairman Bellew		X	Representative Kerzman	X	
Representative Kreidt	X		Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 6 No 2

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 20th amendment alternative A

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 4 No 4

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 20th amendment alternative B

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 21st amendment - alternative A

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom	Y	
Vice Chairman Bellew		X	Representative Kerzman	Y	
Representative Kreidt		X	Representative Metcalf	Y	
Representative Nelson		X			
Representative Wieland		X			

Total (Yes) 3 No 5

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 21st amendment alternative B

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom	X	
Vice Chairman Bellew	X		Representative Kerzman	X	
Representative Kreidt	X		Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 8 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 22nd amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt		X	Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 3 No 5

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 22nd amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 22nd amendment - reconsideration

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 23rd amendment

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 8 No 3

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 24th amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 26th amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom	X	
Vice Chairman Bellew		X	Representative Kerzman	X	
Representative Kreidt		X	Representative Metcalf	X	
Representative Nelson		X			
Representative Wieland		X			

Total (Yes) 3 No 5

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 28th amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom	X	
Vice Chairman Bellew		X	Representative Kerzman	X	
Representative Kreidt		X	Representative Metcalf	X	
Representative Nelson		X			
Representative Wieland		X			

Total (Yes) 3 No 5

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 29th amendment

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson		X			
Representative Wieland	X				

Total (Yes) 4 No 4

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken move to $150,000 #29

Motion Made By Nelson Seconded By Ekstrom

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom	X	
Vice Chairman Bellew	X		Representative Kerzman	X	
Representative Kreidt		X	Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 7 No 1

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Amendment 30

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 31st amendment alternative A

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom	X	
Vice Chairman Bellew		X	Representative Kerzman	X	
Representative Kreidt		X	Representative Metcalf	X	
Representative Nelson		X			
Representative Wieland		X			

Total (Yes) 3 No 5

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 31st amendment alternative B

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 32nd amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 6 No 2

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 33rd amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom	X	
Vice Chairman Bellew		X	Representative Kerzman	X	
Representative Kreidt		X	Representative Metcalf		X
Representative Nelson		X			
Representative Wieland		X			

Total (Yes) 2 No 6

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Remove $600,000 (33)

Motion Made By Bellew Seconded By Wieland

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 8 No 2

Absent

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 36th amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom	X	
Vice Chairman Bellew		X	Representative Kerzman		
Representative Kreidt		X	Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland		X			

Total (Yes) 3 No 4

Absent 1

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 37th amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 38th amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt		X	Representative Metcalf		X
Representative Nelson		X			
Representative Wieland		X			

Total (Yes) 4 No 7

Absent 1

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 39th amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 40th amendment

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 41st amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 43rd amendment

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 05 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 46th amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert		X	Representative Ekstrom	X	
Vice Chairman Bellew		X	Representative Kerzman	X	
Representative Kreidt		X	Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 48th 0154th Amendment

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 49th amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken S1st amendment

Motion Made By _____ Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-11-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken dropping inflators to 0+le except 5

Motion Made By Bellew Seconded By Wieland

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom	X	
Vice Chairman Bellew	X		Representative Kerzman	X	
Representative Kreidt	X		Representative Metcalf	X	X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 8 No 0

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 2-11-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Release at 70% WI 0 & 7 inflation

Motion Made By Kreidt Seconded By Bellew

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom	X	
Vice Chairman Bellew	X		Representative Kerzman	X	
Representative Kreidt	X		Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 8 No 0

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 2-4-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Move from $2 increase to $7 million g.f. and $1.

Motion Made By Wieland Seconded By Kreidt

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom	X	
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 6 No 2

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date:
Roll Call Vote #: 2-11-09

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken include DD people

Motion Made By Kerzman Seconded By Ekstrom

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom	X	
Vice Chairman Bellew	X		Representative Kerzman	X	
Representative Kreidt	X		Representative Metcalf	X	
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 6 No 0

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 2-11-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken move to bring back motion for $2 Salary

Motion Made By Wieland Seconded By Kreidt DD Provided

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 2-11-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Move - to use a

Motion Made By Kreidt Seconded By Bellew

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom	X	
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 6 No 2

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 2-11-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Move to Reconsider $2 Raise

Motion Made By Kreidt Seconded By Nelson

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		X
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 3

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

98013.0104
Title.
Fiscal No. 1

Prepared by the Legislative Council staff for
House Appropriations - Human Resources
February 12, 2009

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 1, line 2, after the semicolon insert "to provide for a legislative council study; to provide statements of legislative intent;" and replace "50-06-29, 50-24.1-02.3, and 50-29-04" with "25-04-05, 50-24.5-04, and 50-30-02"

Page 1, line 3, replace "the establishment of an aging and disability" with "developmental center admission screenings, the personal needs allowance for individuals in basic care facilities, and use of the health care trust fund."

Page 1, remove lines 4 through 6

Page 1, line 18, replace "7,790,774" with "7,506,110" and replace "19,303,132" with "19,018,468"

Page 1, line 19, replace "(13,570,832)" with "(13,603,062)" and replace "46,539,524" with "46,507,294"

Page 1, line 21, replace "($5,780,343)" with "($6,097,237)" and replace "65,842,656" with "65,525,762"

Page 1, line 22, replace "(14,635,996)" with "(14,723,511)" and replace "36,027,838" with "35,940,323"

Page 1, line 23, replace "8,855,653" with "8,626,274" and replace "29,814,818" with "29,585,439"

Page 2, line 4, replace "19,253,918" with "18,933,751" and replace "44,664,959" with "44,344,792"

Page 2, line 5, replace "5,439,280" with "4,364,279" and replace "73,251,082" with "72,176,081"

Page 2, line 7, replace "112,946,092" with "111,111,588" and replace "456,965,308" with "455,130,804"

Page 2, line 8, replace "227,633,993" with "187,431,238" and replace "1,344,821,814" with "1,304,619,059"

Page 2, line 11, replace "352,797,592" with "309,365,165" and replace "1,919,716,163" with "1,876,283,736"

Page 2, line 12, replace "248,526,112" with "222,983,295" and replace "1,375,189,679" with "1,349,646,862"

Page 2, line 13, replace "104,271,480" with "86,381,870" and replace "544,526,484" with "526,636,874"

Page 2, replace lines 18 through 30 with:

"Northwest human service center	$7,493,897	$914,791	$8,408,688
North central human service center	16,782,604	2,386,696	19,169,300

Lake region human service center	9,817,355	1,038,007	10,855,362
Northeast human service center	22,107,349	3,638,550	25,745,899
Southeast human service center	26,061,630	4,035,392	30,097,022
South central human service center	14,683,811	836,678	15,520,489
West central human service center	20,687,272	3,951,652	24,638,924
Badlands human service center	9,798,789	1,046,309	10,845,098
State hospital	57,391,944	10,565,492	67,957,436
Developmental center	46,793,933	6,783,586	53,577,519
Total all funds	$231,618,584	$35,197,153	$266,815,737
Less estimated income	112,757,229	15,479,690	128,236,919
Total general fund	$118,861,355	$19,717,463	$138,578,818"

Page 3, line 4, replace "141,437,021" with "114,725,607" and replace "721,512,545" with "694,801,131"

Page 3, line 5, replace "250,489,786" with "223,739,474" and replace "1,540,574,416" with "1,513,824,104"

Page 3, line 6, replace "391,926,807" with "338,465,081" and replace "2,262,086,961" with "2,208,625,235"

Page 3, line 7, replace "14.00" with "(5.00)" and replace "2237.38" with "2,218.38"

Page 3, line 20, replace "3,943,692" with "2,793,692"

Page 3, line 22, replace "4,296,298" with "3,146,298"

Page 4, line 6, replace "$3,000,000" with "$4,324,506"

Page 4, replace lines 10 through 30 with:

"**SECTION 5. LEGISLATIVE COUNCIL STUDY - CHILD SUPPORT ENFORCEMENT.** During the 2009-10 interim, the legislative council shall consider studying the department of human services' child support enforcement program. The study should include the review of arrearages in terms of total owed and interest accrued and child support enforcement activities in other states. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly.

SECTION 6. SUPPLEMENTAL PAYMENTS - BASIC CARE AND NURSING HOME FACILITY SALARY AND BENEFIT INCREASES. The funding appropriated in subdivision 2 of section 1 of this Act includes $14,739,128, of which $4,950,451 is from the general fund, $1,000,000 is from the health care trust fund, and $8,788,677 is from federal funds, for providing supplemental payments to basic care and skilled nursing care facilities to allow for a salary and benefit increase for individuals making $15 per hour or less employed by basic care and nursing care facilities, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 7. SUPPLEMENTAL PAYMENTS - DEVELOPMENTAL DISABILITIES PROVIDER SALARY AND BENEFIT INCREASES. The funding appropriated in subdivision 2 of section 1 of this Act includes $18,929,151, of which $7,000,000 is from the general fund and $11,929,151 is from federal funds, for providing supplemental payments to developmental disabilities providers to allow for a salary and benefit increase for individuals making $15 per hour or less employed by developmental disabilities providers, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 8. AMENDMENT. Section 25-04-05 of the North Dakota Century Code is amended and reenacted as follows:

25-04-05. Qualifications for admission to state facility - ~~Temporary~~ Screening required prior to admission or readmission - Educational or related services without charge for persons twenty-one years of age and under.

1. The superintendent may admit a person to the developmental center at westwood park, Grafton when all of the following conditions have been met:

   a. Application for admission has been made on behalf of the person by a parent or guardian or the person or agency having legal custody, or by the person seeking admission, in accordance with procedures established by the department of human services.

   b. A comprehensive evaluation of the person has been made within three months of the date of application, a report of which has been filed with the superintendent and which, together with such other information or reviews as the department of human services may require, indicates to the superintendent's satisfaction that the person is eligible for admission to the developmental center at westwood park, Grafton.

   c. The person may be admitted without exceeding the resident capacity of the facility as specified in the professional standards adopted by the department of human services.

2. ~~The superintendent~~ No person may ~~admit~~ be admitted or readmitted to the developmental center at westwood park, Grafton, ~~temporarily for the purposes of observation, without commitment,~~ unless that person has undergone a screening process at the developmental center to determine whether the admission or readmission is appropriate. Length of stay criteria may be established under rules as the department of human services may adopt~~, any~~. Any person who is suspected of being able to benefit from the services offered at the center~~,~~ may be screened to ascertain whether or not that person is actually a proper case for care, treatment, and training ~~in~~ at the ~~state facility~~ developmental center. If in the opinion of the superintendent the person ~~temporarily admitted to the developmental center at westwood park, Grafton~~ screened under this subsection is a proper subject for institutional care, treatment, and training at the developmental center, that person may remain as a voluntary resident at ~~such~~ the center at the discretion of the superintendent if all other conditions for admission required by this section are met.

3. Notwithstanding any other provision of this chapter, no handicapped patient, twenty-one years of age or under, or the estate or the parent of such patient, may be charged for educational or related services provided at the developmental center at westwood park, Grafton. Except as provided in subsection 4, the department of human services has prior claim on all benefits accruing to such patients for medical and medically related services under entitlement from the federal government, medical or hospital insurance contracts, workforce safety and insurance, or medical care and disability programs. For purposes of this subsection, "related services" means transportation and such developmental, corrective, and other supportive services, as determined by the department of public instruction, as are required to assist a handicapped patient to benefit from special education. The cost of related services other than medical and medically related services must be paid by the developmental center at westwood park, Grafton, the school district of residence of the handicapped

child, and other appropriate state agencies and political subdivisions of this state. The department of public instruction, the department of human services, the school district of residence, and other appropriate state agencies and political subdivisions, as determined by the department of public instruction, shall determine and agree to that portion of related services, other than medical and medically related services, for which each agency and political subdivision is liable. The department of public instruction may adopt rules necessary to implement this section.

4. Parents of a handicapped patient, twenty-one years of age or under, are not required to file, assist in filing, agree to filing, or assign an insurance claim when filing the claim would pose a realistic threat that the parents would suffer a financial loss not incurred by similarly situated parents of nonhandicapped children. Financial losses do not include incidental costs such as the time needed to file or assist in filing an insurance claim or the postage needed to mail the claim. Financial losses include:

   a. A decrease in available lifetime coverage or any other benefit under an insurance policy.

   b. An increase in premiums or the discontinuation of a policy.

   c. An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim unless the developmental center pays or waives the out-of-pocket expense.

SECTION 9. AMENDMENT. Section 50-24.5-04 of the North Dakota Century Code is amended and reenacted as follows:

50-24.5-04. Services provided - Limit on cost. Services provided under this chapter must be treated as necessary remedial care to the extent those services are not covered under the medical assistance program. The cost of the services provided under this chapter to a person residing in a basic care or adult family foster care facility for which the rate charged includes room and board is limited to the rate set for services in that facility, plus ~~sixty~~ seventy-five dollars, less that person's total income.

SECTION 10. AMENDMENT. Section 50-30-02 of the North Dakota Century Code is amended and reenacted as follows:

50-30-02. North Dakota health care trust fund created - Uses - Continuing appropriation.

1. There is created in the state treasury a special fund known as the North Dakota health care trust fund. The fund consists of revenue received from government nursing facilities for remittance to the fund under former section 50-24.4-30. The department shall administer the fund. The state investment board shall invest moneys in the fund in accordance with chapter 21-10, and the income earned must be deposited in the North Dakota health care trust fund. All moneys deposited in the North Dakota health care trust fund are available to the department for:

   a. Transfer to the long-term care facility loan fund, as authorized by legislative appropriation, for making loans pursuant to the requirements of this chapter.

   b. Payment, as authorized by legislative appropriation, of costs of other programs authorized by the legislative assembly.

   c. Repayment of federal funds, which are appropriated and may be spent if the United States department of health and human services

determines that funds were inappropriately claimed under former section 50-24.4-30.

2. The department shall continue to access the intergovernmental transfer program if permitted by the federal government and if use of the program is found to be beneficial.

3. Moneys in the fund may not be included in draft appropriation acts under section 54-44.1-06."

Page 5, remove lines 1 through 31

Page 6, remove lines 1 through 10

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT - LC 98013.0104 FN 1

A copy of the statement of purpose of amendment is attached.

STATEMENT OF PURPOSE OF AMENDMENT:

House Bill No. 1012 - Summary of House Action

	Executive Budget	House Changes	House Version
DHS - Management			
Total all funds	$65,842,656	($316,894)	$65,525,762
Less estimated income	36,027,838	(87,515)	35,940,323
General fund	$29,814,818	($229,379)	$29,585,439
DHS - Program/Policy			
Total all funds	$1,919,716,163	($43,432,427)	$1,876,283,736
Less estimated income	1,375,189,679	(25,542,817)	1,349,646,862
General fund	$544,526,484	($17,889,610)	$526,636,874
DHS - State Hospital			
Total all funds	$70,001,527	($2,044,091)	$67,957,436
Less estimated income	19,563,594	(6,930)	19,556,664
General fund	$50,437,933	($2,037,161)	$48,400,772
DHS - Developmental Center			
Total all funds	$54,015,265	($437,746)	$53,577,519
Less estimated income	37,160,672	(228)	37,160,444
General fund	$16,854,593	($437,518)	$16,417,075
DHS - Northwest HSC			
Total all funds	$8,562,127	($153,439)	$8,408,688
Less estimated income	3,680,172	(8,620)	3,671,552
General fund	$4,881,955	($144,819)	$4,737,136
DHS - North Central HSC			
Total all funds	$20,923,799	($1,754,499)	$19,169,300
Less estimated income	8,825,362	(156,988)	8,668,374
General fund	$12,098,437	($1,597,511)	$10,500,926
DHS - Lake Region HSC			
Total all funds	$11,011,109	($155,747)	$10,855,362
Less estimated income	4,747,559	(8,554)	4,739,005
General fund	$6,263,550	($147,193)	$6,116,357
DHS - Northeast HSC			
Total all funds	$26,376,851	($630,952)	$25,745,899
Less estimated income	14,320,535	(162,378)	14,158,157
General fund	$12,056,316	($468,574)	$11,587,742
DHS - Southeast HSC			
Total all funds	$32,020,964	($1,923,942)	$30,097,022
Less estimated income	15,966,058	(441,503)	15,524,555
General fund	$16,054,906	($1,482,439)	$14,572,467
DHS - South Central HSC			
Total all funds	$15,913,332	($392,843)	$15,520,489
Less estimated income	6,970,002	(6,584)	6,963,418
General fund	$8,943,330	($386,259)	$8,557,071
DHS - West Central HSC			
Total all funds	$26,008,933	($1,370,009)	$24,638,924
Less estimated income	12,693,292	(162,815)	12,530,477
General fund	$13,315,641	($1,207,194)	$12,108,447
DHS - Badlands HSC			
Total all funds	$11,694,235	($849,137)	$10,845,098
Less estimated income	5,429,653	(165,380)	5,264,273
General fund	$6,264,582	($683,757)	$5,580,825
Bill total			
Total all funds	$2,262,086,961	($53,461,726)	$2,208,625,235

Less estimated income	1,540,574,416	(26,750,312)	1,513,824,104
General fund	$721,512,545	($26,711,414)	$694,801,131

House Bill No. 1012 - DHS - Management - House Action

	Executive Budget	House Changes[1]	House Version
Salaries and wages	$19,303,132	($284,664)	$19,018,468
Operating expenses	46,539,524	(32,230)	46,507,294
Total all funds	$65,842,656	($316,894)	$65,525,762
Less estimated income	36,027,838	(87,515)	35,940,323
General fund	$29,814,818	($229,379)	$29,585,439
FTE	108.35	(1.00)	107.35

1

Management - House changes:	FTE	General Fund	Other Funds	Total
Administration Support Program				
Remove 1 new FTE position added in the executive budget to perform additional duties required by Statement on Auditing Standards No. 112 regarding communicating internal control matters, including $126,265 for salaries and wages and $2,790 for operating expenses	(1.00)	($56,724)	($72,331)	($129,055)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(131,076)	0	(131,076)
Decrease funding for department travel		(14,256)	(15,184)	(29,440)
Division of Information Technology Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(27,323)	0	(27,323)
Total House changes - Management	(1.00)	($229,379)	($87,515)	($316,894)

Other changes affecting Management programs or multiple programs of the department:
Add a section to provide for a Legislative Council study of the Department of Human Services' child support enforcement program, including the review of arrearages in terms of total owed and interest accrued and the review of child support enforcement in other states.

House Bill No. 1012 - DHS - Program/Policy - House Action

	Executive Budget	House Changes[1]	House Version
Salaries and wages	$44,664,959	($320,167)	$44,344,792
Operating expenses	73,251,082	(1,075,001)	72,176,081
Capital assets	13,000		13,000
Grants	456,965,308	(1,834,504)	455,130,804
Grants - Medical assistance	1,344,821,814	(40,202,755)	1,304,619,059
Total all funds	$1,919,716,163	($43,432,427)	$1,876,283,736
Less estimated income	1,375,189,679	(25,542,817)	1,349,646,862
General fund	$544,526,484	($17,889,610)	$526,636,874
FTE	363.50	(1.00)	362.50

[1]

Program and Policy - House changes:	FTE	General Fund	Other Funds	Total
Economic Assistance Policy Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($48,462)	$0	($48,462)
Child Support Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(68,787)	0	(68,787)
Medical Services Program				
Decrease funding for department travel		(21,830)	(17,306)	(39,136)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(44,010)	0	(44,010)
Decrease funding added in the executive budget for medically needy to reflect income levels of 75 percent of the federal poverty level (The executive budget included funding of $5,520,859, of which $2,041,614 is from the general fund, to increase medically needy income levels to 83 percent of the federal poverty level.)		(376,947)	(642,379)	(1,019,326)
Decrease funding added in the executive budget for rebasing hospital payment rates. The House version provides $14,924,420, of which $5,519,050 is from the general fund, for rebasing rates to 90 percent of cost. The executive budget included funding of $22,013,114, of which $8,140,450 is from the general fund, for rebasing hospital payment rates to 100 percent of cost.		(2,621,400)	(4,467,294)	(7,088,694)
Decrease funding added in the executive budget for rebasing physician payment rates. The House version provides $10,600,000, of which $3,919,880 is from the general fund, for rebasing rates to 20 percent of the amount needed to rebase to 100 percent of cost. The executive budget included funding of $13,250,000, of which $4,899,850 is from the general fund, for rebasing physician payment rates to 25 percent of the amount needed to rebase to 100 percent of cost.		(979,970)	(1,670,030)	(2,650,000)
Decrease funding added in the executive budget for rebasing chiropractor payment rates. The House version provides $312,000, of which $115,377 is from the		(38,459)	(65,541)	(104,000)

general fund, for rebasing rates to 75 percent of the cost report. The executive budget included funding of $416,000, of which $153,836 is from the general fund, for rebasing rates to 100 percent of cost.				
Decrease funding added in the executive budget for rebasing ambulance payment rates. The House version provides $1,508,336, of which $557,783 is from the general fund, to provide funding equal to 75 percent of the funding provided in the executive budget. The executive budget included funding of $2,011,114, of which $743,710 is from the general fund, to rebase ambulance payment rates to Medicare rates.		(185,927)	(316,851)	(502,778)
Decrease funding added in the executive budget for rebasing dentist payment rates from a minimum of 75 percent of average billed charges with inflation increases of 7 percent each year to a minimum of 70 percent of average billed charges with inflation increases of 0 percent the first year and 7 percent the second year		(722,547)	(1,233,388)	(1,955,935)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(111,048)	(561,337)	(672,385)
Decrease funding for medical services to reduce projected caseload/utilization rates		(9,600,000)	(16,359,978)	(25,959,978)
Long-Term Care Program				
Add funding to increase the personal needs allowance for individuals in basic care facilities from $60 to $75 per month (funding provided is for a January 1, 2010, effective date)		112,320	0	112,320
Add funding to increase the personal needs allowance for individuals in an ICF/MR facility from $60 per month as recommended in the executive budget to $75 per month (funding provided is for a January 1, 2010, effective date)		57,511	98,009	155,520
Add funding to increase nursing facility bed limits in the formula for nursing home payments from $138,907 to $169,098 for single rooms and $92,604 to $112,732 for double rooms. (Of the $877,518, $324,506 is from the health care trust fund and $553,012 is from federal funds.)		0	877,518	877,518
Add funding of $14,739,128, of which $4,950,451 is from the general fund, $1 million is from the health care trust fund, and $8,788,677 is from federal funds, to provide a salary and benefit supplemental payment for individuals employed by basic care and nursing care faculties currently making $15 per hour or less		4,950,451	9,788,677	14,739,128
Add funding to provide for a salary and benefit supplemental payment for developmental disabilities providers currently making $15 per hour or less		7,000,000	11,929,151	18,929,151
Remove the new FTE position added in the 2009-11 executive budget relating to the implementation of a home and community-based care waiver to provide support for children who have a diagnosis of autism spectrum disorder	(1.00)	(66,872)	(66,871)	(133,743)
Provide funding for increasing the payment rates for children who are severely medically fragile residing at the Anne Carlsen Center for Children and other developmental disabilities providers experiencing losses		438,900	747,957	1,186,857
Remove funding included in the executive budget for the addition of a third tier of personal care that would allow a maximum of 1,200 units of care per month		(1,021,922)	(1,741,524)	(2,763,446)

Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases	(4,544,584)	(7,103,292)	(11,647,876)
Decrease funding for long-term care to reduce projected caseload/utilization rates	(5,600,000)	(9,543,320)	(15,143,320)
Decrease funding for developmental disabilities grants to reduce projected caseload/utilization rates	(2,476,000)	(4,219,511)	(6,695,511)
Aging Services Program			
Remove funding for a pilot aging and disability resource center	(600,000)	0	(600,000)
Decrease funding for department travel	(3,506)	(10,464)	(13,970)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover	(3,350)	0	(3,350)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases	(15,200)	0	(15,200)
Children and Family Services Program			
Decrease funding for department travel	(1,054)	(2,652)	(3,706)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover	(7,754)	0	(7,754)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases	(436,192)	(823,013)	(1,259,205)
Mental Health and Substance Abuse Program			
Decrease funding for department travel	(15,842)	(45,715)	(61,557)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover	(7,940)	0	(7,940)
Decrease funding for compulsive gambling services by $200,000 from the general fund, from $700,000, of which $300,000 is from the general fund and $400,000 is from special funds from lottery proceeds, as provided for in the executive budget to $500,000, of which $100,000 is from the general fund and $400,000 is from special funds from lottery proceeds. The 2007-09 legislative appropriation for compulsive gambling services is $400,000 of special funds from lottery proceeds.	(150,000)	0	(150,000)
Remove funding for Governor's Prevention and Advisory Council grants	(200,000)	0	(200,000)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases	(21,237)	0	(21,237)
Developmental Disabilities Council			
Decrease funding for department travel	0	(4,446)	(4,446)
Developmental Disabilities Division			
Decrease funding for department travel	(7,536)	(32,975)	(40,511)
Reduce funding for salaries and wages for anticipated savings from vacant positions	(3,455)	0	(3,455)

and employee turnover			
rease funding added in the executive budget for inflationary increases for ll services except the rebased services to provide 6 percent per year increases	(27,199)	0	(27,199)
Vocational Rehabilitation			
Decrease funding for department travel	(17,096)	(56,242)	(73,338)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover	(2,666)	0	(2,666)
Decrease funding for centers for independent living by $400,000 from the general fund, from $2,144,539, of which $1,330,958 is from the general fund, as included in the executive budget, to $1,744,539, of which $930,958 is from the general fund	(400,000)	0	(400,000)
Total House changes - Program and Policy	(1.00)	($17,889,610)	($25,542,817)	($43,432,427)

Other changes affecting Program and Policy programs:

Add a section of legislative intent regarding the funding for basic care and nursing home facility salary and benefit supplemental payments

Add a section of legislative intent regarding the funding for developmental disabilities providers salary and benefit supplemental payments

Amend NDCC Section 50-30-02 relating to the health care trust fund to provide that money in the fund may not be included in drafts of appropriation bills introduced as part of the executive budget

Amend NDCC Section 50-24.5-04 to increase the personal needs allowance for individuals in basic care facilities from $60 to $75 per month

House Bill No. 1012 - DHS - State Hospital - House Action

	Executive Budget	House Changes[1]	House Version
State Hospital	$70,001,527	($2,044,091)	$67,957,436
Total all funds	$70,001,527	($2,044,091)	$67,957,436
Less estimated income	19,563,594	(6,930)	19,556,664
General fund	$50,437,933	($2,037,161)	$48,400,772
FTE	472.51	(6.00)	466.51

1

State Hospital - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Decrease one-time funding for extraordinary repairs from $3,231,017 to $2,231,017		($1,000,000)	$0	($1,000,000)
Remove funding included in the executive budget for the global health initiative, including 6 new FTE positions	(6.00)	(516,815)	0	(516,815)

Decrease funding for department travel		(9,206)	(6,930)	(16,136)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(511,140)	0	(511,140)
Total House changes - State Hospital	(6.00)	($2,037,161)	($6,930)	($2,044,091)

House Bill No. 1012 - DHS - Developmental Center - House Action

	Executive Budget	House Changes[1]	House Version
Developmental Center	$54,015,265	($437,746)	$53,577,519
Total all funds	$54,015,265	($437,746)	$53,577,519
Less estimated income	37,160,672	(228)	37,160,444
General fund	$16,854,593	($437,518)	$16,417,075
FTE	445.54	0.00	445.54

1

Developmental Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Decrease one-time funding for extraordinary repairs from $712,675 to $562,675		($150,000)	$0	($150,000)
Decrease funding for department travel		(148)	(228)	(376)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(287,370)	0	(287,370)
Total House changes - Developmental Center	0.00	($437,518)	($228)	($437,746)

Other changes affecting the Developmental Center:
Amend NDCC Section 23-04-05 regarding admissions to the Developmental Center

House Bill No. 1012 - - General Fund Summary

	Executive Budget	House Changes[1]	House Version
DHS - Northwest HSC	4,881,955	(144,819)	4,737,136
DHS - North Central HSC	12,098,437	(1,597,511)	10,500,926
DHS - Lake Region HSC	6,263,550	(147,193)	6,116,357
DHS - Northeast HSC	12,056,316	(468,574)	11,587,742
DHS - Southeast HSC	16,054,906	(1,482,439)	14,572,467
DHS - South Central HSC	8,943,330	(386,259)	8,557,071
DHS - West Central HSC	13,315,641	(1,207,194)	12,108,447
DHS - Badlands HSC	6,264,582	(683,757)	5,580,825
Total general fund	$79,878,717	($6,117,746)	$73,760,971

House Bill No. 1012 - - Other Funds Summary

	Executive Budget	House Changes[1]	House Version
DHS - Northwest HSC	3,680,172	(8,620)	3,671,552
DHS - North Central HSC	8,825,362	(156,988)	8,668,374
DHS - Lake Region HSC	4,747,559	(8,554)	4,739,005
DHS - Northeast HSC	14,320,535	(162,378)	14,158,157
DHS - Southeast HSC	15,966,058	(441,503)	15,524,555
DHS - South Central HSC	6,970,002	(6,584)	6,963,418
DHS - West Central HSC	12,693,292	(162,815)	12,530,477
DHS - Badlands HSC	5,429,653	(165,380)	5,264,273
Total other funds	$72,632,633	($1,112,822)	$71,519,811

House Bill No. 1012 - - All Funds Summary

	Executive Budget	House Changes[1]	House Version
DHS - Northwest HSC	8,562,127	(153,439)	8,408,688
DHS - North Central HSC	20,923,799	(1,754,499)	19,169,300
DHS - Lake Region HSC	11,011,109	(155,747)	10,855,362
DHS - Northeast HSC	26,376,851	(630,952)	25,745,899
DHS - Southeast HSC	32,020,964	(1,923,942)	30,097,022
DHS - South Central HSC	15,913,332	(392,843)	15,520,489
DHS - West Central HSC	26,008,933	(1,370,009)	24,638,924
DHS - Badlands HSC	11,694,235	(849,137)	10,845,098
Total all funds	$152,511,350	($7,230,568)	$145,280,782
FTE	847.48	(11.00)	836.48

rthwest Human Service Center - House changes:	FTE	General Fund	Other Funds	Total
Decrease funding for department travel		($19,621)	($8,468)	($28,089)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(97,561)	0	(97,561)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(27,637)	(152)	(27,789)
Total House changes - Northwest Human Service Center	0.00	($144,819)	($8,620)	($153,439)

North Central Human Service Center - House changes:	FTE	General Fund	Other Funds	Total
Remove funding added in the executive budget for the global health initiative		($1,358,307)	($100,000)	($1,458,307)
Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Decrease funding for department travel		(2,132)	(1,521)	(3,653)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(122,969)	0	(122,969)

ecrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(55,310)	(3,113)	(58,423)
Total House changes - North Central Human Service Center	(1.00)	($1,597,511)	($156,988)	($1,754,499)

Lake Region Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Decrease funding for department travel		($12,616)	($8,554)	($21,170)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(104,767)	0	(104,767)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(29,810)	0	(29,810)
Total House changes - Lake Region Human Service Center	0.00	($147,193)	($8,554)	($155,747)

Northeast Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative		($280,663)	($81,200)	($361,863)
Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Decrease funding for department travel		(2,654)	(4,571)	(7,225)
educe funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(63,064)	0	(63,064)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(63,400)	(24,253)	(87,653)
Total House changes - Northeast Human Service Center	(1.00)	($468,574)	($162,378)	($630,952)

Southeast Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative	(4.00)	($1,190,124)	($183,746)	($1,373,870)
Provide funding for contract staffing at the Cooper House	0.00	236,520	78,840	315,360
Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Remove funding added in the executive budget for young adult transition residential services		(184,622)	(242,222)	(426,844)
Remove funding and FTE position added in the executive budget for the partnership program	(1.00)	(61,490)	(40,440)	(101,930)
Decrease funding for department travel		(1,707)	(1,414)	(3,121)

Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(164,349)	0	(164,349)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(57,874)	(167)	(58,041)
Total House changes - Southeast Human Service Center	(6.00)	($1,482,439)	($441,503)	($1,923,942)

South Central Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative	(1.00)	($127,669)	$0	($127,669)
Remove funding and FTE position added in the executive budget to complete vulnerable adult protection services	(1.00)	(73,128)	0	(73,128)
Decrease funding for department travel		(10,231)	(6,584)	(16,815)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(128,661)	0	(128,661)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(46,570)	0	(46,570)
Total House changes - South Central Human Service Center	(2.00)	($386,259)	($6,584)	($392,843)

West Central Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative		($279,546)	$0	($279,546)
Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Remove funding added in the executive budget for young adult transition residential services		(650,000)	(100,000)	(750,000)
Decrease funding for department travel		(13,677)	(9,496)	(23,173)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(135,157)	0	(135,157)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(70,021)	(965)	(70,986)
Total House changes - West Central Human Service Center	(1.00)	($1,207,194)	($162,815)	($1,370,009)

Badlands Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative		($665,000)	($140,000)	($805,000)
Decrease funding for department travel		(232)	(163)	(395)

`educe funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(40,139)	0	(40,139)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		21,614	(25,217)	(3,603)
Total House changes - Badlands Human Service Center	0.00	($683,757)	($165,380)	($849,137)

Date: 2-13-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken DP as amended HB 1012

Motion Made By Bellew Seconded By Wieland

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman		
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 2

Absent 1

Floor Assignment Pollert

If the vote is on an amendment, briefly indicate intent:

Date: 2-13-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken accept amendments

Motion Made By Kreidt Seconded By Wieland

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert	X		Representative Ekstrom		X
Vice Chairman Bellew	X		Representative Kerzman	—	—
Representative Kreidt	X		Representative Metcalf		X
Representative Nelson	X				
Representative Wieland	X				

Total (Yes) 5 No 2

Absent 1

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 2-13-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken add "medically fragile + behavioral" engendered.

Motion Made By Nelson Seconded By Wieland

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert			Representative Ekstrom		
Vice Chairman Bellew			Representative Kerzman		
Representative Kreidt			Representative Metcalf		
Representative Nelson					
Representative Wieland					

Total (Yes) 5 No 2

Absent 1

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Voice Vote

Date: 2-13-09
Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Appropriations Human Resources Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken

Motion Made By Nelson Seconded By Metcalf

Representatives	Yes	No	Representatives	Yes	No
Chairman Pollert			Representative Ekstrom		
Vice Chairman Bellew			Representative Kerzman		
Representative Kreidt			Representative Metcalf		
Representative Nelson					
Representative Wieland					

Total (Yes) 7 No 0

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Attachment A
2/17/09

98013.0105
Title.
Fiscal No. 1

Prepared by the Legislative Council staff for
House Appropriations - Human Resources
February 12, 2009

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 1, line 2, after the semicolon insert "to provide for a legislative council study; to provide statements of legislative intent;" and replace "50-06-29, 50-24.1-02.3, and 50-29-04" with "25-04-05, 50-24.5-04, and 50-30-02"

Page 1, line 3, replace "the establishment of an aging and disability" with "developmental center admission screenings, the personal needs allowance for individuals in basic care facilities, and use of the health care trust fund."

Page 1, remove lines 4 through 6

Page 1, line 18, replace "7,790,774" with "7,506,110" and replace "19,303,132" with "19,018,468"

Page 1, line 19, replace "(13,570,832)" with "(13,603,062)" and replace "46,539,524" with "46,507,294"

Page 1, line 21, replace "($5,780,343)" with "($6,097,237)" and replace "65,842,656" with "65,525,762"

Page 1, line 22, replace "(14,635,996)" with "(14,723,511)" and replace "36,027,838" with "35,940,323"

Page 1, line 23, replace "8,855,653" with "8,626,274" and replace "29,814,818" with "29,585,439"

Page 2, line 4, replace "19,253,918" with "18,933,751" and replace "44,664,959" with "44,344,792"

Page 2, line 5, replace "5,439,280" with "4,364,279" and replace "73,251,082" with "72,176,081"

Page 2, line 7, replace "112,946,092" with "111,111,588" and replace "456,965,308" with "455,130,804"

Page 2, line 8, replace "227,633,993" with "187,431,238" and replace "1,344,821,814" with "1,304,619,059"

Page 2, line 11, replace "352,797,592" with "309,365,165" and replace "1,919,716,163" with "1,876,283,736"

Page 2, line 12, replace "248,526,112" with "222,983,295" and replace "1,375,189,679" with "1,349,646,862"

Page 2, line 13, replace "104,271,480" with "86,381,870" and replace "544,526,484" with "526,636,874"

Page 2, replace lines 18 through 30 with:

"Northwest human service center	$7,493,897	$914,791	$8,408,688
North central human service center	16,782,604	2,386,696	19,169,300

Lake region human service center	9,817,355	1,038,007	10,855,362
Northeast human service center	22,107,349	3,638,550	25,745,899
Southeast human service center	26,061,630	4,035,392	30,097,022
South central human service center	14,683,811	836,678	15,520,489
West central human service center	20,687,272	3,951,652	24,638,924
Badlands human service center	9,798,789	1,046,309	10,845,098
State hospital	57,391,944	10,565,492	67,957,436
Developmental center	46,793,933	6,783,586	53,577,519
Total all funds	$231,618,584	$35,197,153	$266,815,737
Less estimated income	112,757,229	15,479,690	128,236,919
Total general fund	$118,861,355	$19,717,463	$138,578,818"

Page 3, line 4, replace "141,437,021" with "114,725,607" and replace "721,512,545" with "694,801,131"

Page 3, line 5, replace "250,489,786" with "223,739,474" and replace "1,540,574,416" with "1,513,824,104"

Page 3, line 6, replace "391,926,807" with "338,465,081" and replace "2,262,086,961" with "2,208,625,235"

Page 3, line 7, replace "14.00" with "(5.00)" and replace "2237.38" with "2,218.38"

Page 3, line 20, replace "3,943,692" with "2,793,692"

Page 3, line 22, replace "4,296,298" with "3,146,298"

Page 4, line 6, replace "$3,000,000" with "$4,324,506"

Page 4, replace lines 10 through 30 with:

"**SECTION 5. LEGISLATIVE COUNCIL STUDY - CHILD SUPPORT ENFORCEMENT.** During the 2009-10 interim, the legislative council shall consider studying the department of human services' child support enforcement program. The study should include the review of arrearages in terms of total owed and interest accrued and child support enforcement activities in other states. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly.

SECTION 6. SUPPLEMENTAL PAYMENTS - BASIC CARE AND NURSING HOME FACILITY SALARY AND BENEFIT INCREASES. The funding appropriated in subdivision 2 of section 1 of this Act includes $14,739,128, of which $4,950,451 is from the general fund, $1,000,000 is from the health care trust fund, and $8,788,677 is from federal funds, for providing supplemental payments to basic care and skilled nursing care facilities to allow for a salary and benefit increase for individuals making $15 per hour or less employed by basic care and nursing care facilities, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 7. SUPPLEMENTAL PAYMENTS - DEVELOPMENTAL DISABILITIES PROVIDER SALARY AND BENEFIT INCREASES. The funding appropriated in subdivision 2 of section 1 of this Act includes $18,929,151, of which $7,000,000 is from the general fund and $11,929,151 is from federal funds, for providing supplemental payments to developmental disabilities providers to allow for a salary and benefit increase for individuals making $15 per hour or less employed by developmental disabilities providers, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 8. AMENDMENT. Section 25-04-05 of the North Dakota Century Code is amended and reenacted as follows:

25-04-05. Qualifications for admission to state facility - ~~Temporary~~ Screening required prior to admission or readmission - Educational or related services without charge for persons twenty-one years of age and under.

1. The superintendent may admit a person to the developmental center at westwood park, Grafton when all of the following conditions have been met:

   a. Application for admission has been made on behalf of the person by a parent or guardian or the person or agency having legal custody, or by the person seeking admission, in accordance with procedures established by the department of human services.

   b. A comprehensive evaluation of the person has been made within three months of the date of application, a report of which has been filed with the superintendent and which, together with such other information or reviews as the department of human services may require, indicates to the superintendent's satisfaction that the person is eligible for admission to the developmental center at westwood park, Grafton.

   c. The person may be admitted without exceeding the resident capacity of the facility as specified in the professional standards adopted by the department of human services.

2. ~~The superintendent~~ No person may ~~admit~~ be admitted or readmitted to the developmental center at westwood park, Grafton, ~~temporarily for the purposes of observation, without commitment,~~ unless that person has undergone a screening process at the developmental center to determine whether the admission or readmission is appropriate. Length of stay criteria may be established under rules as the department of human services may adopt~~, any~~. Any person who is suspected of being able to benefit from the services offered at the center~~,~~ may be screened to ascertain whether or not that person is actually a proper case for care, treatment, and training ~~in~~ at the ~~state facility~~ developmental center. If in the opinion of the superintendent the person ~~temporarily admitted to the developmental center at westwood park, Grafton~~ screened under this subsection is a proper subject for institutional care, treatment, and training at the developmental center, that person may remain as a voluntary resident at ~~such~~ the center at the discretion of the superintendent if all other conditions for admission required by this section are met.

3. Notwithstanding any other provision of this chapter, no handicapped patient, twenty-one years of age or under, or the estate or the parent of such patient, may be charged for educational or related services provided at the developmental center at westwood park, Grafton. Except as provided in subsection 4, the department of human services has prior claim on all benefits accruing to such patients for medical and medically related services under entitlement from the federal government, medical or hospital insurance contracts, workforce safety and insurance, or medical care and disability programs. For purposes of this subsection, "related services" means transportation and such developmental, corrective, and other supportive services, as determined by the department of public instruction, as are required to assist a handicapped patient to benefit from special education. The cost of related services other than medical and medically related services must be paid by the developmental center at westwood park, Grafton, the school district of residence of the handicapped

child, and other appropriate state agencies and political subdivisions of this state. The department of public instruction, the department of human services, the school district of residence, and other appropriate state agencies and political subdivisions, as determined by the department of public instruction, shall determine and agree to that portion of related services, other than medical and medically related services, for which each agency and political subdivision is liable. The department of public instruction may adopt rules necessary to implement this section.

4. Parents of a handicapped patient, twenty-one years of age or under, are not required to file, assist in filing, agree to filing, or assign an insurance claim when filing the claim would pose a realistic threat that the parents would suffer a financial loss not incurred by similarly situated parents of nonhandicapped children. Financial losses do not include incidental costs such as the time needed to file or assist in filing an insurance claim or the postage needed to mail the claim. Financial losses include:

   a. A decrease in available lifetime coverage or any other benefit under an insurance policy.

   b. An increase in premiums or the discontinuation of a policy.

   c. An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim unless the developmental center pays or waives the out-of-pocket expense.

SECTION 9. AMENDMENT. Section 50-24.5-04 of the North Dakota Century Code is amended and reenacted as follows:

50-24.5-04. Services provided - Limit on cost. Services provided under this chapter must be treated as necessary remedial care to the extent those services are not covered under the medical assistance program. The cost of the services provided under this chapter to a person residing in a basic care or adult family foster care facility for which the rate charged includes room and board is limited to the rate set for services in that facility, plus ~~sixty~~ seventy-five dollars, less that person's total income.

SECTION 10. AMENDMENT. Section 50-30-02 of the North Dakota Century Code is amended and reenacted as follows:

50-30-02. North Dakota health care trust fund created - Uses - Continuing appropriation.

1. There is created in the state treasury a special fund known as the North Dakota health care trust fund. The fund consists of revenue received from government nursing facilities for remittance to the fund under former section 50-24.4-30. The department shall administer the fund. The state investment board shall invest moneys in the fund in accordance with chapter 21-10, and the income earned must be deposited in the North Dakota health care trust fund. All moneys deposited in the North Dakota health care trust fund are available to the department for:

   a. Transfer to the long-term care facility loan fund, as authorized by legislative appropriation, for making loans pursuant to the requirements of this chapter.

   b. Payment, as authorized by legislative appropriation, of costs of other programs authorized by the legislative assembly.

   c. Repayment of federal funds, which are appropriated and may be spent if the United States department of health and human services

determines that funds were inappropriately claimed under former section 50-24.4-30.

2. The department shall continue to access the intergovernmental transfer program if permitted by the federal government and if use of the program is found to be beneficial.

3. Moneys in the fund may not be included in draft appropriation acts under section 54-44.1-06."

Page 5, remove lines 1 through 31

Page 6, remove lines 1 through 10

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT - LC 98013.0105 FN 1

A copy of the statement of purpose of amendment is attached.

STATEMENT OF PURPOSE OF AMENDMENT:

ıse Bill No. 1012 - Summary of House Action

	Executive Budget	House Changes	House Version
DHS - Management			
Total all funds	$65,842,656	($316,894)	$65,525,762
Less estimated income	36,027,838	(87,515)	35,940,323
General fund	$29,814,818	($229,379)	$29,585,439
DHS - Program/Policy			
Total all funds	$1,919,716,163	($43,432,427)	$1,876,283,736
Less estimated income	1,375,189,679	(25,542,817)	1,349,646,862
General fund	$544,526,484	($17,889,610)	$526,636,874
DHS - State Hospital			
Total all funds	$70,001,527	($2,044,091)	$67,957,436
Less estimated income	19,563,594	(6,930)	19,556,664
General fund	$50,437,933	($2,037,161)	$48,400,772
DHS - Developmental Center			
Total all funds	$54,015,265	($437,746)	$53,577,519
Less estimated income	37,160,672	(228)	37,160,444
General fund	$16,854,593	($437,518)	$16,417,075
DHS - Northwest HSC			
Total all funds	$8,562,127	($153,439)	$8,408,688
Less estimated income	3,680,172	(8,620)	3,671,552
General fund	$4,881,955	($144,819)	$4,737,136
DHS - North Central HSC			
Total all funds	$20,923,799	($1,754,499)	$19,169,300
Less estimated income	8,825,362	(156,988)	8,668,374
General fund	$12,098,437	($1,597,511)	$10,500,926
DHS - Lake Region HSC			
Total all funds	$11,011,109	($155,747)	$10,855,362
Less estimated income	4,747,559	(8,554)	4,739,005
General fund	$6,263,550	($147,193)	$6,116,357
DHS - Northeast HSC			
Total all funds	$26,376,851	($630,952)	$25,745,899
Less estimated income	14,320,535	(162,378)	14,158,157
General fund	$12,056,316	($468,574)	$11,587,742
DHS - Southeast HSC			
Total all funds	$32,020,964	($1,923,942)	$30,097,022
Less estimated income	15,966,058	(441,503)	15,524,555
General fund	$16,054,906	($1,482,439)	$14,572,467
DHS - South Central HSC			
Total all funds	$15,913,332	($392,843)	$15,520,489
Less estimated income	6,970,002	(6,584)	6,963,418
General fund	$8,943,330	($386,259)	$8,557,071
DHS - West Central HSC			
Total all funds	$26,008,933	($1,370,009)	$24,638,924
Less estimated income	12,693,292	(162,815)	12,530,477
General fund	$13,315,641	($1,207,194)	$12,108,447
DHS - Badlands HSC			
Total all funds	$11,694,235	($849,137)	$10,845,098
Less estimated income	5,429,653	(165,380)	5,264,273
General fund	$6,264,582	($683,757)	$5,580,825
Bill total			
Total all funds	$2,262,086,961	($53,461,726)	$2,208,625,235

Less estimated income	1,540,574,416	(26,750,312)	1,513,824,104
General fund	$721,512,545	($26,711,414)	$694,801,131

House Bill No. 1012 - DHS - Management - House Action

	Executive Budget	House Changes[1]	House Version
Salaries and wages	$19,303,132	($284,664)	$19,018,468
Operating expenses	46,539,524	(32,230)	46,507,294
Total all funds	$65,842,656	($316,894)	$65,525,762
Less estimated income	36,027,838	(87,515)	35,940,323
General fund	$29,814,818	($229,379)	$29,585,439
FTE	108.35	(1.00)	107.35

1

Management - House changes:	FTE	General Fund	Other Funds	Total
Administration Support Program				
Remove 1 new FTE position added in the executive budget to perform additional duties required by Statement on Auditing Standards No. 112 regarding communicating internal control matters, including $126,265 for salaries and wages and $2,790 for operating expenses	(1.00)	($56,724)	($72,331)	($129,055)
ce funding for salaries and wages for anticipated savings from vacant positions d employee turnover		(131,076)	0	(131,0
Decrease funding for department travel		(14,256)	(15,184)	(29,440)
Division of Information Technology Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(27,323)	0	(27,323)
Total House changes - Management	(1.00)	($229,379)	($87,515)	($316,894)

Other changes affecting Management programs or multiple programs of the department:
Add a section to provide for a Legislative Council study of the Department of Human Services' child support enforcement program, including the review of arrearages in terms of total owed and interest accrued and the review of child support enforcement in other states.

House Bill No. 1012 - DHS - Program/Policy - House Action

	Executive Budget	House Changes[1]	House Version
Salaries and wages	$44,664,959	($320,167)	$44,344,792
Operating expenses	73,251,082	(1,075,001)	72,176,081
Capital assets	13,000		13,000
Grants	456,965,308	(1,834,504)	455,130,804
Grants - Medical assistance	1,344,821,814	(40,202,755)	1,304,619,059
Total all funds	$1,919,716,163	($43,432,427)	$1,876,283,736
Less estimated income	1,375,189,679	(25,542,817)	1,349,646,862
General fund	$544,526,484	($17,889,610)	$526,636,874
FTE	363.50	(1.00)	362.50

[1]

Program and Policy - House changes:	FTE	General Fund	Other Funds	Total
Economic Assistance Policy Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($48,462)	$0	($48,462)
Child Support Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(68,787)	0	(68,787)
Medical Services Program				
Decrease funding for department travel		(21,830)	(17,306)	(39,136)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(44,010)	0	(44,010)
Decrease funding added in the executive budget for medically needy to reflect income levels of 75 percent of the federal poverty level (The executive budget included funding of $5,520,859, of which $2,041,614 is from the general fund, to increase medically needy income levels to 83 percent of the federal poverty level.)		(376,947)	(642,379)	(1,019,326)
Decrease funding added in the executive budget for rebasing hospital payment rates. The House version provides $14,924,420, of which $5,519,050 is from the general fund, for rebasing rates to 90 percent of cost. The executive budget included funding of $22,013,114, of which $8,140,450 is from the general fund, for rebasing hospital payment rates to 100 percent of cost.		(2,621,400)	(4,467,294)	(7,088,694)
Decrease funding added in the executive budget for rebasing physician payment rates. The House version provides $10,600,000, of which $3,919,880 is from the general fund, for rebasing rates to 20 percent of the amount needed to rebase to 100 percent of cost. The executive budget included funding of $13,250,000, of which $4,899,850 is from the general fund, for rebasing physician payment rates to 25 percent of the amount needed to rebase to 100 percent of cost.		(979,970)	(1,670,030)	(2,650,000)
Decrease funding added in the executive budget for rebasing chiropractor payment rates. The House version provides $312,000, of which $115,377 is from the		(38,459)	(65,541)	(104,000)

general fund, for rebasing rates to 75 percent of the cost report. The executive budget included funding of $416,000, of which $153,836 is from the general fund, for rebasing rates to 100 percent of cost.				
Decrease funding added in the executive budget for rebasing ambulance payment rates. The House version provides $1,508,336, of which $557,783 is from the general fund, to provide funding equal to 75 percent of the funding provided in the executive budget. The executive budget included funding of $2,011,114, of which $743,710 is from the general fund, to rebase ambulance payment rates to Medicare rates.		(185,927)	(316,851)	(502,778)
Decrease funding added in the executive budget for rebasing dentist payment rates from a minimum of 75 percent of average billed charges with inflation increases of 7 percent each year to a minimum of 70 percent of average billed charges with inflation increases of 0 percent the first year and 7 percent the second year		(722,547)	(1,233,388)	(1,955,935)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(111,048)	(561,337)	(672,385)
Decrease funding for medical services to reduce projected caseload/utilization rates		(9,600,000)	(16,359,978)	(25,959,978)
Long-Term Care Program				
Add funding to increase the personal needs allowance for individuals in basic care facilities from $60 to $75 per month (funding provided is for a January 1, 2010, effective date)		112,320	0	112,320
dd funding to increase the personal needs allowance for individuals in an ICF/MR acility from $60 per month as recommended in the executive budget to $75 per month (funding provided is for a January 1, 2010, effective date)		57,511	98,009	155,5
Add funding to increase nursing facility bed limits in the formula for nursing home payments from $138,907 to $169,098 for single rooms and $92,604 to $112,732 for double rooms. (Of the $877,518, $324,506 is from the health care trust fund and $553,012 is from federal funds.)		0	877,518	877,518
Add funding of $14,739,128, of which $4,950,451 is from the general fund, $1 million is from the health care trust fund, and $8,788,677 is from federal funds, to provide a salary and benefit supplemental payment for individuals employed by basic care and nursing care faculties currently making $15 per hour or less		4,950,451	9,788,677	14,739,128
Add funding to provide for a salary and benefit supplemental payment for developmental disabilities providers currently making $15 per hour or less		7,000,000	11,929,151	18,929,151
Remove the new FTE position added in the 2009-11 executive budget relating to the implementation of a home and community-based care waiver to provide support for children who have a diagnosis of autism spectrum disorder	(1.00)	(66,872)	(66,871)	(133,743)
Provide funding for increasing the payment rates for children and adults who are severely medically fragile and behaviorally challenged residing at the Anne Carlsen Center and other developmental disabilities providers experiencing losses		438,900	747,957	1,186,857
Remove funding included in the executive budget for the addition of a third tier f personal care that would allow a maximum of 1,200 units of care per month		(1,021,922)	(1,741,524)	(2,763,44

;rease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases	(4,544,584)	(7,103,292)	(11,647,876)
Decrease funding for long-term care to reduce projected caseload/utilization rates	(5,600,000)	(9,543,320)	(15,143,320)
Decrease funding for developmental disabilities grants to reduce projected caseload/utilization rates	(2,476,000)	(4,219,511)	(6,695,511)
Aging Services Program			
Remove funding for a pilot aging and disability resource center	(600,000)	0	(600,000)
Decrease funding for department travel	(3,506)	(10,464)	(13,970)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover	(3,350)	0	(3,350)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases	(15,200)	0	(15,200)
Children and Family Services Program			
Decrease funding for department travel	(1,054)	(2,652)	(3,706)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover	(7,754)	0	(7,754)
Decrease funding added in the executive budget for inflationary increases for ll services except the rebased services to provide 6 percent per year increases	(436,192)	(823,013)	(1,259,205)
Mental Health and Substance Abuse Program			
Decrease funding for department travel	(15,842)	(45,715)	(61,557)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover	(7,940)	0	(7,940)
Decrease funding for compulsive gambling services by $150,000 from the general fund, from $700,000, of which $300,000 is from the general fund and $400,000 is from special funds from lottery proceeds, as provided for in the executive budget to $550,000, of which $150,000 is from the general fund and $400,000 is from special funds from lottery proceeds. The 2007-09 legislative appropriation for compulsive gambling services is $400,000 of special funds from lottery proceeds.	(150,000)	0	(150,000)
Remove funding for Governor's Prevention and Advisory Council grants	(200,000)	0	(200,000)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases	(21,237)	0	(21,237)
Developmental Disabilities Council			
Decrease funding for department travel	0	(4,446)	(4,446)
Developmental Disabilities Division			
Decrease funding for department travel	(7,536)	(32,975)	(40,511)
uce funding for salaries and wages for anticipated savings from vacant positions	(3,455)	0	(3,455)

and employee turnover			
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases	(27,199)	0	(27,199)
Vocational Rehabilitation			
Decrease funding for department travel	(17,096)	(56,242)	(73,338)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover	(2,666)	0	(2,666)
Decrease funding for centers for independent living by $400,000 from the general fund, from $2,144,539, of which $1,330,958 is from the general fund, as included in the executive budget, to $1,744,539, of which $930,958 is from the general fund	(400,000)	0	(400,000)
Total House changes - Program and Policy	(1.00) ($17,889,610)	($25,542,817)	($43,432,427)

Other changes affecting Program and Policy programs:

Add a section of legislative intent regarding the funding for basic care and nursing home facility salary and benefit supplemental payments

Add a section of legislative intent regarding the funding for developmental disabilities providers salary and benefit supplemental payments

Amend NDCC Section 50-30-02 relating to the health care trust fund to provide that money in the fund may not be included in drafts of appropriation bills introduced as part of the executive budget

Amend NDCC Section 50-24.5-04 to increase the personal needs allowance for individuals in basic care facilities from $60 to $75 per month

House Bill No. 1012 - DHS - State Hospital - House Action

	Executive Budget	House Changes[1]	House Version
State Hospital	$70,001,527	($2,044,091)	$67,957,436
Total all funds	$70,001,527	($2,044,091)	$67,957,436
Less estimated income	19,563,594	(6,930)	19,556,664
General fund	$50,437,933	($2,037,161)	$48,400,772
FTE	472.51	(6.00)	466.51

[1]

State Hospital - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Decrease one-time funding for extraordinary repairs from $3,231,017 to $2,231,017		($1,000,000)	$0	($1,000,000)
Remove funding included in the executive budget for the global health initiative, including 6 new FTE positions	(6.00)	(516,815)	0	(516,815)

ease funding for department travel		(9,206)	(6,930)	(16,136)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(511,140)	0	(511,140)
Total House changes - State Hospital	(6.00)	($2,037,161)	($6,930)	($2,044,091)

House Bill No. 1012 - DHS - Developmental Center - House Action

	Executive Budget	House Changes[1]	House Version
Developmental Center	$54,015,265	($437,746)	$53,577,519
Total all funds	$54,015,265	($437,746)	$53,577,519
Less estimated income	37,160,672	(228)	37,160,444
General fund	$16,854,593	($437,518)	$16,417,075
FTE	445.54	0.00	445.54

1

velopmental Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
crease one-time funding for extraordinary repairs from $712,675 to $562,675		($150,000)	$0	($150,000)
Decrease funding for department travel		(148)	(228)	(376)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(287,370)	0	(287,370)
Total House changes - Developmental Center	0.00	($437,518)	($228)	($437,746)

Other changes affecting the Developmental Center:
Amend NDCC Section 23-04-05 regarding admissions to the Developmental Center

House Bill No. 1012 - Human Service Centers - General Fund Summary

	Executive Budget	House Changes[1]	House Version
DHS - Northwest HSC	4,881,955	(144,819)	4,737,136
DHS - North Central HSC	12,098,437	(1,597,511)	10,500,926
DHS - Lake Region HSC	6,263,550	(147,193)	6,116,357
DHS - Northeast HSC	12,056,316	(468,574)	11,587,742
DHS - Southeast HSC	16,054,906	(1,482,439)	14,572,467
DHS - South Central HSC	8,943,330	(386,259)	8,557,071
DHS - West Central HSC	13,315,641	(1,207,194)	12,108,447
DHS - Badlands HSC	6,264,582	(683,757)	5,580,825
Total general fund	$79,878,717	($6,117,746)	$73,760,971

House Bill No. 1012 - Human Service Centers - Other Funds Summary

	Executive Budget	House Changes[1]	House Version
DHS - Northwest HSC	3,680,172	(8,620)	3,671,552
DHS - North Central HSC	8,825,362	(156,988)	8,668,374
DHS - Lake Region HSC	4,747,559	(8,554)	4,739,005
DHS - Northeast HSC	14,320,535	(162,378)	14,158,157
DHS - Southeast HSC	15,966,058	(441,503)	15,524,555
DHS - South Central HSC	6,970,002	(6,584)	6,963,418
DHS - West Central HSC	12,693,292	(162,815)	12,530,477
DHS - Badlands HSC	5,429,653	(165,380)	5,264,273
Total other funds	$72,632,633	($1,112,822)	$71,519,811

House Bill No. 1012 - Human Service Centers - All Funds Summary

	Executive Budget	House Changes[1]	House Version
DHS - Northwest HSC	8,562,127	(153,439)	8,408,688
DHS - North Central HSC	20,923,799	(1,754,499)	19,169,300
DHS - Lake Region HSC	11,011,109	(155,747)	10,855,362
DHS - Northeast HSC	26,376,851	(630,952)	25,745,899
DHS - Southeast HSC	32,020,964	(1,923,942)	30,097,022
DHS - South Central HSC	15,913,332	(392,843)	15,520,489
DHS - West Central HSC	26,008,933	(1,370,009)	24,638,924
DHS - Badlands HSC	11,694,235	(849,137)	10,845,098
Total all funds	$152,511,350	($7,230,568)	$145,280,782
FTE	847.48	(11.00)	836.48

Northwest Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Decrease funding for department travel		($19,621)	($8,468)	($28,089)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(97,561)	0	(97,561)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(27,637)	(152)	(27,789)
Total House changes - Northwest Human Service Center	0.00	($144,819)	($8,620)	($153,439)

North Central Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative		($1,358,307)	($100,000)	($1,458,307)
Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Decrease funding for department travel		(2,132)	(1,521)	(3,653)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(122,969)	0	(122,969)

[redacted]ease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(55,310)	(3,113)	(58,423)
Total House changes - North Central Human Service Center	(1.00)	($1,597,511)	($156,988)	($1,754,499)

Lake Region Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Decrease funding for department travel		($12,616)	($8,554)	($21,170)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(104,767)	0	(104,767)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(29,810)	0	(29,810)
Total House changes - Lake Region Human Service Center	0.00	($147,193)	($8,554)	($155,747)

Northeast Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative		($280,663)	($81,200)	($361,863)
Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
[redacted]rease funding for department travel		(2,654)	(4,571)	(7,225)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(63,064)	0	(63,064)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(63,400)	(24,253)	(87,653)
Total House changes - Northeast Human Service Center	(1.00)	($468,574)	($162,378)	($630,952)

Southeast Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative	(4.00)	($1,190,124)	($183,746)	($1,373,870)
Provide funding for contract staffing at the Cooper House	0.00	236,520	78,840	315,360
Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Remove funding added in the executive budget for young adult transition residential services		(184,622)	(242,222)	(426,844)
Remove funding and FTE position added in the executive budget for the partnership program	(1.00)	(61,490)	(40,440)	(101,930)
[redacted]ease funding for department travel		(1,707)	(1,414)	(3,121)

Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(164,349)	0	(164,3
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(57,874)	(167)	(58,041)
Total House changes - Southeast Human Service Center	(6.00)	($1,482,439)	($441,503)	($1,923,942)

South Central Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative	(1.00)	($127,669)	$0	($127,669)
Remove funding and FTE position added in the executive budget to complete vulnerable adult protection services	(1.00)	(73,128)	0	(73,128)
Decrease funding for department travel		(10,231)	(6,584)	(16,815)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(128,661)	0	(128,661)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(46,570)	0	(46,570)
Total House changes - South Central Human Service Center	(2.00)	($386,259)	($6,584)	($392,843)

West Central Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative		($279,546)	$0	($279,546)
Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Remove funding added in the executive budget for young adult transition residential services		(650,000)	(100,000)	(750,000)
Decrease funding for department travel		(13,677)	(9,496)	(23,173)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(135,157)	0	(135,157)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(70,021)	(965)	(70,986)
Total House changes - West Central Human Service Center	(1.00)	($1,207,194)	($162,815)	($1,370,009)

Badlands Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative		($665,000)	($140,000)	($805,000)
Decrease funding for department travel		(232)	(163)	(3

uce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(40,139)	0	(40,139)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		21,614	(25,217)	(3,603)
Total House changes - Badlands Human Service Center	0.00	($683,757)	($165,380)	($849,137)

Date: 2/17/09
Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1012

Full House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 98013.0105

Action Taken Adopt Amend. 0105

Motion Made By Pollert Seconded By Bellew

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan					
Vice Chairman Kempenich					
Rep. Skarphol			Rep. Kroeber		
Rep. Wald			Rep. Onstad		
Rep. Hawken			Rep. Williams		
Rep. Klein					
Rep. Martinson					
Rep. Delzer			Rep. Glassheim		
Rep. Thoreson			Rep. Kaldor		
Rep. Berg			Rep. Meyer		
Rep. Dosch					
Rep. Pollert			Rep. Ekstrom		
Rep. Bellew			Rep. Kerzman		
Rep. Kreidt			Rep. Metcalf		
Rep. Nelson					
Rep. Wieland					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Voice Vote - carries

Attachment B
2/17/09

98013.0107
Title.

Prepared by the Legislative Council staff for
Representative Bellew
February 14, 2009

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 2, line 8, replace "227,633,993" with "227,350,993" and replace "1,344,821,814" with "1,344,538,814"

Page 2, line 11, replace "352,797,592" with "352,514,592" and replace "1,919,766,163" with "1,919,433,163"

Page 2, line 12, replace "248,526,112" with "248,347,034" and replace "1,375,189,679" with "1,375,010,601"

Page 2, line 13, replace "104,271,480" with "104,167,558" and replace "544,526,484" with "544,422,562"

Page 3, line 4, replace "141,437,021" with "141,333,099" and replace "721,512,545" with "721,408,623"

Page 3, line 5, replace "250,489,786" with "250,310,708" and replace "1,540,574,416" with "1,540,395,338"

Page 3, line 6, replace "391,926,807" with "391,643,807" and replace "2,262,086,961" with "2,261,803,961"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment decreases funding relating to the funeral set-aside for Medicaid recipients by $283,000, of which $103,922 is from the general fund, to provide for an increase in the set-aside from $5,000 to $6,000 as provided for in House Bill No. 1377. The executive budget included funding of $566,000, of which $208,571 is from the general fund, to increase the funeral set-aside for Medicaid recipients from $5,000 to $7,000.

Date: 2/17/09
Roll Call Vote #: 2

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1012

Dan 31

Full House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Adopt Amendment .0107

Motion Made By Bellew Seconded By Pollert

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan					
Vice Chairman Kempenich					
Rep. Skarphol			Rep. Kroeber		
Rep. Wald			Rep. Onstad		
Rep. Hawken			Rep. Williams		
Rep. Klein					
Rep. Martinson					
Rep. Delzer			Rep. Glassheim		
Rep. Thoreson			Rep. Kaldor		
Rep. Berg			Rep. Meyer		
Rep. Dosch					
Rep. Pollert			Rep. Ekstrom		
Rep. Bellew			Rep. Kerzman		
Rep. Kreidt			Rep. Metcalf		
Rep. Nelson					
Rep. Wieland					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Voice Vote - carries

Attachment C
2/17/09

98013.0106
Title.

Prepared by the Legislative Council staff for
Representative Metcalf
February 13, 2009

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 1, line 2, after the semicolon insert "to provide for a legislative council study;"

Page 4, after line 9, insert:

"**SECTION 5. LEGISLATIVE COUNCIL STUDY - LONG-TERM CARE.** During the 2009-10 interim, the legislative council shall study long-term care services in the state. The study must include a review of the department of human services' payment system and a review of the state department of health's survey and inspection programs and processes. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly."

Renumber accordingly

Date: 2/17/09
Roll Call Vote #: 3

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1012

Full House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 98013.0106

Action Taken .0106

Motion Made By Metcalf Seconded By Ekstrom

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan					
Vice Chairman Kempenich					
Rep. Skarphol			Rep. Kroeber		
Rep. Wald			Rep. Onstad		
Rep. Hawken			Rep. Williams		
Rep. Klein					
Rep. Martinson					
Rep. Delzer			Rep. Glassheim		
Rep. Thoreson			Rep. Kaldor		
Rep. Berg			Rep. Meyer		
Rep. Dosch					
Rep. Pollert			Rep. Ekstrom		
Rep. Bellew			Rep. Kerzman		
Rep. Kreidt			Rep. Metcalf		
Rep. Nelson					
Rep. Wieland					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Voice Vote - carries

Attachment 10
2/17/09

98013.0109
Title.

Prepared by the Legislative Council staff for
Representative Pollert
February 14, 2009

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 2, line 4, replace "19,253,918" with "19,117,970" and replace "44,664,959" with "44,529,011"

Page 2, line 5, replace "5,439,280" with "5,422,892" and replace "73,251,082" with "73,234,694"

Page 2, line 8, replace "227,633,993" with "224,977,107" and replace "1,344,821,814" with "1,342,164,928"

Page 2, line 11, replace "352,797,592" with "349,988,370" and replace "1,919,716,163" with "1,916,906,941"

Page 2, line 12, replace "248,526,112" with "246,443,915" and replace "1,375,189,679" with "1,373,107,482"

Page 2, line 13, replace "104,271,480" with "103,544,455" and replace "544,526,484" with "543,799,459"

Page 3, line 4, replace "141,437,021" with "140,709,996" and replace "721,512,545" with "720,785,520"

Page 3, line 5, replace "250,489,786" with "248,407,589" and replace "1,540,574,416" with "1,538,492,219"

Page 3, line 6, replace "391,926,807" with "389,117,585" and replace "2,262,086,961" with "2,259,277,739"

Page 3, line 7, replace "14.00" with "12.50" and replace "2237.38" with "2235.88"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment decreases funding for the state children's health insurance program by $2,809,222, of which $727,025 is from the general fund, including the removal of 1.5 new FTE positions. The House version provides funding to increase the state children's health insurance program from 150 percent to 160 percent of the federal poverty level in accordance with provisions of House Bill No. 1478. The executive budget included funding of $4,429,649, of which $1,146,392 is from the general fund, for increasing the eligibility for the state children's health insurance program from 150 percent to 200 percent of the federal poverty level and to add 1.5 new FTE positions.

Date: 2/17/09
Roll Call Vote #: 4

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1012

Full House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 98013.0109

Action Taken .0109

Motion Made By Pollert Seconded By Bellew

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan					
Vice Chairman Kempenich					
Rep. Skarphol			Rep. Kroeber		
Rep. Wald			Rep. Onstad		
Rep. Hawken			Rep. Williams		
Rep. Klein					
Rep. Martinson					
Rep. Delzer			Rep. Glassheim		
Rep. Thoreson			Rep. Kaldor		
Rep. Berg			Rep. Meyer		
Rep. Dosch					
Rep. Pollert			Rep. Ekstrom		
Rep. Bellew			Rep. Kerzman		
Rep. Kreidt			Rep. Metcalf		
Rep. Nelson					
Rep. Wieland					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Voice Vote – carries

Attachment E 2/17/09

98013.0111
Title.
Fiscal No. 2

Prepared by the Legislative Council staff for
Representative Pollert
February 16, 2009

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 1, line 18, replace "7,790,774" with "7,466,777" and replace "19,303,132" with "18,979,135"

Page 1, line 21, replace "($5,780,343)" with "($6,104,340)" and replace "65,842,656" with "65,518,659"

Page 1, line 22, replace "(14,635,996)" with "(14,959,993)" and replace "36,027,838" with "35,703,841"

Page 2, line 4, replace "19,253,918" with "18,872,598" and replace "44,664,959" with "44,283,639"

Page 2, line 11, replace "352,797,592" with "352,416,272" and replace "1,919,716,163" with "1,919,334,843"

Page 2, line 12, replace "248,526,112" with "248,144,792" and replace "1,375,189,679" with "1,374,808,359"

Page 2, line 18, replace "1,068,230" with "868,674" and replace "8,562,127" with "8,362,571"

Page 2, line 19, replace "4,141,195" with "3,889,668" and replace "20,923,799" with "20,672,272"

Page 2, line 20, replace "1,193,754" with "979,459" and replace "11,011,109" with "10,796,814"

Page 2, line 21, replace "4,269,502" with "4,140,508" and replace "26,376,851" with "26,247,857"

Page 2, line 22, replace "5,959,334" with "5,623,167" and replace "32,020,964" with "31,684,797"

Page 2, line 23, replace "1,229,521" with "966,352" and replace "15,913,332" with "15,650,163"

Page 2, line 24, replace "5,321,661" with "5,045,205" and replace "26,008,933" with "25,732,477"

Page 2, line 25, replace "1,895,446" with "1,813,344" and replace "11,694,235" with "11,612,133"

Page 2, line 26, replace "12,609,583" with "11,564,073" and replace "70,001,527" with "68,956,017"

Page 2, line 27, replace "7,221,332" with "6,633,532" and replace "54,015,265" with "53,427,465"

Page 2, line 28, replace "44,909,558" with "41,523,982" and replace "276,528,142" with "273,142,566"

Page 2, line 29, replace "16,599,670" with "13,214,094" and replace "129,356,899" with "125,971,323"

Page 3, line 5, replace "250,489,786" with "246,398,893" and replace "1,540,574,416" with "1,536,483,523"

Page 3, line 6, replace "391,926,807" with "387,835,914" and replace "2,262,086,961" with "2,257,996,068"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment reduces funding for the Department of Human Services by $4,090,893 of special funds to recognize anticipated savings of special funds from vacant positions and employee turnover.

Date: 2/17/09
Roll Call Vote #: 5

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1012

Full House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 98013.0111

Action Taken .0111

Motion Made By Pollert Seconded By Kreidt

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan					
Vice Chairman Kempenich					
Rep. Skarphol			Rep. Kroeber		
Rep. Wald			Rep. Onstad		
Rep. Hawken			Rep. Williams		
Rep. Klein					
Rep. Martinson					
Rep. Delzer			Rep. Glassheim		
Rep. Thoreson			Rep. Kaldor		
Rep. Berg			Rep. Meyer		
Rep. Dosch					
Rep. Pollert			Rep. Ekstrom		
Rep. Bellew			Rep. Kerzman		
Rep. Kreidt			Rep. Metcalf		
Rep. Nelson					
Rep. Wieland					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Voice Vote - carries

Att. F
2/17/09

98013.0112
Title.

Prepared by the Legislative Council staff for
Representative Berg
February 17, 2009

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 3, after line 7, insert:

"**SECTION 2. APPROPRIATION.** There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $20,776, to the department of human services for the purpose of providing funding for expenses relating to the early childhood services advisory board created in House Bill No. 1462, for the biennium beginning July 1, 2009, and ending June 30, 2011."

Renumber accordingly

Date: 2/17/09
Roll Call Vote #: 6

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1012

Full House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 98013.0112

Action Taken .0112

Motion Made By Pollert Seconded By Berg

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan					
Vice Chairman Kempenich					
Rep. Skarphol			Rep. Kroeber		
Rep. Wald			Rep. Onstad		
Rep. Hawken			Rep. Williams		
Rep. Klein					
Rep. Martinson					
Rep. Delzer			Rep. Glassheim		
Rep. Thoreson			Rep. Kaldor		
Rep. Berg			Rep. Meyer		
Rep. Dosch					
Rep. Pollert			Rep. Ekstrom		
Rep. Bellew			Rep. Kerzman		
Rep. Kreidt			Rep. Metcalf		
Rep. Nelson					
Rep. Wieland					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Voice Vote - Carries

Attachment G
2/17/09

98013.0103
Title.

Prepared by the Legislative Council staff for
Representative Pollert
February 12, 2009

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 4, after line 9, insert:

"**SECTION 5. ADDITIONAL FEDERAL FUNDS - AMERICAN RECOVERY AND REINVESTMENT ACT - ACCEPTANCE - LIMITATION ON EXPENDITURE.** If the department of human services receives federal funds made available to the state from the American Recovery and Reinvestment Act or other federal action to stimulate the national economy or to address state fiscal recovery in excess of the federal funding appropriated by the sixty-first legislative assembly for any major program, the department of human services may accept the additional federal funds, but may not spend the funding until appropriated by the legislative assembly for the biennium beginning July 1, 2009, and ending June 30, 2011."

Renumber accordingly

Date: 2/17/09
Roll Call Vote #: 7

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1012

Full House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 98013.0103

Action Taken 0103

Motion Made By Pollert Seconded By Ekstrom

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan					
Vice Chairman Kempenich					
Rep. Skarphol			Rep. Kroeber		
Rep. Wald			Rep. Onstad		
Rep. Hawken			Rep. Williams		
Rep. Klein					
Rep. Martinson					
Rep. Delzer			Rep. Glassheim		
Rep. Thoreson			Rep. Kaldor		
Rep. Berg			Rep. Meyer		
Rep. Dosch					
Rep. Pollert			Rep. Ekstrom		
Rep. Bellew			Rep. Kerzman		
Rep. Kreidt			Rep. Metcalf		
Rep. Nelson					
Rep. Wieland					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Voice Vote - Carries

Date: 2/17/09
Roll Call Vote #: 8

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1012

Full House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

failed

Action Taken adopt 99714

Motion Made By Pollert Seconded By Bellew

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan	✓				
Vice Chairman Kempenich	✓				
Rep. Skarphol	✓		Rep. Kroeber		✓
Rep. Wald	✓		Rep. Onstad		✓
Rep. Hawken		✓	Rep. Williams		✓
Rep. Klein	—				
Rep. Martinson		✓			
Rep. Delzer	✓		Rep. Glassheim		✓
Rep. Thoreson		✓	Rep. Kaldor		✓
Rep. Berg		✓	Rep. Meyer		✓
Rep. Dosch	✓				
Rep. Pollert	✓		Rep. Ekstrom		✓
Rep. Bellew	✓		Rep. Kerzman	—	
Rep. Kreidt	✓		Rep. Metcalf		✓
Rep. Nelson		✓			
Rep. Wieland		✓			

Total (Yes) 9 No 14

Absent 2

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Attachment I
2/17/09

98013.0110
Title.

Prepared by the Legislative Council staff for
Representative Kreidt
February 14, 2009

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 4, replace lines 10 through 30 with:

"**SECTION 5. SUPPLEMENTAL PAYMENTS - BASIC CARE AND NURSING HOME FACILITY SALARY AND BENEFIT INCREASES.** The funding appropriated in subdivision 2 of section 1 of this Act includes $14,739,128, of which $4,950,451 is from the general fund, $1,000,000 is from the health care trust fund, and $8,788,677 is from federal funds, for providing supplemental payments to basic care and skilled nursing care facilities to allow for a salary and benefit increase for each employee earning a salary that is less than the eightieth percentile of the salary range at each facility, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 6. SUPPLEMENTAL PAYMENTS - DEVELOPMENTAL DISABILITIES PROVIDER SALARY AND BENEFIT INCREASES. The funding appropriated in subdivision 2 of section 1 of this Act includes $18,929,151, of which $7,000,000 is from the general fund and $11,929,151 is from federal funds, for providing supplemental payments to developmental disabilities providers to allow for a salary and benefit increase for each employee earning a salary that is less than the ninetieth percentile of the salary range of each developmental disabilities provider, for the biennium beginning July 1, 2009, and ending June 30, 2011."

Renumber accordingly

Date: 2/17/09
Roll Call Vote #: 9

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1012

Full House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 98013.0110

Action Taken .0110

Motion Made By Kreidt Seconded By Wieland

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan					
Vice Chairman Kempenich					
Rep. Skarphol			Rep. Kroeber		
Rep. Wald			Rep. Onstad		
Rep. Hawken			Rep. Williams		
Rep. Klein					
Rep. Martinson					
Rep. Delzer			Rep. Glassheim		
Rep. Thoreson			Rep. Kaldor		
Rep. Berg			Rep. Meyer		
Rep. Dosch					
Rep. Pollert			Rep. Ekstrom		
Rep. Bellew			Rep. Kerzman		
Rep. Kreidt			Rep. Metcalf		
Rep. Nelson					
Rep. Wieland					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Voice Vote - Carries

Attachment 5 2/17/09

99719

Prepared by the North Dakota Legislative Council staff for Representative Svedjan
February 2009

PROPOSED MOTION TO FURTHER AMEND HOUSE BILL NO. 1012

It was moved by _____ and seconded by _____ to further amend House Bill No. 1012 as follows:

	General Fund	Other Funds	Total
Restore funding to provide for the rebasing of hospital payment rates at 100 percent of cost as provided for in the executive budget (The amendments to House Bill No. 1012 provide for the rebasing of hospital payment rates at 90 percent of cost.)	$2,621,400	$4,467,294	$7,088,694
Decrease funding added in the executive budget for inflation increases for hospital payment rates from 7 percent to 6 percent for the second year of the biennium	(793,420)	(1,389,355)	(2,182,775)
Increase (decrease)	$1,827,980	$3,077,939	$4,095,919

Date: 2/17/09
Roll Call Vote #: 12

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1012

Full House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken 99719

Motion Made By Kempenich Seconded By Berg

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan					
Vice Chairman Kempenich					
Rep. Skarphol			Rep. Kroeber		
Rep. Wald			Rep. Onstad		
Rep. Hawken			Rep. Williams		
Rep. Klein					
Rep. Martinson					
Rep. Delzer			Rep. Glassheim		
Rep. Thoreson			Rep. Kaldor		
Rep. Berg			Rep. Meyer		
Rep. Dosch					
Rep. Pollert			Rep. Ekstrom		
Rep. Bellew			Rep. Kerzman		
Rep. Kreidt			Rep. Metcalf		
Rep. Nelson					
Rep. Wieland					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Voice Vote - carries

98013.0113
Title.0200
Fiscal No. 3

Prepared by the Legislative Council staff for
House Appropriations
February 18, 2009

VR
2/18/09
1 of 16

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 1, line 2, after the semicolon insert "to provide for legislative council studies; to provide statements of legislative intent;" and replace "50-06-29, 50-24.1-02.3, and 50-29-04" with "25-04-05, 50-24.5-04, and 50-30-02"

Page 1, line 3, replace "the establishment of an aging and disability" with "developmental center admission screenings, the personal needs allowance for individuals in basic care facilities, and use of the health care trust fund."

Page 1, remove lines 4 through 6

Page 1, line 18, replace "7,790,774" with "2,148,542" and replace "19,303,132" with "13,660,900"

Page 1, line 19, replace "(13,570,832)" with "(13,582,286)" and replace "46,539,524" with "46,528,070"

Page 1, line 21, replace "($5,780,343)" with "($11,434,029)" and replace "65,842,656" with "60,188,970"

Page 1, line 22, replace "(14,635,996)" with "(16,622,573)" and replace "36,027,838" with "34,041,261"

Page 1, line 23, replace "8,855,653" with "5,188,544" and replace "29,814,818" with "26,147,709"

Page 2, line 4, replace "19,253,918" with "18,552,432" and replace "44,664,959" with "43,963,473"

Page 2, line 5, replace "5,439,280" with "4,364,279" and replace "73,251,082" with "72,176,081"

Page 2, line 7, replace "112,946,092" with "111,111,588" and replace "456,965,308" with "455,130,804"

Page 2, line 8, replace "227,633,993" with "189,244,935" and replace "1,344,821,814" with "1,306,432,756"

Page 2, line 11, replace "352,797,592" with "310,797,543" and replace "1,919,716,163" with "1,877,716,114"

Page 2, line 12, replace "248,526,112" with "223,418,640" and replace "1,375,189,679" with "1,350,082,207"

Page 2, line 13, replace "104,271,480" with "87,378,903" and replace "544,526,484" with "527,633,907"

Page 2, replace lines 18 through 30 with:

"Northwest human service center	$7,493,897	$715,235	$8,209,132
North central human service center	16,782,604	2,135,169	18,917,773

Lake region human service center	9,817,355	823,712	10,641,067
Northeast human service center	22,107,349	3,509,556	25,616,905
Southeast human service center	26,061,630	3,699,225	29,760,855
South central human service center	14,683,811	573,509	15,257,320
West central human service center	20,687,272	3,675,196	24,362,468
Badlands human service center	9,798,789	964,207	10,762,996
State hospital	57,391,944	9,519,982	66,911,926
Developmental center	46,793,933	6,195,786	52,989,719
Total all funds	$231,618,584	$31,811,577	$263,430,161
Less estimated income	112,757,229	12,094,114	124,851,343
Total general fund	$118,861,355	$19,717,463	$138,578,818"

Page 3, line 4, replace "141,437,021" with "112,284,910" and replace "721,512,545" with "692,360,434"

Page 3, line 5, replace "250,489,786" with "218,890,181" and replace "1,540,574,416" with "1,508,974,811"

Page 3, line 6, replace "391,926,807" with "331,175,091" and replace "2,262,086,961" with "2,201,335,245"

Page 3, line 7, replace "14.00" with "(6.50)" and replace "2237.38" with "2216.88"

Page 3, line 20, replace "3,943,692" with "2,793,692"

Page 3, line 22, replace "4,296,298" with "3,146,298"

Page 4, line 6, replace "$3,000,000" with "$4,324,506"

Page 4, replace lines 10 through 30 with:

"**SECTION 5. LEGISLATIVE COUNCIL STUDY - CHILD SUPPORT ENFORCEMENT.** During the 2009-10 interim, the legislative council shall consider studying the department of human services' child support enforcement program. The study should include the review of arrearages in terms of total owed and interest accrued and child support enforcement activities in other states. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly.

SECTION 6. LEGISLATIVE COUNCIL STUDY - LONG-TERM CARE. During the 2009-10 interim, the legislative council shall study long-term care services in the state. The study must include a review of the department of human services' payment system and a review of the state department of health's survey and inspection programs and processes. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly.

SECTION 7. ADDITIONAL FEDERAL FUNDS - AMERICAN RECOVERY AND REINVESTMENT ACT - ACCEPTANCE - LIMITATION ON EXPENDITURE. If the department of human services receives federal funds made available to the state from the American Recovery and Reinvestment Act or other federal action to stimulate the national economy or to address state fiscal recovery in excess of the federal funding appropriated by the sixty-first legislative assembly for any major program, the department of human services may accept the additional federal funds, but may not spend the funding until appropriated by the legislative assembly for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 8. SUPPLEMENTAL PAYMENTS - BASIC CARE AND NURSING HOME FACILITY SALARY AND BENEFIT INCREASES. The funding appropriated in subdivision 2 of section 1 of this Act includes $14,739,128, of which $4,950,451 is from the general fund, $1,000,000 is from the health care trust fund, and $8,788,677 is from federal funds, for providing supplemental payments to basic care and skilled nursing care facilities to allow for a salary and benefit increase for each employee earning a salary that is less than the eightieth percentile of the salary range at each facility, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 9. SUPPLEMENTAL PAYMENTS - DEVELOPMENTAL DISABILITIES PROVIDER SALARY AND BENEFIT INCREASES. The funding appropriated in subdivision 2 of section 1 of this Act includes $18,929,151, of which $7,000,000 is from the general fund and $11,929,151 is from federal funds, for providing supplemental payments to developmental disabilities providers to allow for a salary and benefit increase for each employee earning a salary that is less than the ninetieth percentile of the salary range of each developmental disabilities provider, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 10. AMENDMENT. Section 25-04-05 of the North Dakota Century Code is amended and reenacted as follows:

25-04-05. Qualifications for admission to state facility - ~~Temporary~~ Screening required prior to admission or readmission - Educational or related services without charge for persons twenty-one years of age and under.

1. The superintendent may admit a person to the developmental center at westwood park, Grafton when all of the following conditions have been met:

   a. Application for admission has been made on behalf of the person by a parent or guardian or the person or agency having legal custody, or by the person seeking admission, in accordance with procedures established by the department of human services.

   b. A comprehensive evaluation of the person has been made within three months of the date of application, a report of which has been filed with the superintendent and which, together with such other information or reviews as the department of human services may require, indicates to the superintendent's satisfaction that the person is eligible for admission to the developmental center at westwood park, Grafton.

   c. The person may be admitted without exceeding the resident capacity of the facility as specified in the professional standards adopted by the department of human services.

2. ~~The superintendent~~ No person may ~~admit~~ be admitted or readmitted to the developmental center at westwood park, Grafton, ~~temporarily for the purposes of observation, without commitment,~~ unless that person has undergone a screening process at the developmental center to determine whether the admission or readmission is appropriate. Length of stay criteria may be established under rules as the department of human services may adopt~~, any~~. Any person who is suspected of being able to benefit from the services offered at the center~~,~~ may be screened to ascertain whether or not that person is actually a proper case for care, treatment, and training ~~in~~ at the ~~state facility~~ developmental center. If in the opinion of the superintendent the person ~~temporarily admitted to the developmental center at westwood park, Grafton~~ screened under this subsection is a proper subject for institutional care, treatment, and training at the developmental center, that person may remain as a voluntary

resident at ~~such~~ the center at the discretion of the superintendent if all other conditions for admission required by this section are met.

3. Notwithstanding any other provision of this chapter, no handicapped patient, twenty-one years of age or under, or the estate or the parent of such patient, may be charged for educational or related services provided at the developmental center at westwood park, Grafton. Except as provided in subsection 4, the department of human services has prior claim on all benefits accruing to such patients for medical and medically related services under entitlement from the federal government, medical or hospital insurance contracts, workforce safety and insurance, or medical care and disability programs. For purposes of this subsection, "related services" means transportation and such developmental, corrective, and other supportive services, as determined by the department of public instruction, as are required to assist a handicapped patient to benefit from special education. The cost of related services other than medical and medically related services must be paid by the developmental center at westwood park, Grafton, the school district of residence of the handicapped child, and other appropriate state agencies and political subdivisions of this state. The department of public instruction, the department of human services, the school district of residence, and other appropriate state agencies and political subdivisions, as determined by the department of public instruction, shall determine and agree to that portion of related services, other than medical and medically related services, for which each agency and political subdivision is liable. The department of public instruction may adopt rules necessary to implement this section.

4. Parents of a handicapped patient, twenty-one years of age or under, are not required to file, assist in filing, agree to filing, or assign an insurance claim when filing the claim would pose a realistic threat that the parents would suffer a financial loss not incurred by similarly situated parents of nonhandicapped children. Financial losses do not include incidental costs such as the time needed to file or assist in filing an insurance claim or the postage needed to mail the claim. Financial losses include:

   a. A decrease in available lifetime coverage or any other benefit under an insurance policy.

   b. An increase in premiums or the discontinuation of a policy.

   c. An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim unless the developmental center pays or waives the out-of-pocket expense.

SECTION 11. AMENDMENT. Section 50-24.5-04 of the North Dakota Century Code is amended and reenacted as follows:

50-24.5-04. Services provided - Limit on cost. Services provided under this chapter must be treated as necessary remedial care to the extent those services are not covered under the medical assistance program. The cost of the services provided under this chapter to a person residing in a basic care or adult family foster care facility for which the rate charged includes room and board is limited to the rate set for services in that facility, plus ~~sixty~~ seventy-five dollars, less that person's total income.

SECTION 12. AMENDMENT. Section 50-30-02 of the North Dakota Century Code is amended and reenacted as follows:

50-30-02. North Dakota health care trust fund created - Uses - Continuing appropriation.

1. There is created in the state treasury a special fund known as the North Dakota health care trust fund. The fund consists of revenue received from government nursing facilities for remittance to the fund under former section 50-24.4-30. The department shall administer the fund. The state investment board shall invest moneys in the fund in accordance with chapter 21-10, and the income earned must be deposited in the North Dakota health care trust fund. All moneys deposited in the North Dakota health care trust fund are available to the department for:

   a. Transfer to the long-term care facility loan fund, as authorized by legislative appropriation, for making loans pursuant to the requirements of this chapter.

   b. Payment, as authorized by legislative appropriation, of costs of other programs authorized by the legislative assembly.

   c. Repayment of federal funds, which are appropriated and may be spent if the United States department of health and human services determines that funds were inappropriately claimed under former section 50-24.4-30.

2. The department shall continue to access the intergovernmental transfer program if permitted by the federal government and if use of the program is found to be beneficial.

3. Moneys in the fund may not be included in draft appropriation acts under section 54-44.1-06."

Page 5, remove lines 1 through 31

Page 6, remove lines 1 through 10

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT - LC 98013.0113 FN 3

A copy of the statement of purpose of amendment is attached.

STATEMENT OF PURPOSE OF AMENDMENT:

House Bill No. 1012 - Summary of House Action

	Executive Budget	House Changes	House Version
DHS - Management			
Total all funds	$65,842,656	($5,653,686)	$60,188,970
Less estimated income	36,027,838	(1,986,577)	34,041,261
General fund	$29,814,818	($3,667,109)	$26,147,709
DHS - Program/Policy			
Total all funds	$1,919,716,163	($42,000,049)	$1,877,716,114
Less estimated income	1,375,189,679	(25,107,472)	1,350,082,207
General fund	$544,526,484	($16,892,577)	$527,633,907
DHS - State Hospital			
Total all funds	$70,001,527	($3,089,601)	$66,911,926
Less estimated income	19,563,594	(1,052,440)	18,511,154
General fund	$50,437,933	($2,037,161)	$48,400,772
DHS - Developmental Center			
Total all funds	$54,015,265	($1,025,546)	$52,989,719
Less estimated income	37,160,672	(588,028)	36,572,644
General fund	$16,854,593	($437,518)	$16,417,075
DHS - Northwest HSC			
Total all funds	$8,562,127	($352,995)	$8,209,132
Less estimated income	3,680,172	(208,176)	3,471,996
General fund	$4,881,955	($144,819)	$4,737,136
DHS - North Central HSC			
Total all funds	$20,923,799	($2,006,026)	$18,917,773
Less estimated income	8,825,362	(408,515)	8,416,847
General fund	$12,098,437	($1,597,511)	$10,500,926
DHS - Lake Region HSC			
Total all funds	$11,011,109	($370,042)	$10,641,067
Less estimated income	4,747,559	(222,849)	4,524,710
General fund	$6,263,550	($147,193)	$6,116,357
DHS - Northeast HSC			
Total all funds	$26,376,851	($759,946)	$25,616,905
Less estimated income	14,320,535	(291,372)	14,029,163
General fund	$12,056,316	($468,574)	$11,587,742
DHS - Southeast HSC			
Total all funds	$32,020,964	($2,260,109)	$29,760,855
Less estimated income	15,966,058	(777,670)	15,188,388
General fund	$16,054,906	($1,482,439)	$14,572,467
DHS - South Central HSC			
Total all funds	$15,913,332	($656,012)	$15,257,320
Less estimated income	6,970,002	(269,753)	6,700,249
General fund	$8,943,330	($386,259)	$8,557,071
DHS - West Central HSC			
Total all funds	$26,008,933	($1,646,465)	$24,362,468
Less estimated income	12,693,292	(439,271)	12,254,021
General fund	$13,315,641	($1,207,194)	$12,108,447
DHS - Badlands HSC			
Total all funds	$11,694,235	($931,239)	$10,762,996
Less estimated income	5,429,653	(247,482)	5,182,171
General fund	$6,264,582	($683,757)	$5,580,825
Bill total			
Total all funds	$2,262,086,961	($60,751,716)	$2,201,335,245

Less estimated income	1,540,574,416	(31,599,605)	1,508,974,811
General fund	$721,512,545	($29,152,111)	$692,360,434

House Bill No. 1012 - DHS - Management - House Action

	Executive Budget	House Changes[1]	House Version
Salaries and wages	$19,303,132	($5,642,232)	$13,660,900
Operating expenses	46,539,524	(11,454)	46,528,070
Total all funds	$65,842,656	($5,653,686)	$60,188,970
Less estimated income	36,027,838	(1,986,577)	34,041,261
General fund	$29,814,818	($3,667,109)	$26,147,709
FTE	108.35	(1.00)	107.35

1

Management - House changes:	FTE	General Fund	Other Funds	Total
Administration Support Program				
Remove 1 new FTE position added in the executive budget to perform additional duties required by Statement on Auditing Standards No. 112 regarding communicating internal control matters, including $126,265 for salaries and wages and $2,790 for operating expenses	(1.00)	($56,724)	($72,331)	($129,055)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(131,076)	(268,110)	(399,186)
Decrease funding for department travel		(14,256)	(15,184)	(29,440)
Remove funding for state employee salary equity adjustments		(3,458,506)	(1,575,064)	(5,033,570)
Provide funding for expenses relating to the early childhood services advisory board created in House Bill No. 1472		20,776	0	20,776
Division of Information Technology Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(27,323)	(55,888)	(83,211)
Total House changes - Management	(1.00)	($3,667,109)	($1,986,577)	($5,653,686)

Other changes affecting Management programs or multiple programs of the department:

Add a section to provide for a Legislative Council study of the Department of Human Services child support enforcement program including the review of arrearages in terms of total owned and interest accrued and the review of child support enforcement in other states.

Add a section to provide that if the Department of Human Services receives federal funding to stimulate the national economy or to address state fiscal recovery in excess of the federal funding appropriated by the 2009 Legislative Assembly, the department may accept the additional federal funds, but may not spend the funding until appropriated by the Legislative Assembly.

House Bill No. 1012 - DHS - Program/Policy - House Action

	Executive Budget	House Changes[1]	House Version
Salaries and wages	$44,664,959	($701,486)	$43,963,473
Operating expenses	73,251,082	(1,075,001)	72,176,081
Capital assets	13,000		13,000
Grants	456,965,308	(1,834,504)	455,130,804
Grants - Medical assistance	1,344,821,814	(38,389,058)	1,306,432,756
Total all funds	$1,919,716,163	($42,000,049)	$1,877,716,114
Less estimated income	1,375,189,679	(25,107,472)	1,350,082,207
General fund	$544,526,484	($16,892,577)	$527,633,907
FTE	363.50	(2.50)	361.00

[1]

Program and Policy - House changes:	FTE	General Fund	Other Funds	Total
Economic Assistance Policy Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($48,462)	($99,126)	($147,588)
Child Support Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(68,787)	(140,700)	(209,487)
Medical Services Program				
Decrease funding for department travel		(21,830)	(17,306)	(39,136)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(44,010)	(90,020)	(134,030)
Decrease funding added in the executive budget for medically needy to reflect income levels of 75 percent of the federal poverty level (The executive budget included funding of $5,520,859, of which $2,041,614 is from the general fund, to increase medically needy income levels to 83 percent of the federal poverty level.)		(376,947)	(642,379)	(1,019,326)
Decrease funding added in the executive budget for inflation increases for hospital payment rates from 7 percent to 6 percent for the second year of the biennium		(793,420)	(1,389,355)	(2,182,775)
Decrease funding added in the executive budget for rebasing physician payment rates. The House version provides $10,600,000, of which $3,919,880 is from the general fund, for rebasing rates to 20 percent of the amount needed to rebase to 100 percent of cost. The executive budget included funding of $13,250,000, of which $4,899,850 is from the general fund, for rebasing physician payment rates to 25 percent of the amount needed to rebase to 100 percent of cost.		(979,970)	(1,670,030)	(2,650,000)
Decrease funding added in the executive budget for rebasing chiropractor payment rates. The House version provides $312,000, of which $115,377 is from the general fund, for rebasing rates to 75 percent of the cost report. The executive		(38,459)	(65,541)	(104,000)

budget included funding of $416,000, of which $153,836 is from the general fund, for rebasing rates to 100 percent of cost.				
Decrease funding added in the executive budget for rebasing ambulance payment rates. The House version provides $1,508,336, of which $557,783 is from the general fund, to provide funding equal to 75 percent of the funding provided in the executive budget. The executive budget included funding of $2,011,114, of which $743,710 is from the general fund, to rebase ambulance payment rates to Medicare rates.		(185,927)	(316,851)	(502,778)
Decrease funding added in the executive budget for rebasing dentist payment rates from a minimum of 75 percent of average billed charges with inflation increases of 7 percent each year to a minimum of 70 percent of average billed charges with inflation increases of 0 percent the first year and 7 percent the second year		(722,547)	(1,233,388)	(1,955,935)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(111,048)	(561,337)	(672,385)
Decrease funding for medical services to reduce projected caseload/utilization rates		(9,600,000)	(16,359,978)	(25,959,978)
Decrease funding for the funeral set-aside for Medicaid recipients by $283,000, of which $103,922 is from the general fund, to provide for an increase in the set-aisde from $5,000 to $6,000 as provided for in House Bill No. 1477. The executive budget included funding of $566,000, of which $208,571 is from the general fund, to increase the funeral set-aside for Medicaid recipients from $5,000 to $7,000.		(103,922)	(179,078)	(283,000)
Decrease funding for the state children's health insurance program by $2,809,222, of which $727,025 is from the general fund, including the removal of 1.5 FTE positions. The House version provides funding to increase the state children's health insurance program from 150 percent to 160 percent of the federal poverty level in accordance with provisions of House Bill No. 1478. The executive budget included funding of $4,429,649, of which $1,146,392 is from the general fund, for increasing the eligibility for the state children's health insurance program from 150 percent to 200 percent of the federal poverty level and to add 1.5 new FTE positions.	(1.50)	(727,025)	(2,082,197)	(2,809,222)
Long-Term Care Program				
Add funding to increase the personal needs allowance for individuals in basic care facilities from $60 to $75 per month (funding provided is for a January 1, 2010, effective date)		112,320	0	112,320
Add funding to increase the personal needs allowance for individuals in an ICF/MR facility from $60 per month as recommended in the executive budget to $75 per month (funding provided is for a January 1, 2010, effective date)		57,511	98,009	155,520
Add funding to increase nursing facility bed limits in the formula for nursing home payments from $138,907 to $169,098 for single rooms and $92,604 to $112,732 for double rooms (Of the $877,518, $324,506 is from the health care trust fund and $553,012 is from federal funds.)		0	877,518	877,518
Add funding of $14,739,128, of which $4,950,451 is from the general fund, $1 million is from the health care trust fund, and $8,788,677 is from federal funds, to provide a salary and benefit supplemental payment for individuals		4,950,451	9,788,677	14,739,128

employed by basic care and nursing care facilities earning a salary that is less than the 18th percentile of the salary range at each facility				
Add funding to provide for a salary and benefit supplemental payment for developmental disabilities providers currently earning a salary that is less than the 19th percentile of the salary range of each provider		7,000,000	11,929,151	18,929,151
Remove the new FTE position added in the 2009-11 executive budget relating to the implementation of a home and community-based care waiver to provide support for children who have a diagnosis of autism spectrum disorder	(1.00)	(66,872)	(66,871)	(133,743)
Provide funding for increasing the payment rates for children and adults who are severely medically fragile and behaviorally challenged residing at the Anne Carlsen Center and other developmental disabilities providers experiencing losses		438,900	747,957	1,186,857
Remove funding included in the executive budget for the addition of a third tier of personal care that would allow a maximum of 1,200 units of care per month		(1,021,922)	(1,741,524)	(2,763,446)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(4,544,584)	(7,103,292)	(11,647,876)
Decrease funding for long-term care to reduce projected caseload/utilization rates		(5,600,000)	(9,543,320)	(15,143,320)
Decrease funding for developmental disabilities grants to reduce projected caseload/utilization rates		(2,476,000)	(4,219,511)	(6,695,511)
Aging Services Program				
Remove funding for a pilot aging and disability resource center		(600,000)	0	(600,000)
Decrease funding for department travel		(3,506)	(10,464)	(13,970)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(3,350)	(6,852)	(10,202)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(15,200)	0	(15,200)
Children and Family Services Program				
Decrease funding for department travel		(1,054)	(2,652)	(3,706)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(7,754)	(15,860)	(23,614)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(436,192)	(823,013)	(1,259,205)
Mental Health and Substance Abuse Program				
Decrease funding for department travel		(15,842)	(45,715)	(61,557)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(7,940)	(16,241)	(24,181)
Decrease funding for compulsive gambling services by $150,000 from the general fund, from $700,000, of which $300,000 is from the general fund and $400,000 is from special funds from lottery proceeds, as provided for in the executive		(150,000)	0	(150,000)

budget to $550,000, of which $150,000 is from the general fund and $400,000 is from special funds from lottery proceeds. The 2007-09 legislative appropriation for compulsive gambling services is $400,000 of special funds from lottery proceeds.			
Remove funding for Governor's Prevention and Advisory Council grants	(200,000)	0	(200,000)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases	(21,237)	0	(21,237)
Developmental Disabilities Council			
Decrease funding for department travel	0	(4,446)	(4,446)
Developmental Disabilities Division			
Decrease funding for department travel	(7,536)	(32,975)	(40,511)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover	(3,455)	(7,067)	(10,522)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases	(27,199)	0	(27,199)
Vocational Rehabilitation			
Decrease funding for department travel	(17,096)	(56,242)	(73,338)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover	(2,666)	(5,453)	(8,119)
Decrease funding for centers for independent living by $400,000 from the general fund, from $2,144,539, of which $1,330,958 is from the general fund, as included in the executive budget to $1,744,539, of which $930,958 is from the general fund	(400,000)	0	(400,000)
Total House changes - Program and Policy	(2.50)	($16,892,577)	($25,107,472)	($42,000,049)

Other changes affecting Program and Policy programs:

Add a section of legislative intent regarding the funding for basic care and nursing home facility salary and benefit supplemental payments

Add a section of legislative intent regarding the funding for developmental disabilities providers salary and benefit supplemental payments

Amend North Dakota Century Code (NDCC) Section 50-30-02 relating to the health care trust fund to provide that money in the fund may not be included in drafts of appropriation bills introduced as part of the executive budget

Amend NDCC Section 50-24.5-04 to increase the personal needs allowance for individuals in basic care facilities from $60 to $75 per month

Add a section to provide for a Legislative Council study of long-term care services

House Bill No. 1012 - DHS - State Hospital - House Action

	Executive Budget	House Changes[1]	House Version
State Hospital	$70,001,527	($3,089,601)	$66,911,926
Total all funds	$70,001,527	($3,089,601)	$66,911,926
Less estimated income	19,563,594	(1,052,440)	18,511,154
General fund	$50,437,933	($2,037,161)	$48,400,772
FTE	472.51	(6.00)	466.51

[1]

State Hospital - House changes:	FTE	General Fund	Other Funds	Total
Decrease one-time funding for extraordinary repairs from $3,231,017 to $2,231,017		($1,000,000)	$0	($1,000,000)
Remove funding included in the executive budget for the global health initiative, including 6 new FTE positions	(6.00)	(516,815)	0	(516,815)
Decrease funding for department travel		(9,206)	(6,930)	(16,136)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(511,140)	(1,045,510)	(1,556,650)
Total House changes - State Hospital	(6.00)	($2,037,161)	($1,052,440)	($3,089,601)

House Bill No. 1012 - DHS - Developmental Center - House Action

	Executive Budget	House Changes[1]	House Version
Developmental Center	$54,015,265	($1,025,546)	$52,989,719
Total all funds	$54,015,265	($1,025,546)	$52,989,719
Less estimated income	37,160,672	(588,028)	36,572,644
General fund	$16,854,593	($437,518)	$16,417,075
FTE	445.54	0.00	445.54

[1]

Developmental Center - House changes:	FTE	General Fund	Other Funds	Total
Decrease one-time funding for extraordinary repairs from $712,675 to $562,675		($150,000)	$0	($150,000)
Decrease funding for department travel		(148)	(228)	(376)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(287,370)	(587,800)	(875,170)

Total House changes - Developmental Center	0.00	($437,518)	($588,028)	($1,025,546)

House Bill No. 1012 - Human Service Centers - General Fund Summary

	Executive Budget	House Changes[1]	House Version
DHS - Northwest HSC	4,881,955	(144,819)	4,737,136
DHS - North Central HSC	12,098,437	(1,597,511)	10,500,926
DHS - Lake Region HSC	6,263,550	(147,193)	6,116,357
DHS - Northeast HSC	12,056,316	(468,574)	11,587,742
DHS - Southeast HSC	16,054,906	(1,482,439)	14,572,467
DHS - South Central HSC	8,943,330	(386,259)	8,557,071
DHS - West Central HSC	13,315,641	(1,207,194)	12,108,447
DHS - Badlands HSC	6,264,582	(683,757)	5,580,825
Total general fund	$79,878,717	($6,117,746)	$73,760,971

House Bill No. 1012 - Human Service Centers - Other Funds Summary

	Executive Budget	House Changes[1]	House Version
DHS - Northwest HSC	3,680,172	(208,176)	3,471,996
DHS - North Central HSC	8,825,362	(408,515)	8,416,847
DHS - Lake Region HSC	4,747,559	(222,849)	4,524,710
DHS - Northeast HSC	14,320,535	(291,372)	14,029,163
DHS - Southeast HSC	15,966,058	(777,670)	15,188,388
DHS - South Central HSC	6,970,002	(269,753)	6,700,249
DHS - West Central HSC	12,693,292	(439,271)	12,254,021
DHS - Badlands HSC	5,429,653	(247,482)	5,182,171
Total other funds	$72,632,633	($2,865,088)	$69,767,545

House Bill No. 1012 - Human Service Centers - All Funds Summary

	Executive Budget	House Changes[1]	House Version
DHS - Northwest HSC	8,562,127	(352,995)	8,209,132
DHS - North Central HSC	20,923,799	(2,006,026)	18,917,773
DHS - Lake Region HSC	11,011,109	(370,042)	10,641,067
DHS - Northeast HSC	26,376,851	(759,946)	25,616,905
DHS - Southeast HSC	32,020,964	(2,260,109)	29,760,855
DHS - South Central HSC	15,913,332	(656,012)	15,257,320
DHS - West Central HSC	26,008,933	(1,646,465)	24,362,468
DHS - Badlands HSC	11,694,235	(931,239)	10,762,996
Total all funds	$152,511,350	($8,982,834)	$143,528,516
FTE	847.48	(11.00)	836.48

[1]

Northwest Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Decrease funding for department travel		($19,621)	($8,468)	($28,089)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(97,561)	(199,556)	(297,117)

Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(27,637)	(152)	(27,789)
Total House changes - Northwest Human Service Center	0.00	($144,819)	($208,176)	($352,995)

North Central Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative		($1,358,307)	($100,000)	($1,458,307)
Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Decrease funding for department travel		(2,132)	(1,521)	(3,653)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(122,969)	(251,527)	(374,496)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(55,310)	(3,113)	(58,423)
Total House changes - North Central Human Service Center	(1.00)	($1,597,511)	($408,515)	($2,006,026)

Lake Region Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Decrease funding for department travel		($12,616)	($8,554)	($21,170)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(104,767)	(214,295)	(319,062)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(29,810)	0	(29,810)
Total House changes - Lake Region Human Service Center	0.00	($147,193)	($222,849)	($370,042)

Northeast Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative		($280,663)	($81,200)	($361,863)
Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Decrease funding for department travel		(2,654)	(4,571)	(7,225)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(63,064)	(128,994)	(192,058)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(63,400)	(24,253)	(87,653)
Total House changes - Northeast Human Service Center	(1.00)	($468,574)	($291,372)	($759,946)

Southeast Human Service Center - House changes:	FTE	General Fund	Other Funds	Total
Remove funding added in the executive budget for the global health initiative	(4.00)	($1,190,124)	($183,746)	($1,373,870)
Provide funding for contract staffing at the Cooper House	0.00	236,520	78,840	315,360
Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Remove funding added in the executive budget for young adult transition residential services		(184,622)	(242,222)	(426,844)
Remove funding and FTE position added in the executive budget for the partnership program	(1.00)	(61,490)	(40,440)	(101,930)
Decrease funding for department travel		(1,707)	(1,414)	(3,121)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(164,349)	(336,167)	(500,516)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(57,874)	(167)	(58,041)
Total House changes - Southeast Human Service Center	(6.00)	($1,482,439)	($777,670)	($2,260,109)

South Central Human Service Center - House changes:	FTE	General Fund	Other Funds	Total
Remove funding added in the executive budget for the global health initiative	(1.00)	($127,669)	$0	($127,669)
Remove funding and FTE position added in the executive budget to complete vulnerable adult protection services	(1.00)	(73,128)	0	(73,128)
Decrease funding for department travel		(10,231)	(6,584)	(16,815)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(128,661)	(263,169)	(391,830)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(46,570)	0	(46,570)
Total House changes - South Central Human Service Center	(2.00)	($386,259)	($269,753)	($656,012)

West Central Human Service Center - House changes:	FTE	General Fund	Other Funds	Total
Remove funding added in the executive budget for the global health initiative		($279,546)	$0	($279,546)
Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Remove funding added in the executive budget for young adult transition residential services		(650,000)	(100,000)	(750,000)

Decrease funding for department travel		(13,677)	(9,496)	(23,173)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(135,157)	(276,456)	(411,613)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(70,021)	(965)	(70,986)
Total House changes - West Central Human Service Center	(1.00)	($1,207,194)	($439,271)	($1,646,465)

Badlands Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative		($665,000)	($140,000)	($805,000)
Decrease funding for department travel		(232)	(163)	(395)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(40,139)	(82,102)	(122,241)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		21,614	(25,217)	(3,603)
Total House changes - Badlands Human Service Center	0.00	($683,757)	($247,482)	($931,239)

Date: 2/17/09
Roll Call Vote #: 11

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1012

Full House Appropriations Committee

Day 31

☐ Check here for Conference Committee

Legislative Council Amendment Number TBD

Action Taken Do Pass as Amended

Motion Made By Pollert Seconded By Kreidt

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan	✓				
Vice Chairman Kempenich	✓				
Rep. Skarphol	✓		Rep. Kroeber		✓
Rep. Wald	✓		Rep. Onstad	✓	
Rep. Hawken	✓		Rep. Williams		✓
Rep. Klein	—				
Rep. Martinson	✓				
Rep. Delzer	✓		Rep. Glassheim	✓	
Rep. Thoreson	✓		Rep. Kaldor		✓
Rep. Berg	✓		Rep. Meyer		✓
Rep. Dosch	✓				
Rep. Pollert	✓		Rep. Ekstrom		✓
Rep. Bellew	✓		Rep. Kerzman	—	
Rep. Kreidt	✓		Rep. Metcalf		✓
Rep. Nelson	✓				
Rep. Wieland	✓				

Total (Yes) 17 No 6

Absent 2

Floor Assignment Pollert

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1012: Appropriations Committee (Rep. Svedjan, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (17 YEAS, 6 NAYS, 2 ABSENT AND NOT VOTING). HB 1012 was placed on the Sixth order on the calendar.

Page 1, line 2, after the semicolon insert "to provide for legislative council studies; to provide statements of legislative intent;" and replace "50-06-29, 50-24.1-02.3, and 50-29-04" with "25-04-05, 50-24.5-04, and 50-30-02"

Page 1, line 3, replace "the establishment of an aging and disability" with "developmental center admission screenings, the personal needs allowance for individuals in basic care facilities, and use of the health care trust fund."

Page 1, remove lines 4 through 6

Page 1, line 18, replace "7,790,774" with "2,148,542" and replace "19,303,132" with "13,660,900"

Page 1, line 19, replace "(13,570,832)" with "(13,582,286)" and replace "46,539,524" with "46,528,070"

Page 1, line 21, replace "($5,780,343)" with "($11,434,029)" and replace "65,842,656" with "60,188,970"

Page 1, line 22, replace "(14,635,996)" with "(16,622,573)" and replace "36,027,838" with "34,041,261"

Page 1, line 23, replace "8,855,653" with "5,188,544" and replace "29,814,818" with "26,147,709"

Page 2, line 4, replace "19,253,918" with "18,552,432" and replace "44,664,959" with "43,963,473"

Page 2, line 5, replace "5,439,280" with "4,364,279" and replace "73,251,082" with "72,176,081"

Page 2, line 7, replace "112,946,092" with "111,111,588" and replace "456,965,308" with "455,130,804"

Page 2, line 8, replace "227,633,993" with "189,244,935" and replace "1,344,821,814" with "1,306,432,756"

Page 2, line 11, replace "352,797,592" with "310,797,543" and replace "1,919,716,163" with "1,877,716,114"

Page 2, line 12, replace "248,526,112" with "223,418,640" and replace "1,375,189,679" with "1,350,082,207"

Page 2, line 13, replace "104,271,480" with "87,378,903" and replace "544,526,484" with "527,633,907"

Page 2, replace lines 18 through 30 with:

"Northwest human service center	$7,493,897	$715,235	$8,209,132
North central human service center	16,782,604	2,135,169	18,917,773
Lake region human service center	9,817,355	823,712	10,641,067
Northeast human service center	22,107,349	3,509,556	25,616,905

Southeast human service center	26,061,630	3,699,225	29,760,855
South central human service center	14,683,811	573,509	15,257,320
West central human service center	20,687,272	3,675,196	24,362,468
Badlands human service center	9,798,789	964,207	10,762,996
State hospital	57,391,944	9,519,982	66,911,926
Developmental center	46,793,933	6,195,786	52,989,719
Total all funds	$231,618,584	$31,811,577	$263,430,161
Less estimated income	112,757,229	12,094,114	124,851,343
Total general fund	$118,861,355	$19,717,463	$138,578,818"

Page 3, line 4, replace "141,437,021" with "112,284,910" and replace "721,512,545" with "692,360,434"

Page 3, line 5, replace "250,489,786" with "218,890,181" and replace "1,540,574,416" with "1,508,974,811"

Page 3, line 6, replace "391,926,807" with "331,175,091" and replace "2,262,086,961" with "2,201,335,245"

Page 3, line 7, replace "14.00" with "(6.50)" and replace "2237.38" with "2216.88"

Page 3, line 20, replace "3,943,692" with "2,793,692"

Page 3, line 22, replace "4,296,298" with "3,146,298"

Page 4, line 6, replace "$3,000,000" with "$4,324,506"

Page 4, replace lines 10 through 30 with:

"**SECTION 5. LEGISLATIVE COUNCIL STUDY - CHILD SUPPORT ENFORCEMENT.** During the 2009-10 interim, the legislative council shall consider studying the department of human services' child support enforcement program. The study should include the review of arrearages in terms of total owed and interest accrued and child support enforcement activities in other states. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly.

SECTION 6. LEGISLATIVE COUNCIL STUDY - LONG-TERM CARE. During the 2009-10 interim, the legislative council shall study long-term care services in the state. The study must include a review of the department of human services' payment system and a review of the state department of health's survey and inspection programs and processes. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly.

SECTION 7. ADDITIONAL FEDERAL FUNDS - AMERICAN RECOVERY AND REINVESTMENT ACT - ACCEPTANCE - LIMITATION ON EXPENDITURE. If the department of human services receives federal funds made available to the state from the American Recovery and Reinvestment Act or other federal action to stimulate the national economy or to address state fiscal recovery in excess of the federal funding appropriated by the sixty-first legislative assembly for any major program, the department of human services may accept the additional federal funds, but may not spend the funding until appropriated by the legislative assembly for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 8. SUPPLEMENTAL PAYMENTS - BASIC CARE AND NURSING HOME FACILITY SALARY AND BENEFIT INCREASES. The funding appropriated in

subdivision 2 of section 1 of this Act includes $14,739,128, of which $4,950,451 is from the general fund, $1,000,000 is from the health care trust fund, and $8,788,677 is from federal funds, for providing supplemental payments to basic care and skilled nursing care facilities to allow for a salary and benefit increase for each employee earning a salary that is less than the eightieth percentile of the salary range at each facility, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 9. SUPPLEMENTAL PAYMENTS - DEVELOPMENTAL DISABILITIES PROVIDER SALARY AND BENEFIT INCREASES. The funding appropriated in subdivision 2 of section 1 of this Act includes $18,929,151, of which $7,000,000 is from the general fund and $11,929,151 is from federal funds, for providing supplemental payments to developmental disabilities providers to allow for a salary and benefit increase for each employee earning a salary that is less than the ninetieth percentile of the salary range of each developmental disabilities provider, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 10. AMENDMENT. Section 25-04-05 of the North Dakota Century Code is amended and reenacted as follows:

25-04-05. Qualifications for admission to state facility - ~~Temporary~~ Screening required prior to admission or readmission - Educational or related services without charge for persons twenty-one years of age and under.

1. The superintendent may admit a person to the developmental center at westwood park, Grafton when all of the following conditions have been met:

   a. Application for admission has been made on behalf of the person by a parent or guardian or the person or agency having legal custody, or by the person seeking admission, in accordance with procedures established by the department of human services.

   b. A comprehensive evaluation of the person has been made within three months of the date of application, a report of which has been filed with the superintendent and which, together with such other information or reviews as the department of human services may require, indicates to the superintendent's satisfaction that the person is eligible for admission to the developmental center at westwood park, Grafton.

   c. The person may be admitted without exceeding the resident capacity of the facility as specified in the professional standards adopted by the department of human services.

2. ~~The superintendent~~ No person may ~~admit~~ be admitted or readmitted to the developmental center at westwood park, Grafton, ~~temporarily for the purposes of observation, without commitment,~~ unless that person has undergone a screening process at the developmental center to determine whether the admission or readmission is appropriate. Length of stay criteria may be established under rules as the department of human services may adopt~~, any~~. Any person who is suspected of being able to benefit from the services offered at the center~~,~~ may be screened to ascertain whether or not that person is actually a proper case for care, treatment, and training ~~in~~ at the ~~state facility~~ developmental center. If in the opinion of the superintendent the person ~~temporarily admitted to the developmental center at westwood park, Grafton~~ screened under this subsection is a proper subject for institutional care, treatment, and training

at the developmental center, that person may remain as a voluntary resident at ~~such~~ the center at the discretion of the superintendent if all other conditions for admission required by this section are met.

3. Notwithstanding any other provision of this chapter, no handicapped patient, twenty-one years of age or under, or the estate or the parent of such patient, may be charged for educational or related services provided at the developmental center at westwood park, Grafton. Except as provided in subsection 4, the department of human services has prior claim on all benefits accruing to such patients for medical and medically related services under entitlement from the federal government, medical or hospital insurance contracts, workforce safety and insurance, or medical care and disability programs. For purposes of this subsection, "related services" means transportation and such developmental, corrective, and other supportive services, as determined by the department of public instruction, as are required to assist a handicapped patient to benefit from special education. The cost of related services other than medical and medically related services must be paid by the developmental center at westwood park, Grafton, the school district of residence of the handicapped child, and other appropriate state agencies and political subdivisions of this state. The department of public instruction, the department of human services, the school district of residence, and other appropriate state agencies and political subdivisions, as determined by the department of public instruction, shall determine and agree to that portion of related services, other than medical and medically related services, for which each agency and political subdivision is liable. The department of public instruction may adopt rules necessary to implement this section.

4. Parents of a handicapped patient, twenty-one years of age or under, are not required to file, assist in filing, agree to filing, or assign an insurance claim when filing the claim would pose a realistic threat that the parents would suffer a financial loss not incurred by similarly situated parents of nonhandicapped children. Financial losses do not include incidental costs such as the time needed to file or assist in filing an insurance claim or the postage needed to mail the claim. Financial losses include:

   a. A decrease in available lifetime coverage or any other benefit under an insurance policy.

   b. An increase in premiums or the discontinuation of a policy.

   c. An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim unless the developmental center pays or waives the out-of-pocket expense.

SECTION 11. AMENDMENT. Section 50-24.5-04 of the North Dakota Century Code is amended and reenacted as follows:

50-24.5-04. Services provided - Limit on cost. Services provided under this chapter must be treated as necessary remedial care to the extent those services are not covered under the medical assistance program. The cost of the services provided under this chapter to a person residing in a basic care or adult family foster care facility for which the rate charged includes room and board is limited to the rate set for services in that facility, plus ~~sixty~~ seventy-five dollars, less that person's total income.

SECTION 12. AMENDMENT. Section 50-30-02 of the North Dakota Century Code is amended and reenacted as follows:

50-30-02. North Dakota health care trust fund created - Uses - Continuing appropriation.

1. There is created in the state treasury a special fund known as the North Dakota health care trust fund. The fund consists of revenue received from government nursing facilities for remittance to the fund under former section 50-24.4-30. The department shall administer the fund. The state investment board shall invest moneys in the fund in accordance with chapter 21-10, and the income earned must be deposited in the North Dakota health care trust fund. All moneys deposited in the North Dakota health care trust fund are available to the department for:

   a. Transfer to the long-term care facility loan fund, as authorized by legislative appropriation, for making loans pursuant to the requirements of this chapter.

   b. Payment, as authorized by legislative appropriation, of costs of other programs authorized by the legislative assembly.

   c. Repayment of federal funds, which are appropriated and may be spent if the United States department of health and human services determines that funds were inappropriately claimed under former section 50-24.4-30.

2. The department shall continue to access the intergovernmental transfer program if permitted by the federal government and if use of the program is found to be beneficial.

3. Moneys in the fund may not be included in draft appropriation acts under section 54-44.1-06."

Page 5, remove lines 1 through 31

Page 6, remove lines 1 through 10

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT - LC 98013.0113 FN 3

A copy of the statement of purpose of amendment is on file in the Legislative Council Office.

2009 SENATE APPROPRIATIONS

HB 1012

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: March 3, 2009 am

Recorder Job Number: 10056

Committee Clerk Signature Rose Laning

Minutes:

Chairman Holmberg called the committee hearing to order on HB 1012 which is an appropriation for the Department of Human Services. Roll call was taken.

Subcommittee members will be: **Senator Fischer, Senator Kilzer, Senator Krebsbach, Senator Warner, and Senator Mathern.**

Chairman Holmberg asked those who are presenting testimony to be extremely precise about the words "requested", and "OARs" (Optional Additional Requests). Our starting point is what is in the budget that the House passed. If it's something that you asked for and it's in the budget, don't use words like "requested" because then we think you are requesting for us to make some change.

Also don't spend time talking to the committee about reductions in salary from the five and five. The Senate had a position both on salaries and equity.

(4:37)

Carol K. Olson, Executive Director, North Dakota Department of Human Services

Written attached testimony # 1.

Chairman Holmberg said that new FTE (Full Time Equivalent) positions were hard to come by. Was this part of an overall strategy in Human Services also that all new FTEs were denied? Or will we see some sprinkled in as we go?

Carol K. Olson: In the area of Behavioral Health, we had 11 FTEs identified as an increase. Six of them were at the State Hospital, four at Southeast Human Service Center, one at SC Human Service Center. They were to meet the increased need both in the community and state hospital. When we put the budget together, instead of putting all the emphasis on the state hospital which had been operating at about 103% capacity which by the way, 40 % of our admissions to the State Hospital in 2008 were first time admissions as opposed to repeat. We decided to spread it out community based services. In other words, instead of putting everything in the State Hospital, we decided to spread it around. We met throughout the interim with our private providers and they were concerned about how many people are coming thru the doors and how long the patients are staying and how much they are being reimbursed for the care.

Senator Warner asked if there were any infrastructure costs associated with FTEs in terms of space. And there were none.

(22:04)

Chairman Holmberg: We always seem to use the number "family of four". Isn't the date indicating that in many cases, we're talking about a family of two or three, often a women with one or two children? What are the numbers for 200% of poverty levels for a standard family of four? What number is that and what is the 160 number - roughly? Or will we be getting that from Maggie?

Carol K. Olson: A family of four at 200% would be $42,400 and a family of four at 160% would be $33,920.

Senator Krauter: Single parent family of two or three at 200%?

Carol K. Olson: I can get that figure, but I do have the 160% number which is $28,160.

(24:00)

Chairman Holmberg: Is that scenario accurate that there is a lot that the family of four, but three is what we always use when we're discussing this issue. Is this not the norm?

Carol K. Olson replied that the make-up of the family has varied, but one is not pre-dominant.

Senator Fischer asked about a chart that showed the number of children that have dropped off significantly since July of 08. When you re-calculated these numbers, you took that into consideration? Is the trend going to continue?

Carol K. Olson: Yes.

Senator Warner: Funding services, children could continue to live in a foster family and transition out or institutionalize. What is the decision making process for leaving children in foster care and providing support there or creating another institution.

Carol K. Olson: What we're really looking at is the concern that we have for these children either way, who have been in foster homes or an institution. When they turn 18, they are suddenly on their own and are supposed to know how to support themselves, managing their lives when their lives have been managed for them for a good part of their 18 years. They need a little additional assistance and coaching and they'd have a much better chance for achieving further education, job placement, or self sufficiency in apartment living. This is where we see a real gap in services foster care.

Chairman Holmberg reminded everyone that this issue was before the Senate and they killed SB 2302, but the subcommittee can look into the area of foster care area if they wish.

Senator Krauter asked about the federal stimulus money and Carol Olson said we still don't have final numbers of stimulus package. We have various entities that supply them to us, but want to make sure they are real numbers.

(32:40)

Brenda Weisz, Chief Financial Officer, Department of Human Services

Testified in favor of HB 1012. Written attached testimony # 2.

Chairman Holmberg: The House removed the equity funding and underfunded salaries. Is the equity and salaries together, the $6.1M, or is equity separate? Where is that number?

Brenda Weisz: Attachment D walks through all my House changes. Combining that $11.1 M equity and the underfund, that is what the House amendments did. If you add the $1.3M, then we're looking at over $12M.

Chairman Holmberg: But that was your choice.

Brenda Weisz: We did come in knowing at the State Hospital that we would have turnover, and we did try to accommodate that.

(Continuing on page 6) (45:50)

Senator Krauter asked about the rebasing wondering if it was still in place and wasn't changed by the House.

Brenda Weisz: Are you talking for all the rebased providers? And **Senator Krauter** said yes. Brenda continued that the inflation that was brought forward when they looked at the reports by the vendor that did the work for the hospitals. The inflation they used to bring their costs up was near 22%.

Senator Krauter: What is the date of MMIS (Medicaid Management Information System)?

Brenda Weisz: May of 2010.

V. Chair Bowman: On the $4.3 M to state hospital – you said that is now referred to as global behavioral health. What was that referred to before and where was the money at that this is replacing?

Brenda Weisz: This is how Global Behavioral Health came to be. When we were preparing our budget for submission to OMB and the executive office, we recognized capacity issues.

And those capacity issues stand to repeat themselves in the communities and also our occupancy problem at the state hospital. With the system we have, as far as submitting our budget to prioritize your OARs, and all of this was a priority so we lumped it together and to title the OAR, we called it Global Behavior Health because it spanned the states.

V. Chair Bowman: That $4.3 M didn't come out of another budget that it used to be in.

Brenda Weisz: It wasn't in a separate budget. It's actually increased capacity. It's an increase to our current budget to say that our current capacity was not covering the needs that existed out there. So this was an increase to address the needs that were presenting themselves in the community as well as the state hospital, as far as capacity and staffing. It's just our grouping of the same issues, statewide, calling it global.

V. Chair Grindberg: Could you provide us with maybe the last three bienniums; go back to 2000 if you will, to show that historical on inflationary. And then if we could get the percent increases in general fund in the major budgets, in the major divisions so that we can kind of see the historical general fund increases percentage wise, as well as the inflation increase and if that could be done in a concise way, I think that would be helpful.

Brenda Weisz: Just to clarify – The major increases by those same program areas and go back a couple bienniums.

V. Chair Grindberg: Yes.

Senator Krauter: This is probably the first time in four bienniums that I see such a dramatic emphasis on reduction in caseloads utilization- almost entirely across the board. What are your thoughts there, because this is the first time I've seen program after program (inaudible).

Brenda Weisz: Each area is set independently and individually and statistically and so we always do come forth with a budget that is representative of the trend. Some of the areas where there's a decrease, isn't necessary that there's a drastic increase in the program, but

there's a decrease from where we thought 07-09 would be. So our caseload isn't coming in at the same level as 07-09, so it's not a drastic increase per se maybe specifically in the numbers, but how the budget was built for certain areas.

(85:50)

Brenda Weisz, CFO, Department of Human Services.

Written attached testimony #3. Gave an overview of the Administration / Support Area

This area of the budget includes the Executive Office, Legal Advisory Unit, Human Resources, and Fiscal Administration. This budget area also includes centralized costs for department-wide expenditures.

Senator Krauter asked about the audit fees and whether it is an increase or a fee.

Brenda Weisz: The fees didn't go up, but the hours went up, but it is a combination of both. Their rates would be up because of the salary.

Senator Robinson: Go back to page 3, the 31 % rate increase for attorney general. Is that based on something so usual that we have not had a rate increase for some time? We look at salaries and wages in our package. It's certainly not anywhere close to that.

Brenda Weisz: When we prepare our budget, there is a document that goes up and OMB does publish it on their website for budget instructions. It's all the internal service agencies that do services. They do report to us what they anticipate a rate increase would be and how to build your budget based on their hourly rate.

Senator Krauter: On the increase in auditors and attorney generals fees, there is a standard listing that is prepared by agencies to use when they build their budgets?

Lori Laschkewitsch, Fiscal Analyst, OMB: Yes, there is a link on website to fees.

Senator Krauter: Could you print one out please? It keeps coming up when we work on all these agency budgets.

Senator Warner asked if the fiscal audits and performance audits were federally mandated.

Brenda Weisz: We have not been subject to a performance audit for a couple of years, but they do a federal audit as well. They do an agency audit, they do CAFR (Confidence of Annual Financial Report Audit) - the federal, CAFR, and state agency audit. Generally the come through the legislative audit and fiscal review committee.

Senator Wardner: When they set rates at attorney general's office and the auditor, are you involved in any of those or is that an internal thing where they set them.

Lori Laschkewitsch: Those agencies do their own rate settings. We just ask them to provide us with the information so we have lists available to the agencies.

Senator Fischer: Attorney Generals. The attorneys that are within the agency, they're not employees of the agency, they are assistant AGs?

Brenda Weisz: Some of the attorneys within the department have a special designation.

Senator Fischer: So is that part of this increase?

Brenda Weisz: No. That is not part of the increase. This is actually the billing we will receive from the AGs office for the additional work they do for us.

(Continuing on page 5)

Senator Robinson: I have a question on page 3, what type of dollars do we pay in total for AG fees in the course of a biennium?

Brenda Weisz: Currently, our budget is estimated to have about $420,000 paid per biennium to the attorney general's office.

Senator Robinson: What would it cost if we put another fulltime attorney on to the department to reduce the costs? At some point, the department will have that decision to make, would we not?

Brenda Weisz: I don't think we've ever exercised the option. There are some things that the AG office is designated to do.

Brenda Weisz: handed out a **billing rates form – see attached #4.**

(103:48)

Jennifer Witham, Director, Information Technology Services, Dept. Human Services

Written attached testimony # 5.

Senator Warner: When you refer to information technology department, that's the state's agency?

Jennifer Witham: Yes, the state's information technology department.

Senator Warner: Is that the only place the distinction needs to be made between your department and the state agency?

Jennifer Witham: Yes, that $4M is the increase in what we're paying to the information technology department for their services.

Senator Seymour: On top of page 4 when you talk about the increases in rates of senior development and project management staff, what were the increases?

Jennifer Witham: I can give you a detailed breakdown, but they went from $63/hour to $75/hour for senior developers and for the project management staff. There was also an increase that went from $58/hour to $63/hour.

Senator Fischer asked about the cost of MMIS trying to understand the decrease to support the Medicaid Systems project.

Jennifer Witham: The decrease is the cost of the project itself that is continuing through this biennium so that's a onetime cost for development and implementation. There is also the cost of the ongoing maintenance of the system in the 09-11 budget.

Senator Krauter: What additional costs of development are we still to pay?

Jennifer Witham: The entire cost of the project will not change even thought the schedule hasn't been developed. We'll be asking carryover funds that haven't been expended.

Senator Warner: Are there any anticipated low impact costs that aren't on the schedule, like implementation and training? Everything's included in the price we have on the list.

Jennifer Witham: I do not anticipate any additional cost.

(116:54)

Tove Mandigo, Director, Economic Assistance Policy Division

Written attached testimony # 6.

No questions.

Maggie Anderson, Director, Division of Medical Services, Department of Human Services

Written attached testimony # 7.

Senator Krauter asked about the salaries and deductions for families of 3 & 4.

Maggie Anderson: A household of three at 200% is $35,200. A household of three at 160% (where the budget currently is) is $28,160. A household of 4 at 160% is $33,920, and a household of four at 200% is $42,400.

Senator Krauter: Can you give us your definition of net?

Maggie Anderson: The definition technically of gross income is before deductions and net is after. The income level is not gross or net. The income level is what you can deduct to get down to the income level. For example, a family of four at $42,400 at 200%, they could be earning above that, and then with their deductions, we look at the $42,400 as the ceiling of what they could be earning in order to qualify.

Senator Krauter: You say deductions, you mean payroll deductions?

Maggie Anderson: We have mandatory payroll deductions, mandatory retirement plan deductions, expenses, reasonable childcare expenses. If the individual is engaging in necessary employment or training, non-voluntary child or spousal support payments is actually paid. We allow a $30 work training disregard- that means people who are working or in school, they are automatically allowed a $30 disregard.

Senator Christmann asked $30 how often?

Maggie Anderson: $30 per month. And then the cost of premiums for health insurance for other members of the family, so if the children are receiving their healthcare coverage through SCHIP or through Medicaid, the parents have coverage somewhere else and paying for that, then the cost of those premiums can be deducted. And then for necessary medical expenses or remedial care.

Senator Christmann: Non-voluntary child support payments?

Maggie Anderson: Non-voluntary child support and spousal support payments that were actually paid.

Senator Christmann: What's the definition between non-voluntary and voluntary?

Maggie Anderson explained the difference between court ordered and not court ordered.

Senator Fischer asked fiscal year questions.

Senator Warner: What is the base number for immunization before we increased it?

Maggie Anderson: The current fee schedule for an initial injection type of administration is $9.21. Then if they receive a second injection at that same time, we pay a lower fee and that is $6.33. In this scenario, the first injection would receive the $13.90 and then we'd add the $4.69 to the fee schedule of the $6.33 today, so they'll receive that increase on top of the second immunization and they'll receive that same increase on the third injection.

Senator Warner: Do you have an audit process in place to make sure that they're not inflating the claims that they give to the government over those that they charge to private industries.

Maggie Anderson: We don't have a specific audit process for that. We have federal rules as well as state policy that indicate they have to bill at their usual customary fees. If we found someone was not doing that or if we noticed a trend change that was occurring because of some payment methodology that we would identify that. The other thing about this particular area is that we used the estimates from the most recent completed state fiscal year (2008) to establish that average. If the fee schedule would not be re-based annually to that; it's the rebased and then inflated forward.

Senator Kilzer: Why are you rebasing on such a wide variety of things. Could you just put together a chart that shows what the funding or costs would be if you did it at the Medicare rate?

Maggie Anderson: For some services, that may be possible, for example, with ambulance. It's a fairly straight forward comparison. With physicians, there's a conversion factor that's used by Medicare and by Medicaid. For hospitals, we have different methodologies. For Medicare and Medicaid we have different clients. We pay for a lot of births in Medicaid. Medicare doesn't. The waiting factors and restrictions are somewhat prohibitive in doing that; and certainly with dental as well. So comparing to Medicare, it isn't a reliable comparison for many of our services.

Senator Kilzer: I think I'd disagree with that. They all have code numbers that take into consideration all these other things. If you go by code numbers, it should be easy to determine.

Maggie Anderson: We could do that with Physicians and practitioners and also with Medicare. But for hospitals, we have different payment methodology. They don't provide

dental. We probably could do it for chiropractors if they pay off of a conversion factor. We would have to altar some of our payment methodology in addition to looking at changes in the fee schedule.

Senator Kilzer: I think we should look into that.

Chairman Holmberg: We need to caucus at noon. Is there a period we can put here and come back?

Maggie Anderson: I'm in the middle of page 13 and we can stop there.

Chairman Holmberg closed the hearing on HB 1012.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012 - continuing

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: March 3, 2009 - pm

Recorder Job Number: 10092

Committee Clerk Signature Rose Laning

Minutes:

Chairman Holmberg called the committee back to order.

Maggie Anderson, Director of Medical Services, Department of Human Services

Continuing with written attached testimony #7 – starting on page 13.

(14:02)

Senator Kilzer: Of the Funeral Set Aside funds, could you give a historical picture of the funeral set aside has been – about 10 years back?

Maggie Anderson: We can certainly do that.

(15:20)

Senator Warner: Could you provide an executive summary of methodologies for re-basing – is there a short summary of payment methodology?

Maggie Anderson: We can take a look and see what we can pull together on that. Each of the provider groups was done differently, because their payment methodologies were different. When we released the request for proposal on that we actually ended up awarding three separate contracts. Because providers are paid differently, there are different methodologies.

(17:20)

V. Chair Bowman: The budget continues to a skyrocket. Are the numbers of people who are taken care of going up in proportion to the budget? Or is it fairly steady?

Maggie Anderson: If I could have you look at Attachment C. This is a comparison of our eligible and our recipients. The highlighted lines are the number of people who have received at least one service during that particular month. There is a low of around 38,000 and a high around 44,000. Some of that is timing of the year as in flu and cold season when we may have more claims or immunizations for kids going back to school. We'll see some trends as far as payment for those services. We are monitoring the aging population, but nothing specific in terms of the data in front of you.

Senator Robinson: Are there any national norms, surveys or statistical information that would give us a picture of how ND ranks per capita in the area of assistance with the region and the nation.

Maggie Anderson: I'm sure there is some information out there, but every state has different eligibility levels.

Senator Kilzer: A year and half is too short of a period to really answer Senator Bowman's question? Your graph only goes back a year and a half or so.

Maggie Anderson: We could go back farther than 1 ½ years – probably a couple bienniums. (20:50)

Senator Fischer: Could you also supply is with the eligibility for Medicaid and Healthy Steps. I hear different figures and it would help to know how we are in comparison with other states.

Maggie Anderson: You want income eligibility levels for children and adults on Medicaid as well as SCHIP?

Mike Schwindt, Director, Child Support Enforcement (CSE) Department of Human Services

Testified in favor of HB 1012. Written attached testimony # 8.

Senator Fischer: How do you get by with $13,000 for equipment?

Mike Schwindt: We replaced two copiers and trying to be very frugal.

Maggie Anderson, Director, Medical Services, Department of Human Services

Written attached testimony # 9.

She gave overview of the Long-Term Care Continuum budget.

V. Chair Grindberg: Is PACE program similar to Elderberry program where it's a local community initiative? We had some presentations on that about four years ago.

Maggie Anderson wasn't that familiar with that particular program.

Senator Warner: Clarify the term periodically when speaking of MDS (Minimum Data Set)? Is that a quarterly assessment?

Maggie Anderson: The MDS is done upon admission within 14 days, within 14 days of re-admission from a hospital stay and then it's done every 3 months after that.

(66:20)

Senator Robinson: In this category and next, what kind of numbers are we looking at in terms of clients.

Maggie Anderson: We are estimating around 25 individuals and 25 for next as well.

(Continuing on page 11)

Senator Robinson: We heard the budget for the Department of Public Instruction last week and they noted a significant growth in Autism. You have a number of 30. What can you tell us about this age group? Are the numbers increasing?

Maggie Anderson: One of the primary reasons we have it in the executive budget and we prepared a request for this is because through our stakeholder meeting, we've heard about the autism spectrum and the parents concerns. We try to intervene early on with the children.

Senator Robinson: Why all of a sudden we see such a spike in autism.

JoAnne Hoesel: We are identifying more children with developmental delays. We can have more of an impact if we have an earlier intervention.

(72:45)

Maggie Anderson – Continuing page 13 –

Senator Kilzer: A session or two ago, we had a waiting list for SPED (Service Payments for Elderly and Disabled) services and we caught up, how has it been the last year?

Maggie Anderson: There was a freeze placed on the SPED program and then that was removed with a bit of a slow growth after that time period. During the current biennium, we have definitely seen an increase in our SPED numbers and a consistent growth in the number of people receiving services.

(86:44)

V. Chair Bowman: On your implementation date for Home Delivered meals, is that going to be like Meals on Wheels only they're going to take them to more people or is this a completely new program that starts from scratch? If so, how is it going to be paid for?

Maggie Anderson: The Home Delivered meals were first added in the 07-09 budget, so we added those during the current interim. That does look a lot like Meals on Wheels. It's a different population. These are individuals who are Medicaid eligible and they're being served through our Home and Community based waiver. Others who are receiving Meals on Wheels aren't necessarily Medicaid eligible or receiving services through our waiver. This implementation of January 1, 2010 is for the increase in the number of meals. What we implemented this biennium was 3 meals per person per week and this changed that to 7 meals per person per week – and that would be Medicaid funded.

V. Chair Bowman: But who prepares the meals to deliver them and who is responsible for paying for the delivery?

Maggie Anderson: The cost of the delivery would be included in what we reimburse for that meal. We are trying to use the existing Older Americans Act providers who are already preparing and delivering those meals so we can be efficient about it.

V. Chair Bowman: Our county just received a hefty little bill from Meals on Wheels because they were short. Is this 100% funded for the cost or are the counties going to be responsible for picking up part of that?

Maggie Anderson: I can't say that our reimbursement rate is covering 100% of the cost. It's the fee that had out there for that. We think it's covering it very close.

(Continuing on bottom of page 18)

(90:09)

Senator Warner: Elaborate on technology waiver.

Maggie Anderson: These are individuals who are eligible for nursing home level of care but they are receiving services in their home and they are ventilator dependent for 20 or more hours per day and medically stable. The goal of the waiver is to keep them in their home.

Senator Warner: Could you elaborate on costs serving them in the nursing homes or in their own homes.

Maggie Anderson: One of requirements of a Medicaid waiver is that you prove that it's cost effective for the waiver and so we have to look at the cost of that service in the aggregate. Individuals who are on a ventilator are generally in your highest cost category in a nursing facility. We use that category when we establish what the rate would be should someone choose to receive the services. That's the maximum that we'll pay for the services.

Chairman Holmberg any questions.

Andrea Peña, Executive Director, North Dakota State Council on Developmental Disabilities

Written attached testimony # 10.

She gave an overview of the Council's budget request.

V. Chair Grindberg: Assuming you're new director and you'd like your money back?

Andrea Peña: Yes.

V. Chair Bowman closed the hearing on HB 1012.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: March 4, 2009

Recorder Job Number: 10162

Committee Clerk Signature Rose Laning

Minutes:

Chairman Holmberg: Called the committee hearing to order on HB 1012 which is an appropriation for the Department of Human Services. Roll call was taken. All committee members were present.

Carol K. Olson, Executive Director, North Dakota Department of Human Services: Handed out a Glossary of Terms and Acronyms – see attached # 11.

Linda Wright, Director, Aging Services Division, Department of Human Services: Written attached testimony # 12. Additional information was provided about Aging and Disability Resource Center (ADRC) – attachments A-H.

Chairman Holmberg: The budget does include some additional money for the meals program but there is a concern about the formula you use. I am hoping the subcommittee will take a hard look at that formula and equalization, so some of the numbers that we see between regions gets resolved. We don't want to take money from someone else within the program. We need to get that resolved this session.

Linda: I will be happy to provide you with the formula we use. She continues with her written testimony.

Senator Robinson: I've been concerned about the demography and what's happening in the state. We will be in need of thirty percent more medical professionals in the next twelve to

fifteen years. We'll soon be in a situation where there are not enough human resources to care for are elderly. We have programs in place and a number of agencies that are working on these issues. Is there an agency that is being proactive to coordinate the long term or are we going to be in a situation where we are not ready. Where are we as a state, do we have a model out there or best practices that we can emulate? There are many areas of our state that are in impossible situations to sustain are rural culture and viability.

Linda Wright: The Olmstead Commission has established a work group that is looking at a direct care workforce for the needs of now and the future. So we have a broad based committee. We are coordinating are efforts with Job Services, with the colleges that are offering opportunities for older students. We've also joined with MFP, the Money Follows the Person programs, and with that we will be able to access the national technical institutes. We're looking at what other states are doing.

V. Chair Grindberg: When you look at your 2020 map, Sioux County and Grand Forks County are manufacturing younger people. Are you engaging the County Commissioners with stakeholders meetings with this type of data? So every biennium we come in and appropriate and fund programs.

Carol Olson: Yes we do include the county commissioners at local level during are stakeholders meetings. We need to make sure that services are available, but have to make sure we have the availability of the services that they need. We've seen more of our rural citizens are moving into the urban areas. It's something that we've talked about for a number of years. They have more resources available to them. We have a 2020 project that we are working on that should give us some answers to some questions. We know the services they need, the challenge is how to provide them. There are so few people living out there. What's

the answer? How are we going to deal with this in the future? We are trying to come up with solutions.

V. Chair Bowman: To tie the net between what's available, every time there is a new program started, a web page should be available to the counties, so people would know how take care of that need. There are always changes to these programs and the webpage should change with what is available and what the programs are designed to do. Then those at the county level would know what is available to take care of that person.

Linda Wright: Some of that is already available through the Aging Website. You can search by County or Service. It could be expanded beyond what it currently is. Some states even have their assessment documents on line.

Senator Mathern: I've been looking at this website on services. There isn't any agency that wants to take this on?

Linda Wright: Many agencies have developed over a long period of time and because of that there is a lot of ownership among the agencies, organizations and associations. There are some positive things that have happened in rural Cass County with the community care program. We've gotten some people together to serve the rural communities in Cass County. In some of the larger areas they have community services network meetings. There needs to be an incentive to get the agencies to work together.

Senator Mathern: Why don't we have something together right now? We know what the problem is and the solution, why don't we just put it in place?

Linda Wright: It takes resources and a very concerted effort to get it done. It needs to be the local people making that decision and getting together. Linda goes back to her written testimony, starting on page seven.

Senator Robinson: If it wasn't for these centers, we'd have everyone in nursing homes at a higher cost. How active is the partnership with our senior providers and public health in terms of referrals and really being a watchdog for the needs of our senior citizens across the state?

Linda Wright: Our outreach program focuses on people over the age of 60, but also low income, minority or frail. They are coordinating with the public health entities. We do fund across the state the maintenance services such as, foot care, blood pressure, etc. Linda concludes her testimony.

Senator Mathern: In terms of the House decrease, if that were to stay in place, could we eliminate the website services, or would that still be in place and we just won't have the staffing services?

Linda Wright: We want to enhance the aging services. We have voice mail, but if they call on Saturday, they just have to leave a message. If assessments were on website it would be helpful to the individuals, so they could determine what they are eligible for.

Senator Mathern: What are we losing by not funding the 600,000?

Linda Wright: We're losing cost efficiency and effectiveness. We are continuing with some duplicate efforts in information referral. We'd be more efficient and keep more people at home.

Senator Mathern: Doesn't this provide information and referral?

Linda Wright: It does but no benefit and option counseling, and can only provide phone numbers, but they still have to go to several agencies to get the services they need.

Tara Lea Muhlhauser, Director, Children and Family Services, Department of Human Services: Written Testimony # 13.

Senator Fischer: Under the Foster Care, I had parents who had a question; they had a child for 1 to 1 ½ years and they got the child back on track. The child was then placed for adoption and when the procedure started the foster parent wasn't allowed to comment about anything. Can you comment on that and where we should go with that?

Tara Lea Muhlhauser: Those situations can often get very complicated. I would be willing to look into that case. We believe we work as partners with the foster parents. What I hear often is that they don't have any say in the decision, they sit in as a member of the team, but the people in charge of the child will ultimately make that decision. We like to believe that we are good partners with the foster care parents and they are invaluable to us.

Senator Fischer: This person didn't want to be in the room when decisions are being made, but they aren't contacted to be interviewed about the child. Maybe there are laws that should be changed.

Tara Lea Muhlhauser: It is our policy to involve the foster parents into the transition. I'm not sure why it didn't happen in this case. They move from a county manager, to a case manager and they are involved with foster parents. If we didn't do this in this case, I'd be willing to look into it.

Senator Fischer: She didn't expect anything to change at all. Then during the adoption and post adoption they continue to check on the child, when does the state get out of this kid's life?

Tara Lea Muhlhauser: When the child is adopted, we are done. The reason we are involved in post adoption services is we have learned that the children come with a lot of trauma, and

behavior problems. The adoptive parents need someone to connect with to assist them in becoming new parents. Tara continues with written testimony.

Senator Mathern: Before we get off these numbers, the number of children in foster care, is this a reduction?

Tara Lea Muhlhauser: Yes, we see a decline in the number of children in foster care. We ran the percentage of foster kids against the full child rate in ND. It was an interesting piece of research. There was a large rate in children going into foster care in some urban areas than others. Tara goes back to written testimony.

Senator Mathern: On this program is there any plan to put this in the budget once the Bush Grant is over?

Tara Lea Muhlhauser: Yes we do have dollars in the budget. The Villages' hope that this was an enhance service in our budget.

Senator Mathern: It would reduce if there is no longer any Bush money?

Tara Lea Muhlhauser: We would be able to maintain what we have now.

Senator Lindaas: Can you tell us what was lacking in achieving conformity?

Tara Lea Muhlhauser: The Federal IV-E audit? The court wants specific findings on removal and during any judicial activity. This is not a new issue, and we have been working hard to provide training to make sure everything is taken care of. It was all a matter of court order language. Tara goes back to written testimony.

Senator Fischer: What is a RCCF/GH?

Tara Lea Muhlhauser: RCCF is residential child care facility and GH is group home.

Senator Christmann: When there are suspicions of child abuse, how do they get those children to the right specialists to see if there is a problem or severity?

Tara Lea Muhlhauser: There is CPS- Child Protective Services staff in each county. They are well trained and also have 7 specialized projects that are built for rural counties. Dakota Central has two full time positions that go through the entire county. Burleigh has a person stationed in Bismarck but drives. The county and provides services to counties that aren't able to handle case load. These individuals are well trained to both read and engage in some questions to access the kinds of needs that are there when they get a child abuse and neglect report.

Senator Christmann: In the instance when specialized attention is needed do we have contracts with those specialists if they are going to help out for so many dollars per year? How do we work with those specialists?

Tara Lea Muhlhauser: We have five hundred thousand dollars in the budget for those specialized contracts with child advocacy workers. That's the only costs the county would bear would be that of driving in to be a part and hear the interview.

Senator Christmann: Your department oversees who is responsible for those advocacy centers?

Tara Lea Muhlhauser: We don't oversee them we write the contracts. Their oversight comes from the accrediting body the national children's advocacy center. We do contract oversight when we provide them those dollars. But mine is not that deep as far as program quality. Tara finishes with her written testimony.

Senator Kilzer: Under child protective services you list child fatality review, could you explain that?

Tara Lea Muhlhauser: It's a multi-disciplinary team that we bring together. It includes people from health department and the state forensics examiners and we also work with a forensic pathologist from UND. We have high level medical specialties on that team as well as citizen input to review all child deaths that have a potential systemic input.

JoAnne Hoesel, Division Director, Department of Human Services:

Written attached testimony # 14.

Senator Christmann: I don't understand the numbers of soldiers coming back with TBI.

JoAnne Hoesel: The first number is National Guard soldiers and next number is all the returning Vets.

Senator Krauter: Are there any net costs to the state or is it one hundred percent funded through the VA for the services that you are providing?

JoAnne Hoesel: This is a services grant for implementation and for looking into the future in terms of what we need. We're anticipating a 2nd wave – they first have to access services through the guard and VA. Then we have individuals who don't want to access VA because of the stigma that still comes from the services. They access their private insurance and they also come to the centers.

Senator Krauter: Is the department concerned that you will see an increase in cost as well?

JoAnne Hoesel: We do anticipate a shift because it will come from the service. It would show up in our budget, not in this budget.

Senator Fischer: Is there federal money that flows with these veterans?

JoAnne Hoesel: There are some grants available. And they can get help through the VA. There are additional grants available and some come with matches.

Senator Fischer: We're hoping there will be help from the federal government. Have there been any grants issued?

JoAnne Hoesel: This last summer I believe ten were issued.

Senator Krebsbach: The screening for TBI, what process do they go through or what indication do you have?

JoAnne Hoesel: I'm not sure of the exact screening process, but there is a trained individual from UND that processes the information that they look for. JoAnne continues going over her written testimony.

Senator Warner: Do you correlate your numbers with the corrections system, so we know how many are being treated in the sphere of the two budgets? How serious is the problem in our state?

JoAnne Hoesel: We work very closely with corrections and they would be treated in the prisons. Everything else would be accessed through the human service centers. The numbers would reflect those coming out of the prisons on parole or probations or those under supervision of the department of corrections. JoAnne continues with written testimony.

V. Chair Bowman: You've given us the numbers of the amount of people that have a problem, but what is cost to treat an individual one time the program?

JoAnne Hoesel: That would show up in two places. The actual treatment dollars appear out of the Human Service Centers and then in the last session I did provide you with information of what we came up with what North Dakota's average cost per person is. I can provide that to you again.

V. Chair Bowman: Do you have ballpark figure?

JoAnne Hoesel: No.

Senator Christmann: When people choose to get treatment on their own, do most insurance policies pay for this?

JoAnne Hoesel: North Dakota has a law that requires a level of coverage to mental health and substance abuse services, so if it's a group policy there needs to be a level of substance abuse and mental health that they would cover. If it's a single policy it would be what that policy states as covered. Was your question if they choose who covers them?

Senator Christmann: No, if they're incarcerated, do we get stuck with the bill.

JoAnne Hoesel: It is important to know that human services operates on a sliding fee scale so depending on the persons income that would correlate on how much they pay for their treatment if they do not have insurance.

V. Chair Bowman: We have a young group of people in here and if they can associate and see what that person has done to themselves and all of us are paying for this. Maybe it would be a deterrent to them, knowing what it costs to treat someone. I appreciate what Senator Robinson said, it is treatable but it is a path to struggle through that treatment.

Senator Robinson: We were privileged to hear two young people tell of their story. When you see that, it's more than touching.

JoAnne Hoesel: Research shows that it is an investment into these individuals and society and treatment is a return of $7 for every $1 spent. JoAnne returns to written testimony.

Senator Robinson: I want to encourage the subcommittee to look at education prevention and intervention. In a very short period of time, good things have happened. This eliminates duplication. We have a serious problem in our culture, that beer is ok. The trends aren't getting better, they are going off the charts.

Senator Seymour: With your advisory group is that those who have gone through experiences that are the best advisory members?

JoAnne Hoesel: We do have a recovery counsel that actually pulls in a group of people that you are talking about, that are in recovery and they are providing guidance to us and other agencies on how we can give those people a stronger voice. JoAnne returns to testimony.

Senator Krauter: Do you know where it is located and what the rent on that is?

Joanne Hoesel: Yes, $14.05 per square foot at Prairie Hills Shopping Center.

V. Chair Grindberg: Is that triple net or is it gross?

JoAnne Hoesel: Yes, utilities are included.

Senator Robinson: Can we get a print out on who we are renting from, square footage, locations and the amount of square footage.

JoAnne Hoesel: Going back to testimony.

Senator Robinson: With the increase in compulsive gambling, you are going to reduce that by $150,000? How much are we spending on compulsive gambling?

JoAnne Hoesel: We currently stand at $550,000.

Senator Robinson: We're spending about eight to nine hundred thousand dollars in promotion of the lottery and we're spending half that amount dealing with compulsive gambling. I don't know if that's the message we want to send. We're spending twice as much on promoting gambling than we were in dealing with the affects of gambling. How do you defend that?

Senator Christmann: I felt it odd that the House took out all the grants for the advisory council. There was grant money last biennium but it was through the Governor's office. If they

have no money to give out what is the purpose for the counsel? Can you give me an example of a couple of grants they gave out?

Joanne Hoesel: The grants were to Northern Lights in Hillsboro, Western Family Resources in Dickinson, United Tribe Technical Center in Bismarck, Casselton Youth Task Force in Casselton and the Sunrise Youth Force in Dickenson.

These agencies and those that are on the advisory council continue to have federal dollars that come in and we don't have to adjust what we do because the council has always had this hundred thousand dollars to work with and to support what the direction of the council is. Are next meeting is in April. The advisory council needs to decide how to make that adjustment. So I can't tell you where will end up on that but regardless it is important that there is focus on prevention in North Dakota.

Senator Lindaas: I have a bill about the delivery of alcohol to minors. The alcohol lobby mounted quite a campaign against that in the last session. I think we have to realize those entities benefit from are misfortune in regard to alcohol to minors. In fact, the Center for Disease Control says age youth 12-20 consume eleven percent of alcohol in US. So naturally they are out to protect their interests. Do we do anything within your department to counteract the advertising done within alcohol industry? Or is anything effective?

JoAnne Hoesel: We have a specific Federal Grant, it's for enforcing underage drinking laws. We have a campaign with the Attorney General's office where every school aged child's parent will be receiving something in the mail this week, we are also doing media and the kids will be receiving posters and some other things. We are doing this in preparation of Prom season and other things that are coming up this spring. It's to educate people about the server laws in North Dakota that it is illegal to give underage kids alcohol of which we all know happens in our

state and what can happen with an educational campaign. We feel the parents are the key. The First Lady is involved and the money comes from that grant. We contract with the highway patrol to do underage drinking enforcement activities. We need to get more specific on how to handle underage drinking.

JoAnne Hoesel, Division Director, Department of Human Services:

Written attached testimony # 15.

Nancy McKenzie, Vocational Rehabilitation Division, Department of Human Services:

Written attached testimony # 16.

Senator Robinson: Several of these divisions, travel has been reduced by 50%. Did you project travel costs based on the new rates?

Brenda Weisz: They looked at the travel overall. It was across the board eight percent.

Senator Robinson: Where are your projections?

Brenda Weisz: Our projections based on additional meetings that we needed to go to. We need to get out there and we had an increase in travel.

Nancy McKenzie, Statewide Director, Regional Human Service Centers (HSCs):

Written attached testimony # 17.

Senator Robinson: How extensive is our problem in the area as far as funding, payments for services, the lack of Medicad dollars. What type of dollars are we looking at annually for the centers and the hospital in particular?

Nancy McKenzie: I would have to have Brenda address that.

Brenda Weisz: It would be just over five million at the state hospital.

Senator Mathern: Have we ever penciled out what the net difference would be if we took the entire budget at the state hospital and parceled it out to the 8 regional centers?

Nancy McKenzie: We have not. We certainly believe there is a need for the state hospital.

Senator Mathern: I am assuming you could incent local providers to say they can meet the needs.

Nancy McKenzie: It would mean a change in treatment philosophy and approach in terms of having to have a vote. It would require infrastructure changes. Nancy continues with her written testimony.

Senator Krauter: I would like the subcommittee to spend some time on looking at the regional centers, with staffing, dual management that we have between regions is this really working?

Alex C. Schweitzer, Superintendent, ND State Hospital and ND Developmental Center, Department of Human Services:

Written attached testimony # 18.

Senator Mathern: The original budget before the House made changes didn't have enough in it to pay for your staff?

Alex Schweitzer: No that was put in because you get that many vacancies during the biennium, we get that much salary roll off. We're running 95-100% range and staffed at 85% and that's why we need additional FTEs.

Senator Robinson: The sexual program there, you mentioned there have been some releases and those folks who were not released are they going to be there long term?

Alex Schweitzer: Interesting things happen with the growth of the program. We've been doing a lot more paper reviews than when we started. We're not bringing as many people in for

evaluation because we are discovering that the referrals that are being made to the program, those people can easily be treated as an outpatient. We have the individuals who are the most sexually dangerous in our group. Because of that we are seeing less referrals.

Senator Robinson: When we read in the papers that a sexual predator has moved into community, it might be that he spent time in your program, but there are also individuals that are coming out of other programs, correct?

Alex Schweitzer: Yes, they may be in rural programs and we have the high end offenders. There are more restrictions on the evaluation process.

Additional testimony was handed out:

Marilyn Rudolph, Director, NW Human Service Center, Williston and North Central Human Service Center, Minot:

Written attached testimony # 19 in favor of HB 1012.

Kate Kenna, Director, Lake Region Human Service Center, Devils Lake and Northeast Human Service Center, Rolla:

Written attached testimony # 20 in favor of HB 1012.

Candace Fuglesten, Director, Southeast Human Service Center and South Central Human Service Center:

Written attached testimony # 21 in favor of HB 1012.

Tim Sauter, Director, West Central Human Service Center and Badlands Human Service Center:

Written attached testimony # 22 in favor of HB 1012.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012 - continuing

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: March 4, 2009 PM

Recorder Job Number: 10206

Committee Clerk Signature Rose Laning

Minutes:

Chairman Holmberg called the committee hearing back to order on HB 1012.

Chairman Holmberg: Alex was up there saying, "In conclusion....."

Alex C. Schweitzer, Superintendent, North Dakota State Hospital and North Dakota Developmental Center

Continuing on with written attachment # 18 – page 10, the Developmental Center.

Senator Mathern: Is there a corresponding increase in the department's budget that relates to plans to decrease the residents?

Alex C. Schweitzer: Yes there is, in the DD (Developmental Disabilities) budget.

Subcommittee members: **Senator Fischer, Senator Kilzer, Senator Krebsbach, Senator Warner, Senator Mathern.**

JoAnn Ferrie, Director, Professional Home Care, and member of ND Association for Home Care

Testified in favor of HB 1012. Written attached testimony # 23 & map legend # 24

Senator Warner asked how we address the remote areas that don't have home health care.

JoAnn Ferrie answered saying they also have tele-health monitors for remote areas. There could be a scale, blood pressure cuff, monitor breathing all over the phone. Travel is not reimbursable for QSPs (Qualified Service Provider).

Senator Mathern asked if there were some folks receiving QSP services that already have a job and **JoAnn Ferrie** replied that QSPs provide personal care and sometimes homemaking to individuals who can be physically challenged and with a little bit of help every morning with their personal care, they are able to go to a job.

Jo Burdick, Executive Director, MeritCare Home Care, North Dakota Association for Home Care

Written attached testimony # 25 – tele-health.

Beverley Adams, Executive Director, Health Policy Consortium

Testified in favor of HB 1012. Written attached testimony # 26.

41 50

Senator Mathern asked about hospital capital costs and **Beverley Adams** explained the reimbursement structure through Medicaid.

Senator Krauter: Maggie Anderson presented percentages of increase for the re-basing. I think those percentages were in the executive budgets percentages and wondered if she could get us the percentages from house Amendments, so we can correlate.

Al Stenehjehm, Problem Gambling Advisory Committee, Mental Health Substance Abuse, ND Department of Human Services

Testified in favor of HB 1012. No written testimony.

We have some questions after **JoAnne Hoesel's** testimony. We worked with the Governor's office and had an additional $300,000 put into the budget over the $400,000 for a total of $700,000. The House cut out $150,000 of that increase. The problem it creates is that we have no marketing dollars. We put money into marketing in the lottery, but we don't have any dollars. There are services available to people who have a gambling problem. We asked for $300,000 dollars to put a campaign together to promote and advertise that there is treatment

available. The casinos are unique; they come together and put in money to treat problem gamblers. Through that program, anyone who comes in and represents the fact that they have at least 50% of their problem is associated with casino gambling, they get the treatment covered. We used to cover 8 treatment sessions, now we do 16 because 8 are not enough. (47:00)

Lisa Vig, Gambling Addiction Counselor, Problem gambling Advisory Committee

Testified in favor of HB 1012. Written attached testimony # 27.

(51:52)

Brian Arett, Executive Director, Fargo Senior Services

Testified in favor of HB 1012. Written attached testimony # 28.

Chairman Holmberg: The number of meals in your area that was provided in 2007 was roughly 296,000 meals in region 5. One of the things that there has been concern expressed is the formula that is used to disperse the money. We would welcome your input as we work on this portion of the budget. We want to look at both the money and the formula.

Brian Arett: We would certainly be willing to provide our perspective on that.

Senator Mathern: How many other organizations provide meals that are not on your list?

Brian Arett: The entities that are not listed on this list that provide would probably be the Native American reservations. Every entity is listed, but our request would be for them as well.

Additional written testimony -

Pat Hanson, Executive Director, South Central Adult Services

Written attached testimony # 29.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012 – Public Testimony

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: March 4, 2009

Recorder Job Number: 10209

Committee Clerk Signature Rose Laning

Minutes:

Chairman Holmberg called the committee hearing back to order on HB 1012 with the purpose of providing public testimony.

Dianne Sheppard, Executive Director, The Arc of North Dakota

Testified in favor of HB 1012. Written attached testimony # 30.

Developmental Disabilities in North Dakota: 2009 – attachment 30 A

Closing the ND Developmental Center: Issues, Implications, Guidelines – attachment 30 B

Chairman Holmberg: I have a question relating to critical mass. We are at a 130 or so and the goal in 2011 is to get to 67. At what point does number of residents reach a stage where it's just silly to keep it open. Is it 67, is it 30. Any research on that?

Dianne Sheppard: That number would've probably been 240. When the ARC of ND did the research, we thought it would become apparent that people can and do live in the communities. ND is going to be one of the last states to have institutions for people with developmental disabilities.

Senator Mathern: Section 10 of the bill. Do you have specific wording suggestions for that concern you raised?

Dianne Sheppard: We'd be happy to make some recommendations on that language.

Senator Mathern: What is your opinion as to the continued pressure to keep the developmental center open? Where is that energy coming from?

Dianne Sheppard: It comes from a variety of different areas. Perhaps some of it is good-hearted intentions to keep people safe. It's a safe haven and people have dignity. You're going to need bridge funding to close the developmental center and get the people out into community. The developmental center will have to be funded while you're moving people out and providing community resources. This movement has been going for 30 years.

Senator Lindaas: It's been some time since I've been to the developmental center, my observation was that there were some folks severely affected and required 24 hour/day care. Are you suggesting that could be taken care of out in community?

Dianne Sheppard: Yes, people can be served in their home communities or near a medical facility. They could have their own home, maybe shared with another person. If they have 24 hour staff at the developmental center, they could have 24 hour staff in their own communities living next to friends and family.

Senator Lindaas: There are economies of scale. There are services that can overlap from one person to another that would add to the efficiencies.

Dianne Sheppard: That is exactly why we had an institution that housed over 3500 people - one of the biggest institutions in the country and then we take out human dignity and the quality of life issues.

(18:50)

Janell Regimbal, Sr. Vice Pres., Children & Family Services, Lutheran Social Services of ND

Testified in favor of HB 1012. Written attached testimony # 31 and included attachments A-F.

Senator Mathern: Have you ever heard about Pierre the Pelican? There was a program about 30-40 years ago where we thought every young family should just kind of support. (?) Evidently it all went away.

Shari Doe, Director, Burleigh County Social Services

Written attached testimony # 32 in favor of HB 1012.

Constance J. Keller, Program Services Manager, Prevent Child Abuse North Dakota

Written attached testimony # 33 in favor of HD 1012.

Jean Schafer, Principal, Fort Lincoln Elementary, Mandan, ND

Written attached testimony # 34 in favor of HB 1012.

(27:50)

Larry Bernhardt, Director, ND County Social Service Director's Association

Testified in favor of HB 1012. Written attached testimony # 35.

Need to develop one computer system that works across all lines.

Senator Krauter asked about the issue of the case workers in the county having to enter 4-5 systems and wondered how many bienniums they have talked about this.

Larry Bernhardt: We have talked about it in the last three bienniums, but there have always been other computer needs that have taken priority over that, most recently the MMIS system. MMIS (Medicaid Medical Information System) was terribly antiquated and needed to be fixed.

Senator Krauter: What system does SCHIP go thru? And Larry Bernhardt said that some of it is in text and some is in vision, and when they get the new MMIS system, some of it will be in there.

Senator Mathern asked about the MMIS system and whether it would "talk" with the other systems.

Senator Warner: Just a comment. It seems that we've spent enough money on computer systems for Human Services in the last few years, and I know we've passed the cost of Memorial Bridge, and we're also rapidly closing in on the replacement cost of the capitol building. It's an astonishing amount of money. We had the judiciary budget in the first half of the system. To replace the entire software and computer system of the entire judicial branch of government was only $6 M dollars. It's an astonishing amount of money that I can hardly get my head around it.

(43:00)

Barbara Murry, Executive Director, North Dakota Association of Community Providers

Testified in favor of HB 1012. Written attached testimony # 36.

Dan Howell, Chief Executive Officer, Anne Carlson Center, Jamestown, North Dakota

Testified in favor of HB 1012. Written attached testimony # 37– also

Issues Overview – Critical Needs Staffing - # 37 A

Anne Carlson Statement of Need book - # 37 B

Sandi Zaleski, Regional Program Supervisor, The Village Family Services Center

Testified in favor of HB 1012. Written attached testimony # 38

Chairman Holmberg: This is one that wasn't included in the Governor's Budget. It wasn't removed by the House, is that correct?

Sandi Zaleski: Right.

Senator Mathern: The funding for this service. It is funded in the budget at the level that the Foundation was funding the program.

Sandi Zaleski: I know they have three positions in their base budget, but don't know anything more than that.

(58:25)

Amy B. Armstrong, Project Coordinator, ND Medicaid Infrastructure Grant at the ND Center for Persons with Disabilities at Minot State University.

Testified in favor of HB 1012. Written attached testimony # 39 and also handed out brochure- At a Crossroad, A Brief Overview of the ND Home and Community Based Services Report – attached #39 A

Mark Weber, President, North Dakota Emergency Medical Services Association

Testified in favor of HB 1012. Written attached testimony # 40.

Senator Krauter: We asked earlier for information on the rebasing for those 5 entities ask if you could present it now with the House amendments, what percentages of increase would you need.

Maggie Anderson: I don't have the information with me, but I can provide that.

(71:22)

Carol Watrel, Advocacy Volunteer, AARP North Dakota

Testified in favor of HB 1012. Written attached testimony # 41.

Lynn Fundingsland, Executive Director, Fargo Housing and Redevelopment Authority

Testified in favor of HB 1012. Written attached testimony # 42.

Senator Mathern: We have $19 M in the last stimulus package, and we had testimony from Dept. of Commerce saying they didn't have enough projects to work on and wanted to carry it over to the next biennium. It seems a project like this would fit that area. If it did, can you transfer any of this building money to operations? If the Department of Commerce could give you a million or two million to help with this project, beyond what's in there already, are you able to use some of this for operation or is this just not possible?

Lynn Fundingsland: My understanding is that none of those dollars are available for operational funds. So if we were constructing this project, those dollars could go into that. We can build it. We just can't staff it.

Senator Mathern: Could you take out some of these dollars and put it into staffing and then figure out how to put more money into the building.

Lynn Fundingsland: We can put the money together from these various sources specifically for purchasing order, but none of the figures for operations.

V. Chair Bowman: When you were deciding to build this home, why didn't you pursue the funds to take care of it before you decided to build it? It seems to me like you're building the building and then coming to the state for money to run it. Was the state involved in your building this or deciding to build this building first? Did they say that the appropriate place to come for the operating money was here?

Lynn Fundingsland: It all needs to happen concurrently. We involved Human services from day one in the planning process and the intention was to be here today to make this request.

Jon Mielke, foster parent, Burleigh County

Testified in favor of HB 1012. Written attached testimony # 43.

Carroll Burchinal, foster parent 1 29 09

Testified in favor of HB 1012. No written testimony.

Proposed increases in foster care payments.

Senator Krauter : In the budget, there is a 23-26% increase in foster care depending on the age group and placement, is it still certain that both of you are speaking in support of the governor's budget or in addition to.

Carrol Burchinal: We studied the report and the amount in there doesn't meet the need.

Senator Mathern: What does a foster family get? $440/month is the old rate.

Carrol Burchinal: The new rate would be $584/ month.

(93:20)

Rodger Wetzel, Director, Northland PACE Senior Care Services Program

Testified in favor of HB 1012. Written attached testimony # 44 and PACE brochure # 44 A and

PACE Fact Sheet - # 44 B.

Chairman Holmberg closed the hearing on HB 1012.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: March 9, 2009

Recorder Job Number: 10530

Committee Clerk Signature Rose Laning

Minutes:

Chairman Holmberg called the committee hearing to order on HB 1012 in regards to public testimony for the Human Services bill.

Senator Mathern, District 11, Fargo

Testified in favor of HB 1012.

Last week, we had testimony from **Sandi Zaleski** of the Village in Fargo talking about the service they provide for family decision making. There was some testimony that was a little bit unclear as to whether or not the full funding was in HB 1012 or just partial funding. Neither Sandi, nor other members of the Village staff were able to be here today, so I am offering this information for the committee and it basically clarifies that the amount of money that is in HB 1012 would only be enough to continue this program at 2.6 FTEs for the program is actually more like 15 staff persons. This is something the subcommittee will need to work on.

Presented written testimony from

Sandi Zaleski, Statewide Child Services Agency, The Village, Fargo

Written attached testimony # 45.

Matt Schwarz, parent of daughter with Myotonic Muscular Dystrophy.

Testified in favor of HB 1012. Written attached testimony # 46.

Bruce Murry, Lawyer, North Dakota Protection & Advocacy Project

Testified in favor of HB 1012. Written attached testimony # 47.

Senator Mathern: You begin 2nd paragraph saying you support governor's budget, but then the testimony suggests a lot of changes. I would encourage you to clarify those. I'm afraid when that gets into subcommittee, we don't have the things that are clearly not part of budget probably won't make it.

Senator Fischer: On the $40,000, wasn't there $40,000 that was put into petition for guardianship, isn't that what it was for?

Bruce Murray: Exactly, Mr. Senator, that is correct. The requested appropriation we did in the 2005 bill was $780, 000. And the times having been rather tough in 2005, we decided that only $40,000 was available for (inaudible).

Senator Fischer: But wasn't $40,000 adequate for that service?

Bruce Murray: The $40,000 would be adequate for petitioning only. We still see situations where it's difficult to find somebody willing to be the guardian because there's no funding for outgoing expenses.

Senator Fischer: Exactly what Senator Mathern is saying is important for that piece of wealth is that you have to separate those two pieces before we'll work on them. This would be confusing and won't be considered.

Bruce Murray: I'll plan to submit a follow up, maybe a chart that would help.

Senator Krebsbach: In regards to the guardianship, are these court ordered or un-court ordered?

Bruce Murray: These are all court ordered proceedings. If somebody uses a non-court proceeding, like a power of attorney, that is considered a less restrictive alternative.

(15:47)

Carlotta McCleary, Executive Director, ND Federation of Families for Children's Mental Health

Testified in favor of HB 1012. Written attached testimony # 48.

Rob Hasse, President, ND Chiropractic Association

Testified in favor of HB 1012. Written attached testimony # 49.

(24:25)

James Moench, Executive Director, North Dakota Disabilities Advocacy Consortium (NDDAC)

Testified in favor of HB 1012. Written attached testimony # 50.

(31:45)

Lee Erickson, Hillsboro, State Coordinator, ND SADD (Students Against Destructive Decisions)

Testified in favor of HB 1012. No written testimony.

Carrisa Hirchert, New Rockford, SADD Student of the Year

Testified in favor of HB 1012. Written attached testimony # 51 - Effects on Thinking Tasks.

Jessica Roscoe, Junior at New Rockford Sheyenne High school, Northern Lights Advisory Board

Testified in favor of HB 1012. Written attached testimony # 52 – Funding Prevention Makes Economic Sense, Researchers Say

Matthew Perdue, Senior Ray High School, Member Northern Lights Advisory Board

Testified in favor of HB 1012. No written testimony.

Janet Sabol, President & State Coordinator, National Alliance on Mental Illness

Testified in favor of HB 1012. Written attached testimony # 53.

Leanne Johnson, AASK Director, ND Catholic Charities

Testified in favor of HB 1012. Written attached testimony # 54.

Jon Larson, Executive Director, Enable, Inc., ND Association of Community Providers (NDACP)

Testified in favor of HB 1012. Written attached testimony # 55.

Senator Mathern: In terms of staff, are we getting to a situation where we maybe don't have people? If we increased your money, are you comfortable that we'd have staff to attract. Or is it basically a situation where it's not just money anymore in terms of having adequate staff and less turnover? I'd appreciate your comments.

Jon Larson: North Dakota may be a little unique in this as have a limited workforce and we compete with the other workforce that we have. I believe that the people that are out there if they could make this a career because we're competing with everyone else. Our agency has had on average 6-8 positions open for the last five or six years. Whether that's only a wage issue or not, I'm not sure, but I do know if we could pay people more, we could hopefully attract quality persons who end up staying for a long period of time.

(73:35)

Shelly Peterson, President, North Dakota Long Term Care Association

Testified in favor of HB 1012. Written attached testimony # 56 and Attachment A-E.

Senator Fischer: Talking about staff, they use FMAP money and stimulus money, how do we sustain that in the two bienniums?

Shelly Peterson: Sustainability of the Medicaid budget is a big issue for every state. It can go down to 50 % matching, and if it would ever get that low, we would be in a difficult situation. When we are sustaining it, if we didn't provide money to enhance wages, we will have facilities close and there will be a lesson of burden to the budget. We think with the stimulus money,

assuming it does reach North Dakota, that it is an opportunity. If we had more people in the state that we could recruit from Michigan, we'll have more of a tax base. When we look at our aging population, it puts fear into everybody that we're going to lose a big tax base.

Senator Fischer: Do you think that will offset the money that we invest in wages and will bring people to fill spaces.

Shelly Peterson: I could dream that, but probably not. It's going to cost us money, but it's a good investment that will have some dividends.

Senator Fischer: Do you want a large increase in wages for the care givers and then the first year of the second biennium have to cut it?

Shelly Peterson: No, I would never want to do that. That was the fear in 2001 when you divided $1.15. We dropped turnover 30% when you did that and our turnover cost a lot of money. Right now we're spending a lot on overtime and contract agency staff. If we invest in that workforce as well as recruit, it will create a better future for us.

Senator Fischer: If we fund at a more reasonable rate, quite a bit less or somewhere more in the middle, wouldn't we have a better chance to work within our own budget than rely on the stimulus because we'd be more likely to sustain that than if we get excited about a onetime expenditure.

Shelly Peterson: I don't disagree with you. I'd love to see that stimulus put in, the Healthcare trust fund or another fund. And for Medicaid in the future, I think we need to see something like that. I think there are a number of options that we can do, but as long as we have a safety net and poor people and people that run out of funds, we're going to have a need for Medicaid. The thing that's great about ND is that we have one of the lowest populations of people on Medicaid in nursing homes. We are in the top 5 in the nation for people that don't access Medicaid in nursing homes.

Senator Fischer: I'm not picking on you. I'm talking about all the providers in other agencies.

V. Chair Grindberg: I had a question at a Legislative forum on Saturday. The numbers showing that nursing home enrollment is declining and requests for QSPs to keep people at home is increasing. What if your numbers continue to decline? Do you have any projections for in five years? Or ten years, based on the increasing number of folks eligible by demographic profile? Clearly if we came back in 5 years and there was a 30% reduction in nursing homes, then people would say that is a good thing. How do you balance the escalating budgets versus what the trends are indicating?

Shelly Peterson: When you look at the ten year trend of nursing facility utilization is going down. We are discharging many more people back home, but cost per day is continuing to increase every year. We have people who have high medical needs, but we have good use of long term care. Hopefully with early intervention, we are able to care for people with fewer needs for longer periods in their community and home. When you look at demographics of how we are all aging and we live a long time, and the loss of our younger population through a variety of reasons, it is kind of scary. As we look into the future, we will see a decrease in numbers because technology will help keep people at home. Drug therapy and drug research is helping keep people at home. When you look at the CMS data, people are going into institutional care in far less numbers than they were, even in 2002.

V. Chair Grindberg: What are your expectations with Michigan? I'm a skeptic as far as a thousand families moving from Michigan to ND. I'm not sure what it is you're referencing with the Michigan example?

Shelly Peterson: We have two facilities that just received funding from the Office of Rural Health; Bowman and Watford City. They are going to test this model. They are specifically going to Michigan to recruit families to move to ND and offer them good jobs. There doing

housing inventories so that we have available housing. People looking for jobs are looking for comparable wages. (Explains Michigan recruitment).

V. Chair Grindberg: If it's successful, Governor Granholm will call Governor Hoeven and express her displeasure.

Shelly Peterson: To have that many people unemployed, they are looking for any opportunity to other states, but hoping eventually they will come back home. So we want to make this so attractive that when they move here, it's not temporary, but they'll stay here.

Senator Krauter: The concept of recruiting is a challenging one, but when I look at a specific sector of the economy, and the needs that level and the skill sets that are there. I think there is some opportunity. But I want to get back to the question Senator Fischer asked, if you adjust the salary and benefits, what will workers do with that money?

Shelly Peterson: They pay their bills. They maybe go on a family vacation. They buy a car that's not broken down. These are the people that spend that money.

Shelli handed out testimony from:

Kurt Stoner, Administrator, Bethel Lutheran Home, Williston, ND

Written attached testimony # 57.

Jane Strommen, Director, Community Care

Testified in favor of HB 1012. Written attached testimony # 58.

(102:14)

Arnold Thomas, President, North Dakota Healthcare Association

Testified in favor of HB 1012. Written attached testimony # 59 -also presented testimony from:

Bruce Levi, Executive Director, North Dakota Medical Association

Written attached testimony # 60.

Senator Krauter: When the rebasing study was completed, do you know what the recommendation from the study was?

Arnold Thomas: The charge for the study to the research group was directed to 100 % of cost. The recommendation that was brought to the legislature after it went through the development process was 26% which would raise the reimbursement to 64% of cost. I'll try that again. The study was directed to 100% of cost to provide medical service for the Medicaid population. The number from that study was forwarded to OMB. The bill that was introduced to you was part of the governor's recommendation to recommend that doctors be reimbursed at 64% of their cost based on that study. That amount of money in the general fund was approximately $4.9 M which the governor included in his recommendation. They identified the amount and in the testimony, if you're interested in how much additional general funds would be needed to move Medicaid from 64% to 100% of physician cost, that amount of money is also in there.

Senator Mathern: I don't believe that study was to fund at 64%.

Arnold Thomas: No, it did not. The study was not to recommend. The study was to identify a number. The recommendation that was brought forward to you was a budget recommendation. The hospitals tell us what the costs are relative to what the current payment schedule, we did not ask the consultants to give a recommendation. We wanted to make sure we had a defined number. The recommendation that's before you came through the budget development process.

Senator Kilzer: This is more of a comment, but it seems kind of strange that we did receive the actual costs of various providers, including the hospitals, and yet when we get the executive recommendations, they are all over the place including the dental. The dental was by percentage of billed charges which is ancient. Then we have the hospitals coming in at

100% of rebase. To me it doesn't make sense. In my own mind, I'm trying to think, should we try to bring everybody up to 100% - ambulance drivers, optometrists, or should we do like the House has done or even be a little bit more harsh. I think those are the alternatives that we have. They're going to take a little bit more study and a little bit more action, but I really can't make much sense out of what is being presented to us in either the House or executive conclusions.

Arnold Thomas: When we came to you in last session, we made the case which you accepted and which you funded – that mainly there was a discrepancy between the cost of rendering service and what Medicaid was paying for those services. We made the case, as did others that a study could identify what the gap was between what cost abilitive care versus what we were paid would be of value to you as you went through the appropriations cycle and subsequent sessions of the legislature. You funded that request and outside consultants were hired. They were not the same consultants for each provider group. There are some provider groups that have easier time in laying out their cost information than other provider groups and I believe a previous testifier here representing chiropractic association referenced some of those interactions that were required in order to have that aspect of the study done for them. The manner in which bill came in from the governor's recommendation was not 100% for all of the study groups relative to the gap difference between payment and cost. That is a decision that the private sector did not make nor were they privy to the manner in which the criteria were applied that brought the bill from the House too. And I agree, it does appear rather helter skelter or random. But the numbers you have before you are a product of what you funded in the last biennium to give you a number that you could feel comfortable with by an external source. These methodologies map suspect and these results are not tinged by any manner other than the sciencing in which they were produced. It will give you an estimate of how the

gap is between what you currently pay as a state by policy versus what it is to cost to render that service regardless of the provider group that's concerned.

V. Chair Grindberg: How do we determine cost again? Is that an approval process with the provider submitting their costs and it's approved by the state to achieve that level of certainty that these are legitimate costs? Also, with other states, are we apples and apples as to how costs are defined?

Arnold Thomas: Yes, we are apples to apples. That's why we went with an outside firm. This firm has done these kinds of studies across the country. In terms of whether the documents that are submitted, I can only speak for hospitals. The hospitals submit annually to the federal government or audited financial statements of their income & expenses. Those documents were used in terms of analysis by this outside firm to determine our costs just like they determine our costs for Medicare in terms of what's paid us. And then link that to what the current fee schedule is that is used by the State of North Dakota. The information that is submitted is objective in terms of what we use to define our costs. It's not what we're paid however.

V. Chair Grindberg: Does that presume then a certain rate of reimbursement? That audited financial statement being submitted, does that presume then that there is a gap in revenue because of shortage of state support for reimbursement to get your true calculation?

Arnold Thomas: What that would say is that if it costs me a dollar to render that service and I'm paid $.70 by the state of North Dakota for having rendered that service, there's a $.30 gap.

V. Chair Grindberg: And that shows up on audited financial statements?

Arnold Thomas: And that is where we came up with the recommendation on the rebasing and that translated into how much general funds would be needed to pay hospitals 100% cost and if I'm not mistaken, the governor's budget was $8.

V. Chair Grindberg: And so that information, that gap, is reported on certified financial audits.

Arnold Thomas: Yes. It's the only way that information can stand up to any kind of scrutiny. It's the same information that we submit to all payers.

Senator Krauter: This is a really convoluted issue that I think OMB needs to give us some rationale why some rebased on 100%, some are rebased at 25% and some that rebased at a fee schedule of a minimum average of every bill charged. There is so much mishmash in here. We'd like to think that after we fought this from last session and we agreed to go ahead and do this study, that we'd come out with something that calms the water and this is not going to calm the water. This is going to be rougher water than we had before.

Cathy Schmidt, Director, Valley View Heights Assisted Living, Bismarck, ND

Testified in favor of HB 1012. Written attached testimony # 61.

Many run out of money personally and have to go from Assisted Living to nursing homes because its Medicaid funded.

Joe Sitchie, ND Dental Association

Testified in favor of HB 1012. No written testimony.

Handed out additional information:

Dennis Sommers, Dentist, President, ND Dental Association

Written attached testimony # 62.

Royce Schultze, Director, Dakota Centers for Independent Living

Testified in favor of HB 1012. Written attached testimony # 63.

Tom Alexander, Project Director, ND Medicaid Infrastructure Grant with the ND Center for Person with Disabilities at Minot State University

Testified in favor of HB 1012. Written attached testimony # 64 and attached #64-A

Peer Support services Initiative

Charmaine Yvette Boehler, Bismarck resident with disabilities.

Testified in favor of HB 1012. Written attached testimony # 65.

Tonia Johnston, Dakota Center for Independent Living

Testified in favor of HB 1012. Written attached testimony # 66.

Karen Larson, Private Citizen

Testified in favor of HB 1012. No written testimony.

Her mother has to leave independent living and go into nursing home and on Medicaid.

Sheree Spear, Grant Manager, Cass County Justice & Mental Health Collaboration Project

Testified in favor of HB 1012. Written attached testimony # 67.

Patricia Patron, Executive Director, Family Health Care Center

Written attached testimony # 68.

Leontine Gabel, Utilized services of Quality Service Provider.

Written attached testimony # 69.

Randy Solem, Chairman, Mental Health Planning Council, Department of Human Services

Written attached testimony # 70.

Nancy Kopp, North Dakota Optometric Association

Written attached testimony # 71.

Chairman Holmberg closed the hearing on HB 1012.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012 subcommittee

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: March 11, 2009

Recorder Job Number: 10730 (3:44)

Committee Clerk Signature Rose Laning

Minutes:

Senator Fischer called the subcommittee hearing to order on HB 1012.

Subcommittee members **Senator Fischer, Senator Kilzer, Senator Mathern, Senator Warner** were present and **Senator Krebsbach** entered later.

Senator Fischer informed the committee members that if they need other documents from the department, we should give them a list. There will be more information coming on the funding from the prior biennium budget and executive recommendations, House adjustments and into the Senate all into one document.

Brenda Weisz, CFO, Department of Human Services presented:

1) Percentage increase by major areas of the DHS budget since the 2001-2003 biennium.
2) Inflationary increases granted to provider groups since 1997.
3) Write-offs for the Department for the fiscal year ended June 30, 2008.
4) Status of the MMIS project.
5) Department of Human Services OARs. (Optional Adjustment Request)
6) DHS Comparison of Current 2007-2009 Budget to the 2009-2011 Budget to the Senate.

See attached 1-6.

Senator Fischer reminded them of the red covered booklet that was an Analysis of Changes to the Governor's Budget. HB 1012 starts on page 21 and has the executive budget, the House changes and the House version.

Senator Kilzer said that it doesn't have the present biennium in it.

Senator Fischer: The new one does.

Senator Kilzer said that we have to be careful because we have two red folders. He would also appreciate the two documents that you just showed; the OARs (Optional Adjustment Request) and the summary of the present biennium.

Alex C. Schweitzer, Superintendent, DHS presented:

1. The Average Length of Stay at the ND State Hospital (Fiscal 2008)
2. The Occupancy levels compared to Baseline nursing staffing levels at the State Hospital for calendar years 2006, 2007,and 2008.

See attachments 7 & 8.

TaraLea Muhlhauser, Director-CFS, ND Department of Human Services presented:

1. Foster Care data requested during the Children and Family Services budget presentation. See attached 9.

Senator Mathern reviewed all of the requests that have come to the committee asking for amendments on HB 1012. He presented a partial list of 53 items.

1. Amendment requests by person.
2. List of proposed changes to engrossed HB 1012.

See attachments 10 & 11.

Senator Mathern would like to restore the Governor's budget.

Senator Fischer: Because of several situations that are arising out of this session, is that we go back to the Governor's budget, amend it back to there, and send it back to the House. Otherwise we are going to be discussing amendments and there are some things that we'd like to do also. There may be some amendments or other adjustments that will be made before we send it back. This discussion just started this morning, is that we're going to be discussing all these things with them anyway. The stimulus package is an unknown, so that could come into play piece by piece. So rather than have two discussions over where to fund everything in this budget, and at what level, and what to put back that the House took out, what to take out that the House put in (I think that would be a short meeting). Rather than go through all of that, we'd just put it back there and then go over and have the discussion with them. We've got all the notes of what they took out and then we can take it back out if we feel it's justified or our argument to leave it or the opposite. We've all got some things that we'd like to look at. We'll set up incremental meetings next week, maybe 4 or 5. I want to finish it up so we can move it sometime late next week and put things in the order that we want.

Senator Kilzer: I'd like to have OMB listening because my own one out of five votes comes close to the executive budget. Particularly since we're going to be addressing the stimulus package, in order to make it most effective and to have money the next biennium beyond the one we're talking about. Staying close to the executive budget for the present time and then dealing with the stimulus package will be the best way to approach this. Most of this will occur in the conference committee. There is one question mark very much in my mind and that is the provider reimbursement. It seems to be all over the map so I would like from OMB the explanation, if there is one, of how this came to be, how the rebasing was done and I'd like to see that before I go too much further.

Lori Laschkewitsch, Analyst, OMB: Maggie Anderson would probably be able to give the best explanation as to why the different provider groups have their rebasing calculated in a different way. Our understanding was that a lot of it was based on the way the cost information was provided through the survey. I think the dentists were one of those things brought up the other day. Why that was based on their actual billable charges as opposed to costs. Again that has to do with the cost data that was provided to the committee.

Senator Kilzer asked to see what is available. If it isn't available and is just kind of random, I will put together, with any sources I can find, will be of the quality that I have material available. I do want to work along those lines.

Lori Laschkewitsch: I believe there is very documented information as to how we put this together and it was not in a random manner. There is actual documented substantiated information that explains why and how all of those rebasing calculations were done the way they were for each particular group.

Senator Kilzer: I hope to see them.

Brenda Weisz, Chief Financial Officer, Department of Human Services

If you look at each provider group, the increase from the current biennium to what you saw in the governor's budget, percentage-wise varied quite a bit. That is what makes it look haphazard. When we started last legislative session, the predominant conversation circled around hospitals. The hospitals themselves have a cost report that is standard. They complete that every year. They're required to complete a cost report. As we moved through amendments as they went through the session, other provider groups were added to the rebasing study. Many of the providers that we pay under Medicaid, many of them aren't based on a cost basis at all. They are based on a fee schedule. We took a situation where there was no cost data available and not cost report generated and turned it into a situation where they

had a cost report when no such mechanism existed. As we worked with the consultant that was hired through the money that was provided through the budget, they had to work with these groups to come up with what would be a documented way to pull cost data together when you've never pulled cost data together before. Except for the hospitals, they've had a very standard cost reporting mechanism. Because of that, most of these providers are based on a fee schedule or something different than cost. It was creating a whole another methodology for them to be reimbursed. That's why the costs are all over the board as far as percentage increases. It took what used to be a B schedule and they were paid an X amount based on the fee schedule that was inflated, and instead said we'll pay you a different way. That's why the changes were so different. The cost reports all came in to show providing, except dentists, because they did not have a reporting mechanism to go to cost. And the process to pull that together wasn't able to be accomplished in such a short time frame. There was no cost rebasing report for dentists. Instead, they were part of the study, they were part of the intent language. We looked at another way in which to change their rates to compensate them at a higher level. That's why the percentage of bill charged was used as an average. That's their normal mechanism of pay – as a percentage of bill charges, an average. So that's how the dentists were done. We looked at different scenarios. Last session you raised how the children's services were reimbursed or paid at 75% of average bill charges. The governor's budget recommended that for essentially all services under dental average bill charges. The rest of the report, the vendors came in and they were able to work with those groups and develop a cost report where one never existed before. Then what was the total cost to move them to a cost basis rather than a fee schedule. Those were the OARs that were brought forth is to bring them to the level of cost based. The hospitals in that group were the

only ones who truly had a cost report. So that's where it came from and how everything was developed, so it changed their methodology in which they were currently paid for Medicaid.

Senator Kilzer: Is that how you came up with your rebasing then?

Brenda Weisz: Yes, that's how the rebasing came up. It was taking what used to be a fee schedule and say Now we're basing on your cost.

Senator Kilzer: So when you talk about 100%, you're talking about the actual cost.

Brenda Weisz: Yes.

Senator Kilzer: The second part of the reimbursement is the different percentages. Did your consultant advise the schedules that you have?

Brenda Weisz: Are you talking about the current schedule we have in Medicaid?

Senator Kilzer: Not the current one, but the proposed one. Some providers you had at 25%, some you had at 100%.

Brenda Weisz: No, the consultants only provided to us what would be the dollars needed to move this provider to a cost at reimbursement. When we submitted those optional adjustments in our OARs, OMB and the governor's office reviewed that and looked at the dollar value of the total cost.

Senator Kilzer: Does the 25% figure or the 100% figure, does that come from the governor's office?

Brenda Weisz: Yes, they did decide. They looked at all of what we requested. They looked at the information of total cost. They also looked at various scenarios. The governor's office put everything in his budget at 100% of the cost report that was generated, except for physicians, they put that in at 25% and then ambulance. With the ambulance providers, that was funded at a percentage of Medicare reimbursement. The reason for that was the

methodology and the numerous changes that would be required in order to pay them based on cost. It was a methodology they were familiar with.

Senator Kilzer: And you said the governor's office made this decision?

Brenda Weisz: In consultation with us as to what it would cost. What does it take to go to 25%?

Senator Kilzer: I don't think ambulances are any easier to figure out percentages and actual costs than any other provider, but yet you did that?

Brenda Weisz: We did not parade them at a percentage of cost. We changed their fee schedule to be a percentage of Medicare rather than accept the cost report.

Senator Kilzer: Why didn't you do that for other providers? Because Medicare does have an RVRVS system, you know. They've had it for 25 years.

Brenda Weisz: I think in looking at the budget for DHS and then also the governor and OMB having to look at the priorities for the entire state. When you look at the total value of what it would cost out of pocket to move all of them to 100%. Then also taking a look at all the other priorities.

Senator Kilzer: I would hope you wouldn't do that, because if you have a large group that you don't want to pay 100% to, and then you have a small group that your total outlay isn't a lot because it's a small group. That parallels a situation of you guys, what the House did to you, instead of 5 % like the treasurer's office gets for their increases, you guys, because there's 2200 of you, what did the House propose for you, a 2 % raise?

Brenda Weisz: We did turn in a 100% cost base report for all of them.

Senator Kilzer: I'm very skiddish about coming to conclusions that way based upon the size or what the total outlay may be. I think you've got to keep a procedure.

Brenda Weisz: Just remember there wasn't a cost report generated so there was no way to do an OAR at cost.

Senator Warner: I'd like to see some figures from the department indicating what the cost would be to bring them up the Medicare level of reimbursement. I'm not entirely comfortable with the way it was done either.

Senator Mathern: I also think it's a matter of money how much we are willing to spend. Basically there is this elephant in the room – the federal stimulus package. I am willing to work on an amendment that basically restores the governor's budget, address the House issues, and then send it back. In conference committee, as more and more information becomes available, we'll be better able to decide how much more we want to go.

Senator Fischer: I support **Senator Warner** and **Senator Kilzer** because if we do some amending here such as Senator Kilzer is talking about and others that may want to add amendment that aren't in the governor's budget, if we put them back here to the level that we want them, we got more leverage in conference.

Senator Mathern: I think you're correct and many of those things we will address when we actually see what the bill will look like. If we have the governor's budget, and the House additions, we're going to address some of these things, but not all of them.

Senator Fischer: If there is anything that anyone wants, today is the day to ask them for it so we can proceed with not putting them in, putting them in, whatever we feel is right, and then bring it back to the governor's budget, take it over there and argue with them

Senator Warner: I'd like to see information on DD, CNAs and QSPs. I'd like to see some sort of a baseline to see what they are actually getting paid and if there are inequities within the spectrum. A few years ago, there was discussion that there were considerable discrepancies within the QSPs depending on when they assigned contracts. I don't know if

that was resolved or not, but I'd at least like to have someone talk me through that process. And then if we could see some cost analysis of the $1raise and the $2 raise.

Senator Krebsbach: I think I mentioned yesterday what I wanted and that would have been from the council. We had a lot of additional requests over and above what was in the initial governor's budget. I see the information is here. Senator Mathern has already gotten it.

Senator Mathern: I'll continue working on it. That's just 54 of them. There's more and I'll have them done by tonight.

Senator Warner: I'd like to address the kids aging out of foster care system. Seems like we have a couple of paradigms working through the session; we have the creation of halfway houses, if I understand right, is in the governor's original budget which I think the House did not fund. And then we have another initiative which I think is in policy right now to create a more wrap around process or independent living to be supported as well. We can discuss that as we go forward which of the two paradigms we like best. I really want to see some help for these kids. I think we have much better outcomes by doing some relatively minor things. I would hope that we can have some discussion on which of the two paradigms make more sense.

Brenda Weisz: I think it's HB 1140 is where the policy is. That one is expecting the department to develop rules. Initially it had an appropriation of $700,000 and then it was amended out.

Senator Warner: I'd like to ask to deal with the policy bill, but I suppose if there is no appropriation, we'll never see the policy bill.

Senator Mathern: I think it might still come here. But if we move this way about the executive budget, the money would be there. Having the money is probably more important than having

the correct wording in the policy. We can have the correct wording, but if the department doesn't have any money, it's just a smiley face.

Senator Fischer: Maybe we should get that bill over here because it won't be here. There's no money in it. Get a copy of it so we can look at it.

Senator Fischer: One request I have is Continuous eligibility. Whatever information you have on that, how many counties are cooperating? How many counties are looking for base to base to pump up their budget? The other thing, I'd like to get to the bottom and see why SCHIPS is acting the way it is. The decline in children's health insurance happened within one year after the last Back to School. And Back to School has always shown an increase. I'd like to get some information on that.

Senator Fischer adjourned the hearing.

The subcommittee will meet again on Monday.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012 subcommittee

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: March 19, 2009

Recorder Job Number: 11245

Committee Clerk Signature Rose Laning

Minutes:

Senator Fischer called the subcommittee hearing to order on HB 1012. Rather than go thru page by page, we'll let committee members get the information they need and ask the question they have.

Subcommittee members: **Senator Fischer, Senator Kilzer, Senator Krebsbach, Senator Warner, Senator Mathern** were all present.

Those in attendance from Human Services: Brenda Weisz, Maggie Anderson and JoAnne Hoesel and Lori Laschkewitsch from OMB.

Senator Mathern: Would like to encourage us to make some decision on how much money from the stimulus package will be used for the bill. The information we got earlier this week was helpful in terms of understanding what is available. I would encourage the committee to go through that list and provide some direction as to what we would like to put in this bill from the Federal Stimulus package.

Senator Fischer The stimulus package and how it relates to the following biennium and what we can do and still maintain funding at hold even budget for the following biennium. I asked Brenda if she could give us some insight into it.

Senator Warner had asked for information on Direct Care providers and DD(Developmentally Disabled).

Brenda Weisz handed out two sheets of information:

Wage Comparison – (Benefits are not included) 2009-2011 Biennium – see attached # 1

DD (Developmental Disabilities), Nursing Home, Basic Care and QSP(Quality Service Providers) Salary Scenarios – see attached # 2

Question on how many agencies and individuals enrolled QSP

Maggie Anderson: 139 agencies currently enrolled. 1,579 individuals enrolled as of January 2009.

Discusses salaries

Senator Mathern Is the Department looking at equalizing?

Maggie they are becoming more equal but we still leave that up to the policy makers.

Senator Fischer What is the percentage of nursing home beds being utilized or occupied? Compared to two years ago, are we seeing more usage of QSPs and are there any trends you can relate.

Maggie: The number of clients receiving services is up. We haven't run any data but we can do that. We know that people are accessing those services.

Maggie: If it's easier Attachments A & B of her testimony we show you the licensed beds under the Medicaid occupied beds. It has been fairly consistent and it is trending down a little. The percentage of Medicaid occupied bed has been around 54%. Total occupied beds have been around 5900 and as of August it was down around 5800.

Senator Warner: Is the rate we pay DD providers is that uniform across the system or is there some differential built in for medical fragile?

Maggie; There is a differential for medical fragile and behaviorally challenged.

Senator Warner Can you identify geographically where those clients are?

37% are in the Anne Carlson Center.

Brenda There is money in the governor's budget for at home care also.

Senator Warner Do we compensate due to severity of conditions?

Brenda: They set the money accordingly.

Senator Fischer Within agency is there different rate of compensation based on severity.

Brenda: Currently we don't pay based on the severity of each individual one of the five different levels.

Joanne HB 1556 would address that very thing it is a study on changing reimbursement process to an acuity level for medically fragile and behaviorally challenged.

Senator Warner Differential between agency QSPs and individuals QSP is large. Is there a way of addressing just the individuals and bring them up to a closer level. They don't get any health insurance.

Brenda: That is why the agency QSP number was higher. This was looked at last session.

Senator Warner Are they eligible for Medicaid?. A group that's likely underinsured.

Brenda They have to be eligible and follow into one of the criteria's.

1.5 eligible for FMAP

Discussed the governor's budget and stimulus money that is available (62:30)

Senator Fischer Calculate FMAP 2008 and how much of a reduction.

Brenda: This FMAP was a $10 M impact. ND is still doing better than other states so we believe FMAP will drop, (**Federal Medical Assistance Percentage).**

Senator Warner Were the House changes on utilization based on any projections?

Brenda: On the house side, we looked at projections on how we use to build a budget. They looked at utilization and they thought that some of the nursing home programs were high. SPED was not high. They thought DD, MMIS, were high. We have a hard time getting utilization numbers for physicians.

Senator Fischer You're painting a rosy picture then.

Brenda: Looking at the numbers and the executive budget, it's getting better.

Senator Fischer You can't tell what will happen in the nation over the next few years.

Brenda In North Dakota we seem to ride the storm a little better. Our dips aren't as low as the others but our highs aren't as higher either. Food stamp increased but that is a federal program. We will probably see more people coming forward for food stamps.

Senator Fischer: Staying with Medicaid... Does the department project how many more people will be utilizing nursing homes.

Brenda said that they do look forward and try to project the needs. We don't have a crystal ball.

Senator Warner There has been concern about Job Service taking on ongoing obligations. Do you see any areas in Human Services where we might be taking on an ongoing obligation tied to the stimulus package?

Brenda: Not with our programs. Our sustainability is what this budget is decided to be. SNAP is inflated every October. We have not seen anything similar to that program.

Senator Kilzer: This weekend I spent time looking at medical service providers: Hospital inpatient and outpatient; physicians service; chiropractic services; ambulance service; optometric, I was attempting to find the real cost bases of the services that those providers give. Came up with cost basing for rebasing up to the year 2010. However, it looks like in the budget the request is put in at 100%. That is not what came out of the executive budget. If you make an honest attempt to do rebasing you should follow the results rather than picking winners and losers. I would request that we be given a list of what the 100% rebasing would be and how much it would cost. If the total comes out much higher than what was in the executive budget we need to lower the total let's make the pain kind of equal across the board.

Would someone who knows how to deal with proportions give us the grand total of costs with 100% rebasing and the amount that matches the executive budget in the end?

Brenda: We have colored sheet that shows rebasing 100% for everybody. We also looked at 25% and what would be 90% and 75% for all of them

Senator Kilzer an honest effort was made to rebase equally and I think we should follow the requested study.

Brenda: We will do that.

Senator Mathern: Haven't we been moving towards the ideal, aren't we getting closer to a percentage of costs?

Brenda: In some regard we would be but in some regards that was the purpose of the section that was added to the appropriation bill last time. We wanted to take a look at some increases and inequity. Rates aren't necessarily rebased.

Senator Fischer Is there anything else you want to talk about on the stimulus package?
I would like to talk about Children's health insurance.

Brenda Do you want Maggie to walk through S-CHIP?

Handed out S-CHIP Scenarios – see attached #3.

Senator Fischer In August of 08, there was a drop in children's health insurance and no one seems to know why. It was one year after the last back to School effort or it was also one year after a lot of kids enrolled and you re-enroll once a year. If someone in family needs healthcare and has no insurance, they fall under Medicaid. S-CHIP took 200% net hit to 160%. We were at 140 and last session we changed it to 150. The governor put in 200% and House put it back to 160%.

Brenda: The growth we thought would occur when we moved from 140 to 150 didn't occur. Brenda explained what happened. (35:00)

Maggie negotiated a contract with the blues and a premium number in October. We built a budget on $243.93 and that is what the Blues gave us back in August. The Dept. came in with a final premium of $228.71. Part of the savings would be based on the premium savings.

Senator Warner is the blues number actual cost plus administration?

Maggie it is proprietary.

Senator Kilzer: This is a competitive bidding process and it is proprietary. Have there been any other bids?

Brenda IT would cost the state more if we did the bidding every two years. The Blues have been the only bidders.

Senator Fischer Do you think if the numbers would be greater that someone else would bid on it.

Lori: I don't know if they get more bidders than the Blues but others would have difficult bidding because the Blues have the provider groups.

Brenda: What if there's not enough money put in. Some of the options are: We could fund S-Chip budget at the 200% that the governor recommended and stay with the House numbers just in case the economy changes or numbers come forward. Leave the numbers the same and change the level? more options (29:10)

(27:59)Senator Mathern Wouldn't another contingency be keeping the money the same and permitting the eligibility level to move up to use those recourses? If we use the governor's. budget at 200% and if costs are such that we have more resources we could move up to the Federal level without any more appropriations. Does that work?

Brenda Every time you have a change in Medicaid level, you have to have policy . We want a caseload and cost of implementing that.

Senator Mathern Is the scenario in the executive budget already approved in the federal government. If we're going to do it anyway, why not do it at same time. Just make the request once.

Brenda: That will require an approval from the federal government. I don't think the federal government will let you have a floating level.

Senator Mathern Have we ever requested it and they denied it.

Maggie: We haven't requested that specifically. We are currently at net income but when you go to a gross income test certain children would fall off the program. So we have had those conversations and sent some draft language to CMS and they said absolutely not. You have to pick one eligibility level and any changes to that would require statement changes.

Senator Fischer explained what they did the last biennium . And there was some discussion on another amendment that may come this biennium.

Maggie Anderson: I am going to hand out information that you have requested that will be the background for the Medicaid and SCHIP for children.

Handed out

Income Eligibility Levels for Children's Separate SCHIP programs by Annual Incomes and as a Percent of Federal Poverty Level, 2009 – see attached # 4.

Income Eligibility Levels for Children's Regular Medicaid and Children's SCHIP-Funded Medicaid Expansions by Annual Incomes and as a Percent of Federal Poverty Level (FPL), 2009 – see attached # 5.

Health Steps Outreach Statistics – see attached # 6.

Continuous Eligibility for Medicaid – see attached # 7.

Senator Kilzer: Did you say MN included childless adults?

Maggie: That is correct. It is a very small percent and they have to faze some of those programs out.

Senator Mathern: MN has an online eligibility. Does ND have anything like that?

Maggie: We don't currently have anything like that available but the forms are out there. That is something we are hoping to include in the future. It will have to be state specific.

Senator Mathern asked a question on MN and how they cover. Some discussion followed. Family doesn't really know where money comes from. State takes advantage of funding.

Maggie: MN does have a one stop application. It is similar to ours, where we test for other programs.

Maggie played a piece on her computer as an outreach for the SCHIP program and explained the Healthy Steps program. Attachment #6 Many times we follow up with a form after talking with them and send information. Also send information to schools, clinics. We did have television and radio ads totaling about $45,000 that were aired during the months of August and September. We also used billboards.

Senator Warner Do you have access to data base at DPI for free and reduced lunch.

Maggie We don't because of confidentiality. HB 1478 has amendment for legislative intent to improve outreach efforts.

Discussed eligibility.

Senator Fischer adjourned.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012 subcommittee

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: March 24, 2009

Recorder Job Number: 11508

Committee Clerk Signature Rose Laning

Minutes:

Senator Fischer called the subcommittee hearing to order on HB 1012. **Senator Fischer**, **Senator Kilzer, Senator Krebsbach, Senator Warner**, and **Senator Mathern** were all present.

Brenda Weisz handed out a sheet on wage comparisons – see **attached # 1.**

Brenda Weisz also handed out a sheet addressing **Senator Warner's** concerns on the wages of QSPs and also a sheet on rebasing which explained the rebasing costs at varying percentages – see **attached # 2 and # 3.**

Senator Mathern: I'm wondering if we could take the data we have today and make some decisions on them. I'm hoping we could go thru the bills that affect this budget. The first item that Brenda brought to our attention, the different ways of these different groups. I would recommend we send a bill over to the House giving every group here a $2 increase, and that we would take away the requirement about what we spent on that percent of people under the 80%. Then we'd put some wording in there that would direct the Department of Human Services in the interim to consider the ramifications in the next budget, but making all five of these groups so in the future they'd look at one salary for these five different groups.

Senator Fischer: You mean the providers?

Senator Mathern: Right. These providers that are listed on her sheet here, we can rationalize how to equalize all of them because there are a lot of variables that went into this. But I think we could move ahead with the amount of raise that we recommend to everyone and the wording that we want the department to work on during the interim so there would be someway of making sure that in future budgets we make it the same for all four of these.

Senator Fischer: I think we'll have that discussion; however, the thing is to get to the budget itself. Why don't we take divisions and start working through them, whether we start with this one or not is really immaterial. I like to get through the budget and then deal with considerations. **Senator Kilzer** has done some work on the provider and analysis. So until he's done, I'd like to wait on that because he's gotten all the studies from the department so there will be more input that we'll have to consider.

Senator Mathern handed out Listing of Proposed Changes to Engrossed House Bill No. 1012 – see attached # 4).

Discussion then followed going over Senator Mathern's list on children' health insurance and eligibility, FTEs and equity, dental costs and rebasing, and stimulus money.

There was no action taken and the subcommittee will meet again later.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012 subcommittee

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: March 25, 2009

Recorder Job Number: 11531

Committee Clerk Signature Rose Laning

Minutes:

Senator Fischer: Called the subcommittee hearing to order on HB 1012.

Subcommittee members **Senator Fischer, Senator Kilzer**, **Senator Krebsbach, Senator Mathern** and **Senator Warner** were all present.

Senator Kilzer: Went over attachment # 3 on rebasing from the 3-24-09 meeting. If you averaged everything out across the board, it would be about 65%.

Senator Mathern: I am wondering if it might be a good idea to ask legislative council to prepare an amendment for us to consider that would put all providers to 100% - for our consideration and then going over to the House. I would encourage us to consider an amendment.

Senator Kilzer: That would be one of our options. It would be above the executive budget recommendation. To do that it would be eighty million eight hundred and thirty two thousand four hundred and sixty four and that is well above the executive budget. If we're going to do that, I think we need to think about it awhile.

Senator Mathern: I think now is the time to consider the window of opportunity at looking at the rebasing process across the board. We're having things happening in this budget cycle that probably won't be happening in any other budget cycle.

Senator Warner: If it is policy that we need to bring these people up to par, in order to promote public policy and provide public access this is a time to do it. We need to provide payment for providers at par whatever that costs are.

Senator Mathern: I have some amendments for this issue. Handed out Amendment number 99819: Listing of Proposed Changes to Engrossed House Bill No.1012 - see attachment: # 1. I feel that we need to be prudent about the resources that are available to us. I would like to have us to consider this list of proposed changes. We need to take each and every item regarding the stimulus package and amend that into 1012.

Senator Kilzer: Are some or all of these onetime spending or is there a separation someplace that lists the one time spending items?

Senator Mathern: Most of these are continuing programs. It's adding to the programs we have in place. We could identify these as onetime spending.

Senator Fischer: My concern has always been the first year of the following biennium or the following biennium because these supplemental funds if used improperly will get us into trouble. We don't want to have to cut the budget later to continue in the following biennium.

Senator Mathern: I understand but I would suggest in those programs where there is a concern we make it part of the bill. I think we can identify those things that we believe are one time funding.

Senator Kilzer: The first item is FMAP and there is nothing like FMAP in education.

Sheila Peterson, Fiscal Analyst, and OMB: I just wanted to point out that further direction that we've received recently from federal Health and Human Services Department is that any freed up general fund dollars because of the enhanced FMAP we will have to on a quarterly basis, report where those dollars were spent. We are still trying to sort through all of the details on that. We're hoping that it could be used to fund the 7 and 7percent inflation for the

providers, the rebasing, and those types of things that were in the Governor's recommended budget. As we understand it, it's not even limited to Human Services it could be any general government spending but it will have to be reported, this and the next biennium as well. We'll have to work through that.

Senator Fischer: This is the piece that has confused me the most. Where can we put it and how do we supplant you don't have a pat answer for that.

Sheila Peterson, Fiscal Analyst, and OMB: The guidance is very limited, it recognized that every state will have freed up general fund dollars because of the 6.2 enhanced FMAP. There is an expectation that on a quarterly basis states must report where they spent that freed up money.

Senator Fischer: So if we report that we've used the freed up dollars from FMAP for DOT and we report that can we be in trouble with the FEDS and they say you must send some of that money back.

Sheila Peterson: Right now it appears to be general fund money. They want to make sure we spend it and not saved it. At some point they want to know where we spend the freed up dollars. Before you leave on your 80th day, we have to know where the money is going.

Senator Mathern: The best strategy for the Senate is to include all dollars through the stimulus through HB 1012. Then as more details come and we go to conference, we may have more answers. To go into the conference committee, we should have as much information as possible.

Senator Fischer: We go into the conference committee with the bill the way we want it and not go in to negotiate it based on either inflated of short.

Senator Mathern: Handed out a Listing of Proposed Changes to Engrossed House Bill No. 1012 (#99798) – see attached #2.

Senator Fischer: Are these all OARs?

Senator Mathern: No.

Senator Fischer: Are they in the budget?

Senator Mathern: No they are not in the budget. Maybe everyone is I took them from the people who came to the podium. The original spreadsheet of 100 items is whittled down to this.

Brenda Weisz, Chief Financial Officer, and Department of Human Services: This would be the planning or starting phase.

Senator Mathern: It would be sad if we finish MMIS and then we start on this other project and find out that there are ways that they could be talking together that would be helpful to the staff. If we could find that out early, maybe we could still do something about that. It would be better now rather than a couple years down the road.

Senator Fischer: Where did the numbers come from?

Brenda: It was through a request that we start planning for 2010.

Senator Mathern: A lot of these needs really could be addressed. It could be that some of this could be part of the stimulus package; it doesn't have to be all.

Senator Fischer: OK we'll take it under consideration. Is there anything anyone wants to go over? We're adjourned till Monday. Thank you, Senator Mathern.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1012 Human Services subcommittee

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: 04-03-09

Recorder Job Number: 11733

Committee Clerk Signature

Minutes:

Senator Kilzer opened the subcommittee hearing on HB 1012. We need to get this bill out next week.

Senator Mathern explained his amendments dated 3/31/09 listing of proposed changes to engrossed bill 1012. He asked that the committee consider the proposal before they do the details. The proposal is that we adopt this package and in this package we accept the House additions to the Dept. of HS budget, that we restore most of the executive budget, that we incorporate the Federal Stimulus dollars, and that we add items that I believe there is support for in the full committee for this department. In summary of what I said should be a savings of 17 Million dollars of general funds from the executive budget. He further explained the amendments on where all this fit together.

Senator Kilzer what are the eligibility of enrollees.

Senator Mathern didn't have that information here. He believes they are talking about an increase of about 1000 children we are at 3 or 4000 at this point.

Senator Kilzer asked for those numbers from HS.

Brenda it is the green sheet handed out and the increase is 1158 children.

Senator Mathern: It gives us the BCBS data and we have learned that the premium will be $211 per child per month instead of $228. So that is a decrease from original quote.

Senator Warner is Chips reimbursed the same way.

Brenda we pay a premium and I am not sure how they pay out but they give us an updated premium.

Senator Kilzer as I recall the chips is put out on bid. The Blues have their own fee schedule.

Senator Mathern I requested a comparison of Medicaid rates between chips and BC and the payment is higher in chips in Medicaid. Gave an example where you could compare the exact same service and that too demonstrated that the reimbursement was higher? So I think the providers are reimbursed better under chips than under Medicaid.

Senator Kilzer there are no fee schedules lower than Medicaid?

Senator Mathern and the data supported that. He continued explaining his amendments.

Senator Kilzer are these all House cuts or are there some that you did not restore.

Senator Mathern my intent was to restore them all except minor ones. I did review all these items with leg. Council and the dept. to make sure they are correct. The second group of amendments relating to stimulus funds are on page 3, items #1 through 12. I believe all the stimulus money should be spent but I didn't believe that I would get that through the committee so I considered what the governor's office recommendations were to OMB and HS and added stimulus dollars here with what we would have paid for with general funds. (15.3) describing his proposed changes relating to federal fiscal stimulus funds.

Senator Kilzer tell us what option A and B are. Are they two different ways of using the money?

Senator Mathern yes there are different ways of using the stimulus money. There is no change in the program. We will use it as an enhancement to the existing program or use it so they can put some of the general funds aside for future years.

Senator Kilzer What is the difference in the A or B approach?

Senator Mathern the A approach gives the state of ND about 70 million to use at a future time and use stimulus money instead. The A approach uses stimulus fund to what we thought we would spend general fund for.

Senator Kilzer A is playing it close to the book.

Senator Mathern said he thinks it is taking a risk. The federal government may want us to spend it all. This is moving forward and hopefully there wouldn't be any problems.

That combination of items in that section including the adjustment to recognize the general fund turn back of 30 million dollars provides us in general fund dollars about 100 million. So essentially we have those dollars to work with that we didn't anticipate before.

Senator Kilzer: You are thinking of the 66 ½ million plus the 30 million.

Senator Mathern I imagine the 30mil would have been anticipated at one time, it is a moving target, the closer we get to the biennium the closer the amount will be.

Brenda this is tied to the economic stimulus package.

Senator Mathern because of that we have this extra turn back.

Senator Mathern two sets of amendments left on page 4, 16 items. He continued the explanation of other proposed funding enhancements in hopes of preventing family destruction.

Senator Kilzer Why didn't you include this item in your first series in the cuts made by the house?

Senator Mathern I asked leg. council it was my attempt to keep it all together in one place. If it is in the 1st part, there is money that I wasn't aware of. If I made a mistake we have another $400,000.

Roxanne It is a duplication we missed.

Senator Mathern Item #6 program contracted out to Lutheran Social service where mothers at risk are identified. In the testimony to us this actually reduces women that are turned in for abuse and neglect.

Senator Kilzer this was in another bill. Is that bill alive anywhere else?

Senator Mathern there was a bill called a family support act and I don't know if it is alive.

Roxanne it was defeated today in the House.

. 30.27)

Senator Mathern #7 money will go to disability providers. #8 is applying the same 2 dollar per hour increase in reimbursement to quality service providers. #9 supporting what the counties and the dept. needs to move forward toward the 5 eligibility computer programs.

Question for Brenda on the programs.

Brenda (33.24) we did have a OAR and we did propose that this time around. That is our next priority in the dept. and we will bring that forward again next session.

Senator Kilzer in regard to timing where are we at now.

Maggie Anderson Medical Services Division, MIAS roll out May 2010 that will require a round of training and we will begin that in Sept. of this year. Enrollment will happen in Nov. and about that time we finish with that training we will do a second round of training. She explained the MIAS system.

Senator Kilzer I assume you have your countdown to MIAS training. This is bigger than that?

Maggie we have a plan in place and people working in that ... 37.06

Senator Warner everyone has access.

Maggie it is web faced and we will encourage electronically filed claims.

Senator Mathern continued with item #10 providing money for aging services.

Item #11 address children and family services by the county social services staff.

Item 12 addresses long-term care by putting more money into assisted living and this is a way to keep people out of nursing home care.

Item 13 medical services, taking physician payment to 100% of cost. This would go beyond the executive's request and because the executive's request didn't have the 100%.

Item 14 medical services for pregnant women. We passed that bill out of here. It was defeated in the House so this is putting the money in. it was passed by the Senate.

Item 15 is the peer support program, more in the Northwest, with peer program supports people with mental illness.

Item 16 puts additional funding for guardianship services. All items #1 through #16 are above the funded part of the executive budget. They are all items we heard about in committee and I think they are important. I hope the subcommittee will agree that these are the items we can add to this budget.

Other proposed changes (42.31) page 5. This amendment would permit the providers to make that decision as to how that money is spent. But it would limit it from being available to administrators, contracted employees and the Director of nursing. That language was brought to me by Rep. Kreidt and he talked to Senator Fischer so I put it in here.

Senator Fischer joined the committee.

Senator Mathern continued on item 2 regarding leg. Council doing a study on the impact of veterans who are returning from the Iraq and Afghanistan wars and their families.

Item 3 was my attempt to address Senator Kilzer's concern on method of provider payment changes.

Item 4 was a 2.2 million dollar request on the part of the family health care center in Fargo. I didn't put any dollars in this because there was no hearing on this matter before the appropriation committee.

Senator Fischer this is to build a new building. He was told yes.

Senator Mathern if there is extra money. The amendment is intent not appropriation.

Senator Fischer what will happen to the buildings there. They are in the Cass county health department. They need every bit of that. The goal is that this be build down town, most of the people there are low income.

Senator Kilzer is this the old family practice place.

Senator Fischer it is the Fargo Cass Co health in the same building.

Senator Mathern said that this is a private clinic that serves people of low income and they have a relationship with Merit Care and they use common services and common equipment.

Maggie (can't hear)

Senator Fischer has to do with the residency. They provide services there.

Senator Mathern item 5 is a study on salaries and wages.

Item 6 relates to prior screening. Senator Fischer has an amendment to that.

Senator Fischer put on the agenda.

Senator Mathern #7 on reimbursement. #8 reporting to the budget section. This came to me from the ARC they wanted it in the HS bill. The goal was to make sure it would happen.

Item 9 the FMAP changed again. So we were anticipating the rate which means if we were to fund that we would have to put in 60.69%. Small discussion on this. (19:00)

Senator Fischer they are not in favor of it going down. The average income in the state is going up.

Brenda we got the preliminary number in April and they will finalize it in the Sept.

Senator Mathern just as a recap, this entire package I can summarize this way. Reinstate the House cuts to executive budget, retain the House enhancements, and add the stimulus money, while keeping out 70 million dollars, adding these new items. Adding the intent items

and all those things together translate into a savings of the executive budget of 17million of the general fund. We can do this whole package and tell the House the budget is 17 million less than the governor recommended.

Senator Fischer you are talking about using the stimulus money. You are taking 100 million of stimulus money.

Senator Mathern yes, to the degree OMB and I believe the dept. of HS believes stimulus money needs to be spent or lose it. So that general fund dollars aren't used. That would be the summary of this plan. I heard some other things today, we found another $400,000 that was duplicated and I also recall a conversation with Mr. Schweitzer at the state hospital wherein item 23, 5 staff instead of 6 that is another savings we can place. This is going to be a moving target as we learn more about the stimulus package and the needs in our state. If we adopt this we will be in a good position to negotiate with the House. Our colleagues on the appropriation committee would be delighted if they found we took off 17 million in general funds.

Senator Mathern you will note that these amendments are not in the final style, we hoped that they would be easier to understand.

Senator Fischer I appreciate that

Senator Warner I think this has been quite an adjustment.

Senator Fischer there are almost as many red envelopes on my desk as yours.

We will look at all of these on Monday. We need to start the process.

Senator Mathern we found a few mistakes here, I would like to take out that staff person item 23, at state hospital. Ask leg council how much that saves.

Roxanne $83,508 savings.

Senator Mathern I would have one other suggestion on items on 2nd page, # 2, 3, and 5, there is an option to use stimulus money or increase the program.

Senator Fischer OMB is not ready to answer questions on the stimulus money.

Lori we are hoping to have that tied down soon.

Senator Fischer will they be ready the first of the week?

Lori maybe.

Senator Mathern I took these numbers by what is considered ok with stimulus dollars.

Brenda we will have a child support number on Monday.

Discussion on how much of the stimulus money should be used.

Senator Mathern are you oriented toward using as much stimulus money as possible. They all said yes. I would ask Roxanne in items 2, 3, 5 use the option where we are using the stimulus dollars and that settles that issue.

??Some of those numbers might change.

Senator Fischer I fear we will put in the increases, and then all of the sudden the rug gets pulled.

Senator Mathern I wonder if we don't need a fancy amendment to address that.

Discussion followed on how to do that.

Senator Mathern asked Brenda and Roxanne to work on that and get some workable language.

Senator Warner KEEP THIS AWAY FROM THE BUDGET SECTION if possible.

Senator Fischer dismissed the hearing.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012 subcommittee

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: April 7, 2009

Recorder Job Number: 11773

Committee Clerk Signature Rose Laning

Minutes:

Senator Fischer: called the committee hearing to order on HB 1012. Subcommittee members **Senator Fischer, Senator Kilzer, Senator Krebsbach, Senator Warner** and **Senator Mathern** were present.

Senator Fischer: proposed an amendment that has to do with the Westwood Park in Grafton.

Roxanne Woeste: Legislative Council: It's exactly the same wording as in the bill.

Senator Fischer: Then we'll leave it.

Senator Mathern: The amendment I handed out earlier changes it and that was the reason it was handed out earlier.

Senator Fischer: I'm really happy with this one.

Senator Mathern: I think we have other people on this committee looking at the issue of admissions and readmissions. And would suggest another amendment, involves a screening process of local and regional staff.

Senator Mathern: moved amendment "23-04-05"

Senator Warner: seconded.

Senator Kilzer: Why would you want it that way? So the Developmental center would or would not be forced to take patients.

Senator Mathern: I think the opposite; some of these individuals could be cared for in these communities.

Senator Kilzer: Don't you think the Developmental center do that, rather than the outlying areas?

Senator Mathern: These Centers have excellent staff but should have other input. It doesn't give authority differently, but includes more people choice.

Senator Kilzer: Who do you propose the local people be? Local who?

Senator Mathern: I think the wording on page two, item two of "25-04-05", Proposed Amendment to House Bill No. 1012 – " language of the bill was discussed"

"**23-04-05**" – see attached # 1.

Voice vote on Mathern amendment. Amendment failed.

Senator Krebsbach: Considerable jump in audit fees brought up administration support and audit fees.

Senator Kilzer: monitor FTE and oversees financial statements for OMB.

Senator Krebsbach: I wanted justification for large increase. And haven't had time to do the math. Want to move that the money of $129, be reinstated.

Senator Mathern: (Directed at Leg. Council) is this in the governor's budget or reduction?

Roxanne Woeste: I don't know what audits you are referring to.

Brenda Weisz: (discussed her previous testimony)

Senator Mathern: This is currently in the bill?

Brenda Weisz: Yes.

Senator Kilzer: Is this an additional FTE?

Brenda Weisz: No, It was removed. (Explained reason)

Senator Mathern: I am concerned about the FTE. I am satisfied with audit fees and standards. There were internal controls that were brought up by the auditor. (Directed to Senator Krebsbach) Are you saying you want the fee and staff person?

Senator Krebsbach: I'm not sure the staff person is included. This is just the fees from the auditor's office.

Senator Mathern: I would agree with the fees, the increase makes sense.

Senator Krebsbach: The other question we had was the four FTEs for the Human Service centers and the one FTE for the State Hospital. As we visited, we determined all 4 of those positions should be put back.

Senator Kilzer: This says the administrative code says they need 1 case manager for 60 cases.

Senator Mathern: If that is a move to restore those to the budget, I would second it.

Senator Warner: Move to restore FTE for state hospital.

Senator Mathern: Seconded.

Voice vote passed.

Discussion continued with regards to case managers for the State Hospital in the Global Behavior area. (22:00-

Senator Krebsbach: these are case managers.

Senator Kilzer: they want 5 case managers for health centers. This is acute care at the State Hospital in the Global Behavior area.

Senator Krebsbach: When is the Cooper House going to be up and running?

Senator Mathern: There are people working on it, but it's not running yet.

Senator Krebsbach: It's not connected through the Service Center?

Senator Mathern: It is a separate entity.

Nancy McKenzie: Vocational Rehabilitation, Department of Human Services –

This is a collaborative program – housing, apartments to try and prevent homelessness. It's not a licensed treatment facility; it is a housing program for Fargo. We know that because it was designed for individuals who are homeless or at risk of homelessness, many of the individuals do in fact have very serious mental illnesses and/or substance abuse problems. We have been asked to bring those services these individuals will need to help maintain them in those housing units. These are human service employees who live at the center. Addiction staff and employees assigned to case workers.

Senator Krebsbach: How many patients would 5 FTEs take care of?

Nancy McKenzie: The housing facility is 42 units, so 42 individuals, couples, or small families who are living there.

Senator Krebsbach: Motion to restore 5 FTE positions.

Senator Kilzer: Seconded.

Voice vote passed.

Senator Krebsbach: The House reduced $1M of salaries and wages from general fund and then House removed $2 M from general fund.

Senator Mathern: I presume that's the amendment we've been doing in other bills – basically restoring salary and equity?

Senator Krebsbach: Moved to restore $2 M.

Senator Mathern: Seconded.

Voice vote passed.

Senator Krebsbach: Page 5 of green sheets (see attached #2) #15? – Bottom line – what the House removed. . Personal care option – if they can get an extra person to help they can keep those individuals in their homes longer.

Senator Kilzer: This increases personal care from 8-10 hours.

Senator Krebsbach: Moved to restore the House deletions in personal care.

Senator Mathern: Seconded.

Voice vote passed.

Discussion continued between Sen. Krebsbach and Sen. Fischer with regards to nursing homes and long term care.

Senator Krebsbach: long term care for nursing homes. House decreased this from 7 to 6%.

Senator Fischer: I have notes to keep everything

Shelley Long: Why House went from 7 & 7 to 6 & 6, and $1?

Senator Fischer: On page 4 of green sheets (# 9 & 10), inflationary increases to 6%. More importantly, the House increased money for long term care by $15M of which $5.6M from the general fund to reduce projected caseload utilization. When we were discussing this, how do they project caseload utilization, is it based on the past or numbers looking into the future?

Shelley Long: It has been historically based on past caseloads and historical data which we then project forward. The House had budget targets to reach and this was a way to do it.

Senator Fischer: The department put the number in and the House took it out based on methodology?

Shelley Long: Unless the Department could explain to me otherwise, I believe that was their motive.

Senator Kilzer: Question I have. A 7% increase on inflationary changes of itself; is rather high. Is this really caught up rather than inflation?

Shelley Long: Last summer we were running in double digit inflation, so at that point in time, we made a request to the Governor's office to provide 7% annual inflation for current inflation (summer of 2008), then when we went back and looked when inflators were provided in the previous year of 4% in 07 and 5% in 08, inflation was running higher in both those years, so "Yes" Senator Kilzer it was issue of catch up and inflation was at a higher rate than it is today.

Senator Mathern: I think we should take the governors recommendation when we go to House. As we move to conference committee, let's go back to governor's budget.

Senator Fischer: Gov budget was 7-7-2 and was too much. If we do the 6-6-1 we'll just have another argument in conference committee.

Senator Fischer: Can nursing home capacity.

Shelley Long: We 17% stopped admissions because we don't have staff.

Senator Fischer: You have 4 & 5. 6-6-1 would be good. That is a pretty significant increase

Shelley Long: We'd appreciate anything you can give us because we can't get help.

Senator Krebsbach: moved to stay with House at 6-6-1 for basic care and nursing facilities.

Senator Kilzer: Seconded.

Senator Mathern: That's already in bill.

Senator Krebsbach: I guess we don't need a motion.

Senator Mathern: I move we go to 7-7 for all providers to total $16,208,752, which calculates to a 7% increase across the board.

Senator Warner: seconded.

Voice vote – failed.

Senator Krebsbach: House had done something with the 80th percentile which would not affect all. If we bring it to 100%, it would be $2.9M more dollars in general funds, with that an additional $4.9M federal funds. Can someone explain what the 80th percentile is?

Shelley Long: The 80th percentile limit requires each facility to rank salaries highest to lowest and take 80%. If you have 100 employees, arrange them in highest to lowest and take person #80. Salaries need to be adjusted across the board. What we found wrong with this formula in practice was those with longevity weren't getting raises. To follow up on Sen. Krebsbach's question: To provide $1 to everyone to except administrators, contract employees.

Senator Mathern: We have wording about formula. Formula would say this money is available to all except administrators, and contract employees.

Shelley Long: You don't negotiate with contract employees.

Senator Mathern: I'm ok with leaving that out. Policy question – do we have agreement?

Brenda Weisz: handed out Salary Scenarios. – see attached 3 and explained the $1 increase in salaries.

Senator Kilzer: Is the 80% or 95% reflected in these figures?

Brenda Weisz: IGT is the same as Health Care Trust Fund. There is $50,000 in the fund.

Senator Mathern: I suggest that we do this only using general fund. Would you be interested in going to $2? There is need and we're going to close down a bunch of nursing homes in ND.

Senator Mathern: moved $2 increase in salaries.

Senator Warner: seconded.

Voice vote – failed.

Senator Krebsbach: From the standpoint of avoiding compression and being fair, we should look at 100% and so **I move $1 change.**

Senator Mathern: seconded.

Senator Warner: People at bottom don't get very much and we should make the $1 change.

Senator Kilzer: need to go to source of funding. Some of these funds are anemic and dry because 80% of it has to go to tobacco on measure 3. Money in community health is not there.

Senator Mathern: I view the motion as coming from general funds.

Voice vote – passed.

Senator Kilzer: Various providers have been rebased with projections to June 30, 2010. I reviewed them and they are about as good as you can get. The goal should be to cover costs rather than others making up the difference. Legislature should take some blame because there has been no attempt to pay basic costs. I propose to have a goal of reaching 100% of rebasing costs. Recommend that the hospitals at 100% as in executive budget and all other providers at 75% with the goal of reaching 100%. What can you pay for service and how many people are eligible?

Discussion pertaining to INTENT ensued

Senator Mathern: Wording you are talking about – Roxanne has developed that wording already. Item # 3 of page 5.

Senator Kilzer: Need to have a goal of rebasing to 100% as a goal or there's no purpose in having it done.

Senator Fischer: increases are across the board at 75%

Senator Krebsbach: House left hospitals at 100%. And basically we're restoring back to governor's budget and that was to go to Medicare rates.

Senator Kilzer: proposing everything outside of hospital to go to 75% of rebased figure.

Senator Mathern: Now rebase hospitals and physicians at 100%.

Senator Kilzer: Physicians are paid at 51% of cost. To maintain access, it's better to go this route.

Senator Warner: Is problem that physicians are self employed and not associated with network

Maggie Anderson: We use national, state data.

Senator Mathern: Pay according to cost.

Senator Kilzer: All third party payers have a fee schedule.

Senator Mathern: Move to increase provider rates of physician to 100%. We could take advantage of this data, establish base and it would bring in about $40M to state.

Senator Warner: Seconded.

Voice vote – failed.

Senator Kilzer: moved to 75% of rebased rate. Medicare rates of ambulances are close to 100% of rebasing which are Medicare rates.

Senator Warner: If Medicare rates go up, to have stop loss to keep them from taking advantages rebased to Medicare and then 75% of billable costs, not less than Medicare rates.

Roxanne Woeste: I have hospitals at 100% physicians at 75% and chiropractors at 75%, and restore ambulances to the Medicare rate.

Senator Warner: Moved to add chiropractors to 100%

Senator Mathern: Seconded.

Voice vote – failed

Senator Krebsbach: Where are chiropractors today?

Maggie Anderson: Currently they are all paid at same rate. They are at $19.68. We only cover three codes. With rebasing reports – anywhere from ½ to

Senator Kilzer: Motion to rebase physicians to 75%

Senator Krebsbach: Seconded.

Voice vote – passed.

Senator Kilzer: restore average bill charges to 75%

Senator Warner: Seconded.

Voice vote – passed.

Senator Krebsbach: Moved to restore ambulances to Medicare rate as in executive budget.

Senator Kilzer: Seconded.

Voice vote – passed.

Senator Fischer: Has to do with hospitals that have a high rate of Medicaid reimbursement.

Arnold Thomas: Asked legislature to rebase hospitals at cost. We rebased 33 hospitals up to cost. There was interim study. Based on language put in the amendment before you is for one facility that is high provider. We suggest direct appropriation that triggers threshold.

All this not to be addressed until the new MMIS system is installed.

Senator Kilzer: Was this part of hearings or is this something new? When the department appeared before the whole appropriations bodies in both the House and Senate. Why are we just seeing it now?

Arnold Thomas: There is no federal, state – it's just a matter of timing.

Senator Mathern: The problem was addressed of reimbursement of lab services but no solution was brought forward.

Arnold Thomas: critical access level brought out. Said there was a work in process.

Senator Warner: Moved that the Thomas amendment be approved

Senator Mathern: Seconded.

Roxanne Woeste: This would be $400,000 general fund to department and they'd have to provide grant to facility.

Maggie Anderson: I don't think we can; it would be nice to clarify it over night. We'd have to look into. Federal regulations say one must accept Medicaid payment in full and can't target specific facility. Reading language, I'd need to study this and seek input from CMS. You're looking at a supplemental facility making a payment.

Senator Fischer: We'll table this till morning.

Senator Krebsbach: Move to restore funding for salaries and equity to the Dept. of Human Services which were removed from the House.

Senator Mathern: Seconded.

Voice vote – passed.

Senator Mathern: #7 on page 4. Moved to approve

Senator Fischer: How is daily rate calculated?

Cal Rolfson: Anne Carlson Center: There many levels of disability and this would provide additional funding for developmental disabilities. (This is OAR #5 and didn't make it into governor's budget) (Discussed the different levels)

Senator Warner: If we were to adopt this, how many tiers of severity would there be?

Maggie Anderson: I don't know how this looks with HB 1556 which is a study to study the tier of rates in nursing homes. (Discussion continued)

Senator Warner: This would likely be a provisional solution.

Senator Krebsbach: Move to adopt item # 7 on the Mathern sheets # 99829.01- Long term care

Senator Mathern: Seconded.

Voice vote – passed.

Senator Mathern: Moved- page 2, items 19, 20, 21 of Mathern handouts # 99829.01.

(Read and discussed various minor items left off the executives budget)

Senator Kilzer: Adds up to $1.3 M?

Senator Mathern: This is the House decrease restored and not anything additional. Item #'s 21, 24, and 25 on green sheet.

Roxanne Woeste: – House removed general funds.

Senator Kilzer: Another affected by tobacco money.

Senator Kilzer: Community Health Trust Fund takes 80%

Senator Mathern: Moved to restore compulsive gambling at $100,000 instead of $150,000 as governor budget had. (#25 on the green sheet)

Senator Warner: Seconded.

Voice vote – passed.

Senator Mathern: Moved to restore $150,000 instead of $200,000. This is $50,000 for the Governor's Prevention & Advisory Council grants (#24 on the green sheets).

Senator Warner: Seconded.

Voice vote –failed.

Senator Fischer: Restore $10,000 to Governor's Prevention & Advisory Council grant as in budget.

Senator Kilzer: Seconded.

Voice vote passed

Senator Mathern: Moved Centers for Independent Living to $400,000 of governor's budget. (#21 in green sheet)

Senator Warner: Seconded.

Voice vote –failed.

Senator Fischer: Moved to $150,000 for Centers for Independent Living. (#21 in green sheet)

Senator Kilzer: Seconded.

Voice vote passed.

Senator Fischer: Senior and aging wait until tomorrow because there may be stimulus money.

Brenda Weisz: This takes everything -------NDCC The century code has to be amended. It's not worded correctly. Need this before we can get grants. It gives the department the ability to apply for grants.

Senator Fischer: How much?

Brenda Weisz: We requested $600,000

Roxanne Woeste: Right now there is no funding available. The CC needs the language changed regardless of the funding.

Senator Mathern: Moved amendment – draft # 03122009 – see attached 4.

Senator Krebsbach: Seconded to get language in code.

Voice vote passed.

Senator Fischer: (#5 page 7 of green sheet) onetime funding for extraordinary repairs

Senator Mathern: Moved

Senator Krebsbach: Seconded.

Voice vote passed.

Senator Fischer: (#3 on page 7 of green sheet).

Senator Mathern: Moved funding for 6 FTE positions at State Hospital

Senator Krebsbach: Seconded.

Voice vote passed.

Senator Fischer: Moved to 200% of poverty level

Senator Mathern: Moved to adopt funding for S-CHIP bill.

Senator Krebsbach: Seconded.

Voice vote passed.

Roxanne Woeste: The money is in 1043, but language in 1012.

Senator Krebsbach: Moved to adopt language for HB 1012 that Roxanne proposed – amendment 98013.0205 – see attached 5.

Senator Mathern: Seconded.

Voice vote passed.

Senator Fischer: page 3, paragraph above #7 on green sheet – to restore the medically needy income levels to 83 % of the federal poverty level. Governor's budget level.

(Discussion ensued regarding poverty levels at various income levels)

Senator Mathern: seconded.

Senator Fischer: stepped out of the room

Discussed Senator Mathern page 8 - # 5 green sheet (adult transition residential services)

Talked about stimulus money

Tabled until tomorrow.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012 subcommittee

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: April 8, 2009 am

Recorder Job Number: 11776

Committee Clerk Signature Rose Laning

Minutes:

Senator Fischer called the Human Services subcommittee hearing to order. All subcommittee members were present: **Senator Fischer, Senator Kilzer, Senator Krebsbach, Senator Mathern** and **Senator Warner**.

Senator Fischer asked if there was anything yet from the green sheets that needed to be addressed. One was the family group conferencing initiative.

Senator Mathern: The case load projection from the House - $9.6 M and then the proper funding of FMAP change (Federal Medical Assistance Percentages).

Senator Fischer: We need to do something about the FMAP. The utilization - the rationale is one of the things I would like to know the methodology they used.

Brenda Weisz, Department of Human Services: They did what they had to spend down, but they didn't necessarily agree with our caseload and projections, but in our executive budget, they had already taken into account the decreases in utilization in nursing homes and Medicaid. We reflected those reductions in the budget we brought forth to the House and they felt the utilization was too high, so they brought it down further.

Senator Fischer: When they talk utilizations, are they talking all programs – or for example, you never did access the $1.5 M loan at the bank?

Brenda Weisz: We did not.

Senator Fischer: Did they use that kind of rationale when talking about that. And yet talking to providers, they were in the 90s which would tell me that wouldn't you need that $1.5 M or did you transfer from somewhere else?

Brenda Weisz: We did not transfer it. We had some group homes that didn't open. A group home we had planned to open in the Rolla area didn't open this biennium.

Senator Fischer: And that was included in the appropriation?

Brenda Weisz: Correct. If that had opened we would have cashed part of that loan fund. The discussion about that was more we were right about our caseloads by putting it in a loan fund. We didn't need it. Then our projections for the DD caseloads, we showed them the growth. We showed them the growth in each one of our programs and they felt that $2.476 M of general funds was the number they were going to adjust for caseloads in DD. The same for Medicaid; they looked at our spend down tables for the major areas of spend in hospital physicians. We had done reductions in the executive budget for those areas in utilization, and they reduced the utilization further by $9.6 M general funds. Then when we went to the other area of long term care, we provided them the spend downs and how things were trending. For example, in nursing homes, we reduced our executive budget, which already had a reduction of 94 nursing home beds/month, that we brought forward and they made an additional reduction of $5.6 M general funds to utilization for all services and long term care, except SPED.

Senator Fischer: So you had trend monies on everything?

Brenda Weisz: Right.

Senator Fischer: And you looked into the 09-11?

Brenda Weisz: Right. And that's how we prepare a budget. Based on what we're seeing happening right now, and seeing that trend going down in nursing home beds, for example, we

built a budget and worked with long-term care associations for our bed count to see if we were both seeing things the same way and then brought that forward in the executive budget recommendation.

Senator Mathern: (explained House differences) By all these decreases, the House says they know better than the Department of Human Services. I believe that the DHS numbers are probably correct. If it's a major stumbling block of getting this bill out, maybe we should take those three areas and reduce them somewhat from what the department says, but not go the whole way that the House says we ought to go. That would still give us an opportunity to negotiate. If we just take the House numbers, then what they've got is probably a done deal. That would be $17.6 M taken out. There are actually more people going into the nursing home than allocation.

Senator Fischer: That's the one area there may be less, but the other program that we've developed, that's the one area that could be less people – admissions.

Senator Fischer: Roxanne, if we were to make it contingent dollars, if they should run out. How does that reflect in the budget? As money that's appropriated, no matter what the language is?

Roxanne Woeste: In most cases, we do reflect contingent general fund appropriations and budget status because we assume that they will be spent. There are a few cases where we don't; when they're tied to additional fund revenue growth above and beyond what the legislature is projecting from total general fund revenue growth.

Senator Mathern: That also includes the fact that if the House is correct, then the money isn't spent. It's not permitted to be spent for other areas, or is it?

Roxanne Woeste: That is correct. If contingent appropriation is not accessed, it would be considered turn back at the end of the biennium.

Senator Mathern: It's not like we would lose this money if we put it in and it was not needed. It would come back.

Senator Fischer: It's not a premium, it's only used when there's a case that is eligible and accessed. Roxanne, how was the loan treated last session? There was $1.5 M in available loan to the department. When that was written in, was that loan considered in the budget?

Roxanne Woeste: The loan from the Bank of ND – I do believe we provided the authority for the department to go to the bank and get a loan. And we had to provide them with special fund authority to spend those loan proceeds. Then we had to add in language that if they took out loan, they would need to ask a deficiency appropriation to repay that loan. The Bank of ND loan increases the department's special fund authority because they need authority to spend this. This is considered special funds, but we do need to provide for a way to pay back that loan, so that's the language we add. They have to ask in their budget request for the next biennium, money to pay back that loan. In most cases, that would need to be general fund dollars, unless there's another creative funding source available.

Senator Fischer: If you accessed the loan then, you couldn't match it?

Roxanne Woeste: No. It could be a match with federal dollars, it's just not a general fund appropriation, it's special funds. If the money was accessed, we'd have to figure out how they were going to pay for it.

Senator Mathern asked about the numbers of Developmental Disabilities (DD).

Senator Fischer: The trend lines over the US show that DD is running over 90%. The long term care, with an increase in funding, have fallen in numbers.

Brenda Weisz explained the long term care continuum. .

Senator Mathern: I would suggest that we restore those items that we feel fairly comfortable on and reduce others, and then cut the ones where there are questions.

Senator Fischer: Rather than discuss with Chet Pollert, we can just argue with him.

Senator Mathern moved to put $17 M back in the general fund that they took out. When you're in a conference committee, then the House can explain why they took it out.

Senator Kilzer: Of the $17 M, what is it from the present biennium? How much of a difference? How much difference was it from the present biennium to the executive budget?

Brenda Weisz: The total changes for Medicaid only are $30M in general funds.

Senator Kilzer: So the governor increased his budget by $30 M?

Brenda Weisz replied yes and explained more changes.

Senator Fischer: Thoughts?

Senator Mathern: Let's go one at a time: DD, Long term care, medical services. On DD one, the departments projection of use, we'd need to add $2,476,000. (Green sheet page 6, 1st paragraph, #16) – see attached # 2, dated April 7, 2009.

Senator Warner: DD, long term care, and medical services are all a blend of entitlements?

Brenda Weisz: All of Medicaid funded programs are entitlements.

Senator Mathern moved developmental disabilities services to $2,476,000 (green sheet, page 6 - #16)

Senator Krebsbach seconded.

Discussion – **Senator Krebsbach** said that the department has done a good job and we should support this vote. **Senator Kilzer** agreed.

Voice vote – passed.

Senator Mathern moved to restore long term care to $5,600,000 of general fund. (Green sheets, page 4 - # 10) to reduce projected caseload/utilization rates. The only way this goes down is if people died.

Senator Warner seconded.

Senator Kilzer: Is this skilled care?

Roxanne: It's in #9 and #10 but would restore the money.

Voice vote passed.

Senator Krebsbach: Page 3, item 6.

Senator Mathern moved to restore funding to $9.6 M funding for medical assistance grants.

Senator Warner seconded.

Voice vote passed.

Senator Mathern: One thing not addressed were the things outside of the governor's budget and was not brought by the House. I have list that brought it back to 16 and now it's down to 8.

Senator Mathern presented Listing of Proposed Changes to Engrossed House Bill No. 1012 (99829.01) - see attached #1. He explained the 8 items.

Page 4 - #3, 4 and 6.

Page 5 - #9, 11, 14, 15, 16.

They are important items and have broad support in Senate. If there are others, I would be supportive of that **and I move those 8 items.**

Senator Krebsbach – In #16, are those ordered through the court system?

Senator Mathern: This would not go into effect until a court ordered guardianship would be put into place.

Senator Krebsbach: Do you know if the department has had money available for this in the past?

Senator Mathern: Generally, no. This would just be building on $40,000 that we've tried before to do this or that and $40,000 hasn't really provided the service that is needed. They've had $40,000 and this is requesting $350,000 to actually pay the bill.

Senator Warner: I think what we've had in the past was an amount of money sufficient to establish the framework and the parameters of the equation. It's had a successful test and now it's time to launch.

Senator Krebsbach: If we have a resolution into to study this issue on guardianship because it's a very confused area. The counties are the ones that basically fund it now. It's a question whether it should be funded through the court system or through the Human Service or where it's all at. I'm hoping the study can bring to life what and how we should deal with this because it is becoming a real problem in the state. I'm going to rely on the study to tell me what we should be doing.

Senator Mathern: I support the study, but we've had it before us for a number of bienniums and the need has been demonstrated that the $40,000 that we have put in it so it continues that investigation and continues to support the fact that this is needed.

Senator Fischer: I have to leave and meet with the Lt. Gov., but providing additional funding for family group conferencing initiative, and that's the one where they monitor expectant mothers even from prenatal and decide.....

Senator Mathern: That would be #6, and they're doing that already.

Senator Fischer: I can't support that. It's very intrusive. You're going to ask somebody that knows how to live your life better than you do, and I don't care for that. Somebody has to decide; if you aren't wearing the proper clothing when you come in for prenatal care, someone is going to decide that they need help. My vote would be no.

Senator Mathern: Do you want to exclude that item from the list?

Senator Fischer: My vote would be no, and I think you need to do them one at a time.

Senator Mathern withdrew the motion for the eight items.

Senator Warner moved (# 14 –page 5 on Mathern handout 99829.01) medical assistance benefits for pregnant women.

Senator Krebsbach seconded saying that the language and dollar amount would have to be added to the bill.

Voice vote – passed.

Senator Mathern moved (# 3 – page 4 on Mathern handout 99829.01) adoption services.

Senator Warner seconded and commended people taking on adoption.

Voice vote – failed.

Senator Mathern moved # 4 – family group conferencing.

Senator Warner seconded.

Senator Krebsbach: I could support it if it was at a reduced amount.

Senator Mathern withdrew motion and moved to change #4 to a general fund appropriation of $1.2 M.

Senator Warner: Are we jeopardizing a match?

Brenda Weisz: Those should be ok.

Senator Kilzer: How much money do they have in the budget prior to adding this on?

Senator Mathern: I believe there was a million dollars in this program from a foundation that has ended.

Brenda will check and the item is tabled.

Senator Mathern moved #6 – page 4 of handout 99829.01 (Lutheran Social Services) Healthy Families. They are not judgmental in this approach and this is for people who voluntarily want this service. It's a matter of providing support where requested.

Senator Warner seconded.

Senator Krebsbach: I think this was in SB2396 to expand this program to other communities and it was defeated in House. The $200,000 appears to be to continue the program in Burleigh and Morton Counties.

Senator Mathern: Correct, so that other bill was an expansion which did pass the Senate, but was defeated in the House. This amount of money was not part of that bill.

Voice vote passed.

Senator Mathern moved #9 – page 5 of Mathern handout 99829.01 - information technology program

Senator Fischer would oppose this because I think we need to get MMIS up and running in t the planning and get it in place. Unless the department can tell me how they're going to do this so we're sure that it will match with MMIS. I don't mind doing it, they can start planning on their own and we can fund next session.

Senator Mathern: MMIS is going to go down this track and the hope is that all of these programs will in fact connect; however, this is really trying to bring these programs together.

Brenda Weisz explained eligibility system of counties to start planning process and how they will integrate.

Senator Krebsbach: Is this premature until we get our system up and running?

Brenda Weisz: We had it as an OAR and it was listed. The most we can do is start the planning.

Senator Mathern: My goal would be to spend the $342,500 to get a federal match.

Senator Mathern: I would move item #9.

Senator Warner seconded.

Senator Warner: The cost is part of the state's responsibility, correct?

Brenda Weisz: The replacement of it would be a state expense.

Senator Warner: 100% of the money we are talking about in the next biennium would be a state expense?

Brenda Weisz said they can draw down federal funds at a 50-50 match, but yes, it would be a state expenditure.

Senator Fischer: You're saying this is an obligation to the state at some time or another?

Brenda Weisz: Right. We will have to do something with the systems at one time or another to help with consolidating the number of systems and determine eligibility.

Senator Fischer: At this amount of money?

Brenda Weisz: The OAR was at $18.9 M and this would be the preliminary planning.

Senator Krebsbach: I'm confused. It looks as though we're going to use $685,000 for planning?

Brenda Weisz: Right.

Voice vote – failed.

Senator Mathern: #11 is children and family services. Parent Aide services provided by the county staff. This was brought to us by the counties.

Sandy Bendewald, County Director, Stutsman County Social Services: There are a lot of counties that do not have parent aide services at this point. The funding is limited. It's helping keep kids out of foster care and returning them quicker. It's cost effective by helping to train parents to actually parent their children. It's mostly for expansion to counties.

Senator Warner: Can you distinguish between this and the Healthy Families Initiative that we spoke of a few minutes ago – which is run by a private agency rather than counties?

Sandy Bendewald: The Lutheran Social Services is not a parent aide at all. That's not sending a person actually into the home. Typically it's for kids that are not in foster care yet. We have a social worker that is working with them. One of the tools they have is to send in a parent aide who is the person who actually goes in and teaches them how to get their kids up and go to school. Help teach them how to put together healthy meals, to play with them – and all those skills. So they usually go in three times a week.

Senator Krebsbach: I could probably go with a third of it at $350,000. I don't know.

Senator Mathern moved #11 (page 5 of handout 99829.01) at $350,000.

Senator Warner seconded.

Senator Fischer: Is this new or is this an existing program funded by?

Brenda Weisz: There are no federal funds available. To increase the program, it would have to come from state general funds.

Voice vote – failed.

Senator Mathern moved peer support program (# 15) at an amount of $600,000.

Senator Warner seconded.

Senator Mathern: We need to be open to new programs and keep people out of hospitalization services not only for their benefit, but also for the cost of hospitalization. This peer program has a creative approach to helping.

Senator Krebsbach: I see great value in this program. It sounds good, but not at $600,000.

Senator Mathern moved to substitute $300,000 for the peer support program.

Voice vote passed.

Senator Mathern moved (#16) which was additional funding for guardianship services and moved the amount to $200,000.

Senator Warner seconded.

Senator Warner: Did **Senator Krebsbach** say there was language in another bill?

Senator Krebsbach: I feel this area definitely needs to be funded, but I think I would prefer to hold off until after this interim to see what the study produces.

Senator Mathern: There is great need for this. People are getting many more services because this is not available. One example is to help someone remember to take their medication.

Senator Fischer: We already have those services.

Senator Mathern: Correct, but they don't have full faculties to make that decision and this lets court to help appoint guardian.

Voice vote – failed.

Senator Mathern asked if they want to work on legislative intent language – page 5, #2 & 4.

Senator Fischer: We'll continue this afternoon.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012 subcommittee

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: April 8, 2009 pm

Recorder Job Number: 11795

Committee Clerk Signature Rose Laning

Minutes:

Senator Fischer opened the subcommittee hearing on HB 1012 and all committee members were present.

They want to address the items on the Priorities List passed out by **Senator Fischer** – see attached #1.

Brenda Weisz, Chief Financial Officer, Department of Human Services: Brenda explained the funding that concerns the family group conferencing and the federal funding needed.

Senator Mathern was concerned about the language intent of the bill. Page 5 & 6 on handout #99829.01 – see attachment # 1 (dated 4/8/09 am).

#2 – Returning veterans and their families. Asking the Department of Human Services to come back next legislative session and tell us what kind of impact there is.

#4 - Family healthcare centers and providing legislative intent for the family healthcare centers. The facility in Fargo was asking $3.2 M. I put no dollars in this, but it was intent for the department to work with them if there were some resources, but it directs them to move forward and make direct application for stimulus money. There are no dollars in this wording.

#5 - A study of salaries and wages for employees at basic care and nursing home facilities and employees of developmental disabilities providers to bring them to the same payment level.

#7 – Reimburse home health agencies for home telemonitoring services under the Medicaid program at the same rate as skilled nurse visits. This would be intent language.

#8 – Developmental Center Transition Plan. The DHS shall report to the budget section during the 2009-10 interim on the status of the developmental center's transition plan.

Senator Fischer: They have a plan for that already. In fact, it's updated every biennium. All we'd have to do is ask for it.

Senator Mathern: Would like to cover #2, #4, #5, and #7.

Senator Fischer: Don't we already have a bill or something for returning veterans?

Senator Mathern: That was the agreement that we would put it in this bill. Senator Krauter had wanted another bill and there was a separate amendment to do that. We decided instead to put it into a study format.

Senator Krebsbach: When was the last time we studied the salaries? Home health care, DD, providers.

Brenda Weisz: We've looked at them individually and made adjustments but each legislative session is different.

Senator Kilzer: If we're going to do a study, it should be in coordination with Human Resources because they do a lot of studies.

Senator Krebsbach: Human resources doesn't touch this area. This is outside.

Senator Kilzer: You mean outside of this area.

Senator Mathern: I believe we came up with this wording because as a Senate Appropriations committee, we were getting messages about one person was paid $10/hour or in a different industry it was $12/hour; a different one $13/hour and there were some sense that the level should be about the same for all three groups. But that seemed kind of complicated to really put in a bill and maybe it shouldn't be. It's more of a study.

Senator Kilzer: If we're going to do a study, then we should probably coordinate between instate government and outside of state government through the Human Resources.

Roxanne Woeste, Legislative Council: SB 2044 as amended by the House does provide for a legislative council study and it looks like it's a mandated study referring to the state's long term care system, including geographical boundaries for determining capacity, the need for home and community based services and methodology to identify areas in the state which are in need of additional skilled nursing facility beds, access workforce reimbursement and payment incentives.

Senator Fischer: Everything but disabilities.

Brenda Weisz informed the committee that HB 1556 has rate methodologies.

Senator Krebsbach: Is there a difference in pay by region rather than methodology?

Senator Fischer: There is in everything else. (Gave some Job Service statistics)

Senator Mathern: What would be the changes necessary to establish consistent salaries and wages among the groups? I think that's what the committee was zeroing in on.

Senator Fischer: How do you compare someone in DD as opposed to someone in QSP?

Senator Mathern: When we tried to make those changes to make them all the same thinking it would be fair for everybody. We came to the conclusion that you're coming to that there are some different issues there. So we decided to put it into a study and not to actually make it across the board the same. Some of them get paid windshield time. Some don't. It's a complicated thing. Instead of making all the salaries the same, it seemed like a study would be more appropriate to start out with.

Senator Fischer: How do you put that together?

Senator Mathern: That's why we hire people with a master's degree.

Senator Krebsbach: Roxanne, are you aware of any studies that have been requested of veteran's returning home from service? Roxanne replied that she was unaware of any.

Senator Warner: The language sounds so negative and makes it look like an emerging problem. If we could have a more affirmative description of the services, perhaps the opportunities to provide services, and I think any study should involve some examination of the federal or veterans administration components so we'd see what services are there. Then we can work toward filling in the gaps and bringing a more wrap around approach rather than trying to reinvent the entire process. If we could look at what will be coming from the federal government, in response to their return, and then ways that the state can provide services rather than look at them as an emerging problem.

Senator Fischer: Some of things they are dealing with at Veteran's Home now is different than the Korean War vs. Viet Nam vs. Desert Storm. They all become different because of road side bombs vs. different things. They're having more cases that are specific to different conflicts.

Senator Krebsbach: Senator Warner is on the right track and maybe we should work up something.

Senator Fischer requested Roxanne put some language together to adopt a study for the veterans' issues. Roxanne said she would incorporate it if someone could put it in writing.

Senator Warner: "Shall consider" or mandatory study.

Senator Fischer: "Shall" consider is probably what we want.

Senator Krebsbach: I don't think we should limit it to just those two. It should be all those returning from wars and their families within the system.

Senator Krebsbach moved to changes proposed in #2 (returning veterans and families) – page 5 (#99829.01) in Senator Mathern's handout.

Senator Mathern seconded.

Voice vote carried.

#4 page 5 - Legislative intent – grant- family healthcare center.

Senator Mathern moved #4 in handout # 99829.01.

Failed for lack of second.

#5 page 6 of handout # 99829.01 – Study for salaries and wages

No motion. Dropped.

#7 page 6 of handout # 99829.01 - Reimburse home telemonitoring services.

Senator Krebsbach moved approval.

Senator Warner seconded.

Voice vote passed.

#8 of handout # 99829.01 - Developmental Center Transition Plan

Roxanne Woeste informed them this was already in place.

Senator Warner asked to consider #29 on page 3 Mathern's sheets or #5 on page 8 of the green sheet. To restore funding for an FTE position.

Senator Krebsbach moved to approve #5 on page 8 of green sheet – the young adult transition residential services.

Senator Warner seconded.

Senator Kilzer questioned Brenda. Can you tell me the definition of Medicare disabled is then? If these people don't qualify, who does?

Senator Warner: I would think a good share of these people are fully functional and have employment eventually. That's why it's called transitional.

Senator Kilzer: Under TANF laws isn't there a 5 year maximum eligibility?

Brenda Weisz: But these wouldn't be TANF eligible. We don't know the criteria for disabilities for Medicare.

Discussed the youth transitional homes and providers that work with the youth. This was determined to be a new program. There would be 2 eight bed units – one in Bismarck and one in Fargo. There would be 24 hour staffing. Human Services provides the treatment, but have no place for them to stay.

Senator Fischer said it would be about $50,000 a bed.

Senator Krebsbach said since this is a new program she amended her motion to put in half the money $417,311 and let them decide which location – Fargo or Bismarck.

Alex Schweitzer, Developmental Center of DHS: said they started a transitional program at the state hospital and it's very cost effective.

Senator Warner seconded.

Senator Fischer: Before we vote, add amendment to report back and give a process report.

Voice vote passed.

#4 page 8 of green sheet – restore FTE position. Care coordinators with large caseloads to work with children.

Senator Warner moved the motion.

Senator Mathern seconded.

Senator Mathern this would be support for parents who care for their child at home.

Voice vote –failed.

Senator Fischer's Priorities List – see attached #1.

Roof leak at state hospital - #3 on Priorities list

Senator Warner: Didn't we have a million dollars somewhere else for extraordinary repairs?

Senator Fischer: This was discovered later.

Senator Mathern moved adoption.

Senator Krebsbach seconded.

Voice vote passed.

FMAP drop - #2 on Priorities list - see attached # 1

Senator Fischer: Can stimulus take care of FMAP?

Brenda Weisz: You'll have to offset it. The FMAP money will come in as current servicing. After the economic stimulus goes away, the FMAP will drop even lower than what the current budget is. You'd have to do an offset because we will be short.

Senator Fischer: If we put this in, can we offset it with stimulus?

Brenda Weisz: You can use the general funds that are in the transition column.

Roxanne Woeste: You may talk about transition dollars, it is simply a funding source change from increasing general funds, decreasing special for $9.5 M. When we talk about stimulus

and we talk about a funding source change the other way due to the enhanced FMAP where we're going to decrease the general fund and increase special funds. The two kind of offset one another.

Senator Krebsbach approve FMAP change and have Roxanne draft it properly.

Senator Kilzer seconded.

Voice vote passed.

Aging services – ADRL (Aging and Disabled Resource Link) - #1 on Priorities list – see attached #1.

Brenda Weisz - Yesterday we added the amendment language for that. The executive budget has $600,000 dollars for that purpose and then it was moved into HB 1476 which failed in the House side. There is no money to do this at all. The money started in HB 1012 and it was taken out after 1476 failed and so in order to do this there would have to (inaudible). And regardless of what money is put in, the Century Code would need to be changed based on how it was written.

Senator Krebsbach: So you need language?

Brenda Weisz: The language you took care of yesterday. So we took care of the language and now it's the decision on the money – whether or not you want to put any money in here.

Senator Krebsbach: But you can go after grants?

Brenda Weisz: Yes, with the change.

Senator Krebsbach moved to approve and take $300,000 to get the project off the ground, but wanted to know chances of putting it back in the bill after the House removed it.

Senator Mathern seconded.

Voice vote passed.

Senator Krebsbach moved $100,000 for community of Care project.

Senator Mathern seconded.

Voice vote passed.

Rolla hospital -

Roxanne Woeste read Allen Knudson's draft legislation. Discussion over definition of small hospital.

Arnold Thomas, ND Healthcare Association explained Medicaid reimbursement costs for hospitals and Rolla is just one of many. It's special legislation, there is no other institution eligible and suggested they put a sunset clause on it?

Senator Krebsbach: Is there a way to tie funding to any money that may be received?

Senator Mathern: I don't think relief will come that soon.

Senator Mathern moved for Roxanne to complete amendment with Allen Knudson's help and to figure appropriate money.

Senator Warner seconded.

Voice vote passed.

Brenda Weisz handed out 2009-2011 Selected General Fund Increases – see attached #2.

Roxanne Woeste: Discuss how general fund dollars are going to be used after FMAP. We need a motion to appropriate those dollars. This will be in a separate section of bill and adopting this plan puts money in transitionary and should respect the stimulus money intent.

Senator Kilzer asked about the 7-7 and **Brenda Weisz** said if budget passes out as 6-6-1 then we'll be ok.

Senator Mathern moved the amendments to permit the legislative council to adopt this schedule of use of federal stimulus dollars and to make it consistant with regular requirements with OMB. (#3 page 3 of Mathern handout)

Senator Krebsbach seconded.

Voice vote passed.

Page 5 #10 on Mathern sheets. Older Americans Act meal service providers.

Senator Fischer: I understood there would be stimulus money for this and was told yes.

Roxanne Woeste: In previous motion, you reduced general fund, so if use stimulus money, you need a motion.

Senator Mathern moved to add additional $485,000 dollars.

Senator Warner seconded.

Voice vote passed.

Senator Fischer handed out Proposed Amendment to Engrossed House Bill No. 1012 – see attached #3.

Maggie Anderson: Children would qualify for SCHIP but not Medicaid. The match is higher under SCHIP and explained changes in the bill.

Senator Warner moved the adoption of amendments given by the Department.

Senator Krebsbach seconded.

Voice vote passed.

Senator Mathern brought up item 5 – page 3 on Mathern sheets.

Allows influx of stimulus money to be available for this biennium for independent living. This money will be ending after stimulus money is gone.

Senator Mathern moved to accept Brenda's amendment.

Senator Krebsbach seconded.

Voice vote passed.

Travel expense –

Senator Krebsbach: The House removed $153,344 for travel expense for the department.

I moved to restore 50% of that.

Senator Mathern seconded.

Voice vote passed.

(160:00)

Senator Fischer handed out amendment 98013.0204 by **Senator Christmann** – see attached **#4**.

Senator Krebsbach moved to consider the Christmann amendment.

Senator Kilzer seconded.

Discussion followed on audio or video recording alleged or neglected child abuse cases.

Senator Mathern moved Do Not Pass.

Senator Krebsbach seconded.

Amendment failed.

Senator Fischer closed the hearing on HB 1012.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: April 10, 2009

Recorder Job Number: 11817

Committee Clerk Signature Rose Laning

Minutes:

Chairman Holmberg called the committee hearing to order on HB 1012. Roll call was taken.

Amendment 98013.0206 was handed out – see attached 1. Roll call was taken.

Chairman Holmberg said we'll look at these amendments and also any others.

Senator Fischer moved the amendments .0206.

Senator Krauter seconded.

Senator Fischer began explaining the .0206 amendments reading from the amendment.

Senator Kilzer explained the medical services section of the bill.

Voice vote passed.

Roxanne Woeste, Legislative Council: To increase the funding for rebasing the physician rates to 75%, the increase need from the House version is $29.1 M of which $10.8 M is from the general fund.

Senator Mathern: The options of bringing the physicians up to the same as the hospitals at 100% of cost would be $14 M. That was an option that was considered by the subcommittee, but not adopted. If we went to 100%, we'd have the biggest providers then on an even basis in terms of going forward over the next couple decades. I suspect this budget will be used to consider increases over the next two decades, and rebasing doesn't happen that often, so this would be an opportunity to put those the same.

Senator Christmann: Questioned House's rebasing figures.

Senator Warner: Just a comment. Chiropractors are very small provider group and the difference between 75% and 100% is only $38,000.

Senator Christmann: Is anyone getting slashed?

Senator Fischer: No. (continuing with explanation of amendments)

Senator Kilzer: Situation at Rolla hospital - 31% of total annual revenue is from Medicaid – the only hospital with over 25% of their revenue from Medicaid. Federal CMS will not reimburse outpatient lab and anesthesia services. It's a request for $450,000 – this allows them to stay on their feet.

Senator Warner: I think we need to look at this as temporary expedient. We need to have a series of conversations with the federal delegation, particularly in the area of Indian Health Services.

V. Chair Grindberg: There's a different interpretation with CMS of out Chicago or CMS out of Denver with coding and what is the acceptable cost of reimbursement. There are administrative differences that our national delegation could be of assistance.

Senator Fischer: We could also put a sunset clause on this? Otherwise we will be back here. There has to be help to get these things covered. The hospital administrator said she would love to have any help.

Senator Mathern: Note to committee that there is additional language in this section to make sure Medicaid uses dollars first in this area. In case something would be worked out, those provisions protect the state and make the greatest use of federal dollars.

Senator Fischer read on Section 14 – Developmental Disabilities - $5.13 M Anne Carlson school.

Senator Krauter: Why do we need Section 14 language if it's for all facilities?

Senator Fischer: It's only for the facilities that care for those folks. The only difference between that and developmental disabilities is for the medically fragile and behavioral challenged.

Maggie Anderson, Department of Human Services: Section 22 is related to 2007 HB 1453 that the legislature increased the Healthy Steps model to 150 and authorized the movement of Medicaid from 100 to 133.

Senator Mathern: Can we make a minor change in that section. There are concerns among some families that the movement between Medicaid and S-CHIP is actually a decrease in benefits. Generally they are an increase in resources for a family, but there are families right in the middle of these two programs who have a medically fragile child or a special circumstance. Hopefully we can come up with some language that we could come up by next Monday that would solve that narrow problem with the small number of families. It's a small unintended consequence.

Chairman Holmberg: There may be a few other amendments offered down here and there will be an amendment or two on the floor. We want to button this up so the Council can complete the bill this weekend.

Senator Fischer: I agree there are unintended consequences and some of the things in the Medicaid buy-in with disability children. I think that could be easily fixed.

Brenda Weisz, Department of Human Services: We don't know of any specific case of someone in this situation.

Senator Fischer: Restored the salaries and equity and was told this would be a point of discussion.

Senator Krauter: Section 2?

Senator Fischer: That's stimulus funds.

Allen Knudson, Legislative Council: Section 2 appropriates the stimulus dollars and section 3 is a concern on OMBs part because it says they need to report on use of all stimulus money to the federal government. There are provisions that none of the general fund savings from the FMAP change can be put in rainy day fund. The provision from section 3 indicates that the state treasurer and OMB cannot use any general fund savings resulting from the FMAP change if in this biennium it will be going to the budget stabilization fund. And that amount is $30M. That will show up as an additional general fund turn back.

Senator Krauter: How get $30M?

Allen Knudson: That's the department's estimate of the general fund savings from the FMAP change.

Senator Krauter: Does that include the increase that FMAP is going to experience now in 2009? Wasn't there an increase- or is that in 2012?

Allen Knudson: There's another change in here that adds in general fund dollars for that anticipated change. This just deals with the 07-09 biennium. The remainder of it, OMB also wants to indicate to the federal government where the state is going to use the general fund savings from the FMAP change to the 07-09 biennium and the 09-11 biennium, and the 09-11 biennium is about $66 M. These are where the general fund savings are going to be spent.

Senator Fischer: Continuing explanation of amendments - page 2 in Statement Of Purpose

Senator Krauter: Want to understand rebasing in relation to amendment that was added. The goal should be 100% but we're rebasing physicians to 75%. We're still not providing 100%.

Senator Mathern: The intent is to move to that level in the next biennium

Chairman Holmberg: We set the goal and went three quarters of the way and said next session the department should be looking at that as what the legislature says they should be doing. Then hopefully their budget request to the governor will be at the 100%.

Senator Mathern: Correct.

Senator Fischer: Long term projected caseload/ utilization rates – wherever you see that, we put that in because we don't know the methodology or why the House took those out. We want to get those into conference committee and ask them their rationale for doing that. Same with Developmental disabilities, in talking to providers, they're running at over 90% and we don't know why they took those two out, so there may be changes in those two line items, but we'd like to know why they did it.

Senator Fischer: There are things in here that we need info on. There are also a couple things in here to debate, to like and to take a shot at.

Chairman Holmberg: They must have used a formula. We have gone through these now and it's not perfect, at least it's a step in the right direction. Is it appropriate to pass these and then do amendments and changes to them so we have that basic document? I know there is going to be some discussion on the hospital and a few other things.

Voice vote approval of .0206.

Chairman Holmberg: We have adopted the amendments.

Senator Mathern: I would summarize the presentation by Senator Fischer and we basically did four things. We moved toward governor's budget. We restored items. We verified the federal stimulus and added legislative options and we created intent policy language. The whole thing here is really just four things. I would just suggest that we have a few corrections. One would be S-CHIP that I think we understand.

Chairman Holmberg: That's the one you're going to work out the language with the department and if we have to, we'll do a floor amendment whenever it comes to the floor. A floor amendment with the support of everyone is not a big deal.

Senator Mathern: In the item of legislative initiative - We had a request of $2.3 M for a program called family group conferencing. This is a program that essentially is contracted out to a private agency, the Village Family Service Center. The request was for $2.3 M, however, in our negotiations, it went to $1.2 M at the request of the majority. It was unclear in the amendment process, so it was difficult for Legislative Council to put that amendment in. If majority would agree, I don't' see amendment in there. I think it was the intent of the entire subcommittee to have it in and you'd agree, I'd suggest we move that item in, so legislative council has it. That would be an item under children's family services.

Chairman Holmberg: What page are you looking at?

Senator Mathern: It's not in the notes. It would be placed under the children and family services section and it would be $1.2 M of general funds.

Senator Krebsbach: We intended for that to be included in that at the $1.2M level and I so move.

Senator Mathern seconded.

Voice vote passed.

Senator Mathern: One item we never discussed. After going through the minutes of the folks who testified here - was personal care allowance. That is the number of dollars available for people to have for their personal needs and this is for people most dependant where they have no income. If they are clothing dependent and money that comes to them as gift or money through a benefit program, how much of that money are they able to keep without it being

counted against their eligibility? Going out to eat, going to a movie, buying clothing, paying on potential burial, getting a ride to church. All of this fits under personal care allowance.

I would suggest that we raise that to $100. There was supposed to be an amendment drafted specifically to that effect to bring up here, but it didn't get translated between me and the department correctly. I could bring it up Monday or we could act on it now. The House is at $75 and I think we go with $100 across the board and I suspect we'll negotiate it down the middle when we get it over to the House.

Senator Krebsbach: The initial amount in there was $50/month. The governor had raised it to $60/month and the House amended it to $75/ month which is where we, on this side of the aisle, decided to leave it at the House rate.

Senator Mathern moved we increase to $100 in personal care allowance.

Senator Warner seconded.

Senator Mathern: This is for those who have no means of income. This would provide personal care like hair being done and eating out once a month. I'd like to see that at $100. IF we negotiate to the middle we'd be about the same as MN.

Senator Krauter: It's my understanding that not every individual has $100. Some may have $20, some maybe $30. So say that everyone is going to max out at $100. That's not the scenario. It is not that tough of a dollar amount that we can't negotiate.

Senator Mathern: That would be up to that amount and it's matched by federal dollars. This would be putting in general fund dollars and the federal dollars would then flow into that to make the entire amount.

Voice vote – failed. Motion did not carry.

Senator Robinson: – page 5 of notes in back. I would like to propose for our efforts going in to conference committee that for the Governor's Prevention and Advisory Council, we should go back to the level that was funded in the governor's budget and we use general fund dollars. We're talking the difference of $190,000. I have the privilege of serving on this council. We had enabling legislation two years ago. It's all about prevention and intervention in alcohol and substance abuse across the state. There are grants to communities and organizations that work to provide programming to try and reverse the negative trends we've been experiencing. The group is very broad based; Human Services, Highway patrol, judiciary, higher education. These dollars are an investment in the kids of our state. If we can impact the lives of one or two people, we have more than offset the cost of this program. I commend the active involvement on the part of the First Lady and she has done a lot in the area of tobacco and other substance abuse. Let's go into conference at the governors level – statement that the Senate is behind this program.

Chairman Holmberg: Is that a motion?

Senator Robinson: Yes. $200,000 – general funds.

Chairman Holmberg: Is that $200,000 in addition to the $10,000?

Senator Robinson: No. I would move $190,000 in addition, but the funding source would be general fund dollars.

Chairman Holmberg: Where's the other $10,000 coming from?

Senator Kilzer: That comes from the community health trust fund.

Roxanne Woeste: These grants are currently, for this biennium 2007-09, from the community health trust fund. There will be no money in that fund for 09-11 for this particular program. The governor recommended $200,000 from the general fund. That money was removed by the

House. The Senate subcommittee added back in $10,000 and the motion back on the floor is to add back in $190,000 to get to $200,000 recommended by the governor's budget.

Chairman Holmberg: All in favor of the amendment say "Aye".

Voice vote carried.

Senator Christmann asked about global behavioral health.

Brenda Weisz: Labelled this for capacity issues and explained the program.

Senator Christmann handed out amendments 98013.0207 – see attached #2 and explained them as they related to child abuse investigations. He stated that a parent was accused by social services that his child had abused another child. Social Services ended up putting him on a child abuse & neglect registry. That meant no participation in coaching kids, etc. He appealed it and was denied, but ultimately got the court to overturn the ruling and get him off the registry. The interviews that took place apparently provided the evidence that placed him on the registry, but he could never see them because it was basically notes that someone had taken. He spent a year on the registry and as most of you know, in a small town, the word of things like that spread fast and then when you get taken off the registry, word of that, if it moves at all, moves slow. At best, people hear that there wasn't sufficient evidence. What I believe needs to happen here is when we interview these children in a situation where the interview might be used as evidence against someone, they ought to be taped so that someone can access that tape to provide for their own defense. That's basically what this does. Originally this would have required that the interview be video recorded, but if that wasn't possible to at least audio record it. After talking to some lawyers yesterday, the flaw is that a very good case against someone where something definitely happened, could be thrown out because the tape recorder malfunctioned. This amendment says they have to try to tape it whenever possible. I'm bringing this up with the department here because I respect their

views and they are professionals. They feel that taping could cause kids not to speak out. I respect that, but frankly I don't think there's that much difference in a child's view between being taped as opposed to having someone in the room taking good notes. What little chance there is for that to be an intimidating factor more so than the note taking I think is more than offset by the fact that we need to be able to let people defend themselves.

Senator Christmann moved do pass on amendment .0207.

V. Chair Bowman seconded.

Chairman Holmberg: What is "accordance with section 50-25.1-11"? What are the specifics of that?

Senator Warner: It's the privacy laws.

Chairman Holmberg: These things would be private. They would not be public record.

Senator Seymour: This scares me because it reminds me of the Nixon tapes. They're going to come back and haunt this child someday. In other words, we have this permanent record. I'm not worried about the person being accused. I'm worried about the child that 20 years later a movie shows up.

Senator Christmann: I'm worried about both of them. In this case, things were thrown out because there was insufficient evidence. There were no tapes. Imagine if it really happened and now the case was thrown out because there was insufficient evidence.

Voice vote – carried.

Senator Warner passed out amendment .0208 and explained it. This amendment takes 6-6 which was previously approved by the House and raises it to 7-7-$2. I'm asking this so there is a distinction between the Senate and the House versions. There are two changes in the bill as it stands and this amount would become an item of discussion. Perhaps the 7-7+$2 would be

considered an extravagance, but at least it's a distinction between what the House passed and it would become an item to debate between the conference committees.

Senator Mathern: Remind everyone that the 7-7 increase is the executive budget and I think we should go to that as we go to conference.

Senator Kilzer: A lot of economic changes have occurred since the budget was put together last fall. 7-7-2 may be needed but it's out of line with economic times.

Senator Robinson: I'll support this, but we're turning down people in nursing homes because there is no staff. Not a good trend when we can't staff nursing homes.

Senator Mathern: We can add 7-7 and still, in the entire budget, would still be below the executive budget. The entire budget we're talking about is roughly $11 M from the executive budget and includes a $30 M turn back that we weren't expecting. We can do this and go to House and say our version of HB 1012 is less money than was recommended by the executive budget.

Senator Krauter: Page 2 of amendments. We're $11 M below where the House is at and we're probably about $41 M below the governor's budget. The dollars are there, the economic times may have changed, but when I look at the reduction of the permanent oil trust fund – almost 50%, we're still at a $500,000. The revenues are here to support the governor's budget to do the 7-7-$2. We can be conservative on our conservative numbers and still have positive numbers at the end of the day. I think there's dollars to do this.

Senator Lindaas: My district lies between large metropolitan areas and there are three nursing homes in the area. Nursing home administrators across the state say there are other employment opportunities and so people go from nursing homes to work elsewhere. The competition is pretty fierce. It's been a real struggle for staffing. Let's do this $2 increase and through and put this up where it should be.

Senator Fischer: I intend to resist motion. My emails say they are happy with 6-6-1. It's an increase from the 5-4. If they realize that dollar is $817,000. The concerns were lower rates.

Senator Warner: Economy changing and unavailability of labor – I think we've seen economy become so affluent that people are moving away from this type of work. Oil patch wages are higher, so it's hard to find staff.

Senator Kilzer: FMAP is extremely important and should be paid attention to. With stimulus package at $66 M that is available and will be used for the upcoming biennium. It's not going to be available for the 11-13 biennium, so we need to watch what we're doing here because if FMAP takes a double drop, we'll be in trouble down the road.

Senator Mathern: It's not clear. This budget does not take in an extra $66M in FMAP and say there's nothing available for next time. We're actually socking away a lot of money. The general fund will be going up because of what we have done in this department. The FMAP has been taken into this budget to replace what was anticipated to be general fund dollar use by that amount in section 2 & 3. That money that we thought we were going to spend is now set aside for this use in the future. This increase doesn't mean that we haven't thought of the future. Some think we should have spent that because it came in stimulus dollars. Every dollar that we thought the federal government would not object to us moving over, we actually spent this area of general fund and then moved the general fund dollars over to save.

Chairman Holmberg: Thank you very much. We have a motion and will call the roll on raising it to 7-7-$2 an hour.

A Roll Call vote was taken. Yea: 6 Nay: 8 Absent: 0

Amendment failed.

Senator Warner moved Do Pass as Amended on HB 1012.

Senator Kilzer seconded.

A Roll Call vote was taken. Yea: 14 Nay: 0 Absent: 0

Senator Kilzer will carry the bill.

Chairman Holmberg closed the hearing on HB 1012.

April 7, 2009 1

Mathern amendment

PROPOSED AMENDMENT TO HOUSE BILL NO. 1012

Page 1, line 2, after "sections" insert "23-04-05,"

Page 1, line 3, after "to" insert "requiring a screening prior to admission or readmission to the developmental center at westwood park, Grafton,"

Page 4, line 10, after the second period, insert:

"Section 23-04-05 of the North Dakota Century Code is amended and reenacted as follows:

25-04-05. Qualifications for admission to state facility - ~~Temporary~~ Screening required prior to admission or readmission - Educational or related services without charge for persons twenty-one years of age and under.

1. The superintendent may admit a person to the developmental center at westwood park, Grafton when all of the following conditions have been met:
   a. Application for admission has been made on behalf of the person by a parent or guardian or the person or agency having legal custody, or by the person seeking admission, in accordance with procedures established by the department of human services.
   b. A comprehensive evaluation of the person has been made within three months of the date of application, a report of which has been filed with the superintendent and which, together with such other information or reviews as the department of human services may require, indicates to the superintendent's satisfaction that the person is eligible for admission to the developmental center at westwood park, Grafton.
   c. The person may be admitted without exceeding the resident capacity of the facility as specified in the professional standards adopted by the department of human services.

2. ~~The superintendent~~ No person may ~~admit~~ be admitted or readmitted to the developmental center at westwood park, Grafton, ~~temporarily for the purposes of observation, without commitment,~~ unless that person has undergone a screening process at the developmental center to determine whether the admission or readmission is appropriate. Length of stay criteria may be established under rules ~~as~~ the department of human services may adopt~~, any~~. Any person who is suspected of being able to benefit from the services offered at the center, may be screened to ascertain whether or not that person is actually a proper case for care, treatment, and training ~~in~~ at the ~~state facility~~ developmental center. If in the opinion of the superintendent the person ~~temporarily admitted to the developmental center at westwood park, Grafton~~ screened under this subsection is a proper subject for institutional care, treatment, and training at the developmental center, that person may remain as a voluntary resident at ~~such~~ the center at the discretion of the superintendent if all other conditions for admission required by this section are met.

3. Notwithstanding any other provision of this chapter, no handicapped patient, twenty-one years of age or under, or the estate or the parent of such patient, may be charged for educational or related services provided at the developmental center at westwood park, Grafton. Except as provided in subsection 4, the department of human services has prior claim on all benefits accruing to such patients for medical and medically related services under entitlement from the federal government, medical or hospital insurance contracts, workforce safety and insurance, or medical care and disability programs. For purposes of this subsection, "related services" means transportation and such developmental, corrective, and other supportive services, as determined by the department of public instruction, as are required to assist a handicapped

patient to benefit from special education. The cost of related services other than medical and medically related services must be paid by the developmental center at westwood park, Grafton, the school district of residence of the handicapped child, and other appropriate state agencies and political subdivisions of this state. The department of public instruction, the department of human services, the school district of residence, and other appropriate state agencies and political subdivisions, as determined by the department of public instruction, shall determine and agree to that portion of related services, other than medical and medically related services, for which each agency and political subdivision is liable. The department of public instruction may adopt rules necessary to implement this section.

4. Parents of a handicapped patient, twenty-one years of age or under, are not required to file, assist in filing, agree to filing, or assign an insurance claim when filing the claim would pose a realistic threat that the parents would suffer a financial loss not incurred by similarly situated parents of nonhandicapped children. Financial losses do not include incidental costs such as the time needed to file or assist in filing an insurance claim or the postage needed to mail the claim. Financial losses include:
   a. A decrease in available lifetime coverage or any other benefit under an insurance policy.
   b. An increase in premiums or the discontinuation of a policy.
   c. An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim unless the developmental center pays or waives the out-of-pocket expense."

SECTION 6. AMENDMENT."

Page 5, line 1, replace "**6**" with "**7**"

Page 5, line 18, replace "**7**" with "**8**"

Renumber accordingly

25-04-05. Qualifications for admission to state facility - ~~Temporary~~ Screening required prior to admission or readmission - Educational or related services without charge for persons twenty-one years of age and under.

1. The superintendent may admit a person to the developmental center at westwood park, Grafton when all of the following conditions have been met:
   a. Application for admission has been made on behalf of the person by a parent or guardian or the person or agency having legal custody, or by the person seeking admission, in accordance with procedures established by the department of human services.
   b. A comprehensive evaluation of the person has been made within three months of the date of application, a report of which has been filed with the superintendent and which, together with such other information or reviews as the department of human services may require, indicates to the superintendent's satisfaction that the person is eligible for admission to the developmental center at westwood park, Grafton.
   c. The person may be admitted without exceeding the resident capacity of the facility as specified in the professional standards adopted by the department of human services.
2. ~~The superintendent~~ No person may ~~admit~~ be admitted or readmitted to the developmental center at westwood park, Grafton, ~~temporarily for the purposes of observation, without commitment,~~ unless it is first established that the person cannot be appropriately served through community-based programs and services in the person's home community, or as close to as possible. If admission is sought because programs or services are not available in the person's home community, the programs and services necessary to allow for education or related services to be provided in the student's home community must be identified and a plan to develop those programs and services shall be created and fully implemented by the appropriate agency no later than the next school year. Any person recommended for admission may not be admitted unless that person has undergone a screening process at the developmental center, with the involvement of local and regional staff, to determine whether the admission or readmission is appropriate. Length of stay criteria may be established under rules as the department of human services may adopt, ~~any~~ but no person may remain. Any person who is suspected of being able to benefit from the services offered at the center, to ascertain whether or not that person is actually a proper case for care, treatment, and training ~~in~~ at the ~~state facility~~ developmental center. If in the opinion of the ~~superintendent~~ interdisciplinary team, the person temporarily ~~admitted to the developmental center at westwood park, Grafton~~ screened under this subsection is a proper subject for institutional

care, treatment, and training at the developmental center, that person may remain as a voluntary resident at ~~such~~ the center at the discretion of the superintendent on a temporay basis only until the community based services required by this section are in place if all other conditions for admission required by this section are met.

3. Notwithstanding any other provision of this chapter, no handicapped patient, twenty-one years of age or under, or the estate or the parent of such patient, may be charged for educational or related services provided at the developmental center at westwood park, Grafton. Except as provided in subsection 4, the department of human services has prior claim on all benefits accruing to such patients for medical and medically related services under entitlement from the federal government, medical or hospital insurance contracts, workforce safety and insurance, or medical care and disability programs. For purposes of this subsection, "related services" means transportation and such developmental, corrective, and other supportive services, as determined by the department of public instruction, as are required to assist a handicapped patient to benefit from special education. The cost of related services other than medical and medically related services must be paid by the developmental center at westwood park, Grafton, the school district of residence of the handicapped child, and other appropriate state agencies and political subdivisions of this state. The department of public instruction, the department of human services, the school district of residence, and other appropriate state agencies and political subdivisions, as determined by the department of public instruction, shall determine and agree to that portion of related services, other than medical and medically related services, for which each agency and political subdivision is liable. The department of public instruction may adopt rules necessary to implement this section.
4. Parents of a handicapped patient, twenty-one years of age or under, are not required to file, assist in filing, agree to filing, or assign an insurance claim when filing the claim would pose a realistic threat that the parents would suffer a financial loss not incurred by similarly situated parents of nonhandicapped children. Financial losses do not include incidental costs such as the time needed to file or assist in filing an insurance claim or the postage needed to mail the claim. Financial losses include:
   a. A decrease in available lifetime coverage or any other benefit under an insurance policy.
   b. An increase in premiums or the discontinuation of a policy.
   c. An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim unless the developmental center pays or waives the out-of-pocket expense.

April 8, 2009 PM 3

PROPOSED AMENDMENT TO ENGROSSED HOUSE BILL NO. 1012

Page 1, line 3, after "25-04-05" insert ", 50-24.1-02.6"

Page 1, line 4, after "screenings" insert ", to medical assistance eligibility for minors"

Page 1, line 5, after "fund" insert "; and to repeal section 4 of chapter 422 of the 2007 Session Laws, relating to the effective date of the expansion of medical assistance benefits"

Page 7, line 22, after "Section" insert "50-24.1-02.6 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-02.6. ~~(Contingent effective date - See note) Medical assistance benefits - Eligibility criteria.~~

~~1. The department shall provide medical assistance benefits to otherwise eligible persons who are:~~

~~a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and~~

~~b. Minors who have countable income that does not exceed an amount determined under subsection 3.~~

~~2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.~~

~~3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law, that provide an income level for all minors born before September 30, 1983, equal to one hundred percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined and that do not exceed legislative appropriations for that purpose.~~

~~4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.~~

~~(Contingent effective date - See note)~~ Medical assistance benefits – Eligibility criteria.

1. The department shall provide medical assistance benefits to otherwise eligible persons who are:
   a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and
   b. Minors who have countable income that does not exceed an amount determined under subsection 3.
2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.
3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law~~, that provide an income level for all individuals~~

~~from birth through age eighteen equal to one hundred thirty-three percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined~~.

4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.

SECTION 12. AMENDMENT. Section"

Page 7, line 30, replace "**12**" with "**13**"

Page 8, after line 21, insert:

"**SECTION 14. REPEAL.** Section 4 of chapter 422 of the 2007 Session Laws is repealed."

Renumber accordingly

4-8-09 pm 4

98013.0204
Title.

Prepared by the Legislative Council staff for
Senator Christmann
April 1, 2009

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

Page 1, line 3, after the semicolon insert "to create and enact a new subsection to section 50-25.1-05 of the North Dakota Century Code, relating to the recording of interviews in child abuse or neglect cases;"

Page 7, after line 29, insert:

"**SECTION 12.** A new subsection to section 50-25.1-05 of the North Dakota Century Code is created and enacted as follows:

All interviews of the alleged abused or neglected child conducted under this section must be audio-recorded and, when possible, video-recorded. A recording may not be disclosed except in accordance with section 50-25.1-11."

Renumber accordingly

Prepared by the Legislative Council staff for
Senator Fischer
April 2, 2009

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

Page 5, after line 13, insert:

"**SECTION 10. LEGISLATIVE INTENT - DEMENTIA CARE SERVICES.** It is the intent of the sixty-first legislative assembly that the department of human services integrate the dementia care services program established in House Bill No. 1043 with the home and community-based care services programs of the department."

Renumber accordingly

Prepared by the Legislative Council staff for
Senator Fischer
April 9, 2009

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

Page 1, line 2, after the first semicolon insert "to provide a contingent appropriation"

Page 1, line 3, remove the first "and" and after "25-04-05" insert ", 50-06-29, 50-24.1-02.6"

Page 1, line 4, after "screenings" insert ", the establishment of an aging and disability resource link, medical assistance eligibility"

Page 1, line 5, after "fund" insert "; and to repeal section 4 of chapter 422 of the 2007 Session Laws, relating to the effective date of the expansion of medical assistance benefits"

Page 1, line 17, replace "2,148,542" with "7,664,509" and replace "13,660,900" with "19,176,867"

Page 1, line 18, replace "(13,582,286)" with "(12,979,144)" and replace "46,528,070" with "47,131,212"

Page 1, line 20, replace "($11,434,02911)" with "($5,314,920)" and replace "60,188,970" with "66,308,079"

Page 1, line 21, replace "(16,622,573)" with "(14,544,808)" and replace "34,041,261" with "36,119,026"

Page 1, line 22, replace "5,188,544" with "9,229,888" and replace "26,147,709" with "30,189,053"

Page 2, line 3, replace "18,552,432" with "16,221,145" and replace "43,963,473" with "41,632,186"

Page 2, line 4, replace "4,364,279" with "5,166,224" and replace "72,176,081" with "72,978,026"

Page 2, line 6, replace "111,111,588" with "111,596,588" and replace "455,130,804" with "455,615,804"

Page 2, line 7, replace "189,244,935" with "214,327,791" and replace "1,306,432,756" with "1,331,515,612"

Page 2, line 10, replace "310,797,543" with "334,836,057" and replace "1,877,716,114" with "1,901,754,628"

Page 2, line 11, replace "223,418,640" with "271,469,623" and replace "1,350,082,207" with "1,398,133,190"

Page 2, line 12, replace "87,378,903" with "63,366,434" and replace "527,633,907" with "503,621,438"

Page 2, line 17, replace "715,235" with "1,026,397" and replace "8,209,132" with "8,520,294"

Page 2, line 18, replace "2,135,169" with "4,080,946" and replace "18,917,773" with "20,863,550"

Page 2, line 19, replace "823,712" with "1,153,359" and replace "10,641,067" with "10,970,714"

Page 2, line 20, replace "3,509,556" with "4,178,237" and replace "25,616,905" with "26,285,586"

Page 2, line 21, replace "3,699,225" with "5,370,959" and replace "29,760,855" with "31,432,589"

Page 2, line 22, replace "573,509" with "1,101,416" and replace "15,257,320" with "15,785,227"

Page 2, line 23, replace "3,675,196" with "4,489,089" and replace "24,362,468" with "25,176,361"

Page 2, line 24, replace "964,207" with "1,891,646" and replace "10,762,996" with "11,690,435"

Page 2, line 25, replace "9,519,982" with "12,508,784" and replace "66,911,926" with "69,900,728"

Page 2, line 26, replace "6,195,786" with "7,221,144" and replace "52,989,719" with "54,015,077"

Page 2, line 27, replace "31,811,577" with "43,021,977" and replace "263,430,161" with "274,640,561"

Page 2, line 28, replace "12,094,114" with "16,139,178" and replace "124,851,343" with "128,896,407"

Page 2, line 29, replace "19,717,463" with "26,882,799" and replace "138,578,818" with "145,744,154"

Page 3, line 3, replace "112,284,910" with "100,443,152" and replace "692,360,434" with "680,518,676"

Page 3, line 4, replace "218,890,181" with "359,035,678" and replace "1,508,974,811" with "1,649,120,308"

Page 3, line 5, replace "331,175,091" with "459,478,830" and replace "2,201,335,245" with "2,329,638,984"

Page 3, after line 6, insert:

"**SECTION 2. APPROPRIATION - FEDERAL FISCAL STIMULUS FUNDS - ADDITIONAL FUNDING APPROVAL.** The funds provided in this section, or so much of the funds as may be necessary, are appropriated from federal funds made available to the state under the federal American Recovery and Reinvestment Act of 2009, not otherwise appropriated, to the department of human services for the period beginning with the effective date of this Act and ending June 30, 2011, as follows:

Federal medical assistance percentage	$66,500,000
Elderly nutrition services	485,000
Child support incentive matching funds	3,200,000
Rehabilitation services and disability assistance and independent living	2,043,000
Individuals with Disabilities Education Act - Part C	2,140,000
Supplemental nutrition assistance program benefits and administration	9,874,747
Senior employment program	143,288

Older blind	3,170
Total federal funds	$84,389,205

The department of human services may seek emergency commission and budget section approval under chapter 54-16 for authority to spend any additional federal funds received under the federal American Recovery and Reinvestment Act of 2009 in excess of the amounts appropriated in this section for the period beginning with the effective date of this Act and ending June 30, 2011.

Any federal funds appropriated under this section, except for the funding of $66,500,000 relating to the federal medical assistance percentage and funding of $2,763,082 of child support incentive matching funds, are not a part of the agency's 2011-13 base budget. Any program expenditures made with these funds will not be replaced with state funds after the federal American Recovery and Reinvestment Act funds are no longer available.

SECTION 3. GENERAL FUND TRANSFER TO BUDGET STABILIZATION FUND - EXCEPTION - USE OF GENERAL FUND AMOUNTS. Notwithstanding section 54-27.2-02, the state treasurer and the office of management and budget may not include in the amount used to determine general fund transfers to the budget stabilization fund at the end of the 2007-09 biennium under chapter 54-27.2 any general fund amounts resulting from the increased federal share of medical assistance payments resulting from federal medical assistance percentage changes under the federal American Recovery and Reinvestment Act of 2009. The state treasurer and the office of management and budget shall separately account for these amounts and 2009-11 biennium general fund amounts resulting from federal medical assistance percentage changes under the federal American Recovery and Reinvestment Act of 2009 and use these amounts to defray the expenses of continuing program costs of the department of human services from the general fund for the biennium beginning July 1, 2009, and ending June 30, 2011, as follows:

Inflationary increases for human service providers	$32,564,450
Rate increases for selected medicaid services due to rebasing	21,788,982
Rate increases for nursing homes due to property limit changes	3,000,000
Wage increases for employees of nursing homes, basic care, and developmental disabilities services providers and qualified service providers	15,867,327
Global behavioral health initiative	4,088,873
Salary increases for department of human services employees	18,949,591
Total	$96,259,223

SECTION 4. CONTINGENT APPROPRIATION. If section 23 of this Act becomes effective, there is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $964,031, or so much of the sum as may be necessary, and from special funds derived from federal funds, the sum of $1,582,480, or so much of the sum as may be necessary, to the department of human services for the purpose of defraying the expenses of implementing the expansion of medical assistance benefits for pregnant women as provided for in section 23 of this Act for the biennium beginning July 1, 2009, and ending June 30, 2011."

Page 3, line 19, replace "2,793,692" with "3,943,692"

Page 3, line 21, replace "3,146,298" with "4,296,298"

Page 4, remove lines 22 through 29

Page 5, line 1, replace "$14,739,128" with "$22,576,412" and replace "$4,950,451" with "$7,927,252"

Page 5, line 2, replace "$8,788,677" with "$13,649,160"

Page 5, line 4, replace "each employee earning a salary that is less than the eightieth" with "employees beginning July 1, 2009. Basic care and skilled nursing care facilities may not use the money received under this section for providing salary and benefit enhancements to administrators or directors of nursing."

Page 5, remove lines 5 and 6

Page 5, line 9, replace "$18,929,151" with "$21,639,106" and replace "$7,000,000" with "$7,086,807"

Page 5, line 10, replace "$11,929,151" with "$14,552,299"

Page 5, line 11, replace "each employee earning a" with "employees beginning July 1, 2009. Developmental disabilities service providers may not use the money received under this section for providing salary and benefit enhancements to administrators."

Page 5, replace lines 12 and 13 with:

"**SECTION 12. LEGISLATIVE INTENT - MEDICAID PROVIDER PAYMENTS.** It is the intent of the legislative assembly that the department of human services establish a goal to set medicaid payments for hospitals, physicians, chiropractors, and ambulances at 100 percent of cost.

SECTION 13. SUPPLEMENTAL PAYMENT - CRITICAL ACCESS HOSPITALS. The grants - medical assistance line item in subdivision 2 of section 1 of this Act includes the sum of $400,000 from the general fund that the department of human services shall use for providing a supplemental payment to eligible critical access hospitals. A critical access hospital is eligible for a payment under this section only if its percentage of medical payments exceeds 25 percent of its total annual revenue in its most recent audited financial statements and is located in a city with a population that does not exceed 1,450. The department shall seek federal medicaid funding to provide a portion of the $400,000 supplement payment. If federal medicaid funding is not available for a portion of the payment, the department may spend the $400,000 from the general fund for making the supplemental payment only if the action will not result in a reduction in federal medicaid funding to the state.

SECTION 14. LEGISLATIVE INTENT - DEVELOPMENTAL DISABILITIES MEDICALLY FRAGILE. It is the intent of the sixty-first legislative assembly that the additional funding for severely medically fragile and behaviorally challenged individuals be provided to the Anne Carlsen Center and other similar private providers serving individuals with developmental disabilities in proportion to the respective severity of the critical medical and behavioral needs of each individual served by these providers. The funding is to become part of each provider's annual base budget and is not to reduce each provider's entitlement to additional critical needs staffing in future ratesetting by the department.

SECTION 15. LEGISLATIVE INTENT - DEMENTIA CARE SERVICES. It is the intent of the sixty-first legislative assembly that the department of human services integrate the dementia care services program established in House Bill No. 1043 with the home and community-based care services programs of the department.

SECTION 16. LEGISLATIVE COUNCIL STUDY - RETURNING VETERANS AND THEIR FAMILIES. During the 2009-11 interim, the legislative council shall consider studying the impact of veterans who are returning from wars and their families on the state's human services system. The study must include an analysis of the

estimated cost of providing human service-related services to the returning veterans and their families, including treatment for traumatic brain injury and mental illness. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly.

SECTION 17. LEGISLATIVE INTENT - HOME TELEMONITORING SERVICES. It is the intent of the sixty-first legislative assembly that the department of human services consider the changes necessary to reimburse home telemonitoring services under the medicaid program at the same rate as skilled nursing visits provided in person.

SECTION 18. UNSPENT 2007-09 BIENNIUM - GENERAL FUND APPROPRIATIONS - EXCEPTION. The amount of $270,000 of the $3,100,000 for a sexual offender treatment addition at the state hospital appropriated in subdivision 3 of section 3 of 2007 Senate Bill No. 2012 is not subject to section 54-44.1-11 and may be spent during the 2009-11 biennium for completing roof repair at the state hospital."

Page 7, after line 21, insert:

"**SECTION 21. AMENDMENT.** Section 50-06-29 of the North Dakota Century Code is amended and reenacted as follows:

50-06-29. ~~Application for aging~~ Aging and disability resource ~~center funding~~ link - No wrong door model. ~~No later than December 31, 2007, the~~ The department of human services, within the limits of legislative appropriation, shall ~~seek federal funds for the planning~~ plan and ~~implementation of~~ implement an aging and disability resource ~~center for~~ link, "no wrong door" model, initially in up to two regions of the state. The department also may provide additional services or may provide services in multiple regions as required or allowed by any source providing funds for these purposes. The initial resource ~~center will be a single point of information program at the community level which~~ link model will help people residing in the state make informed decisions about the full range of long-term care service and support options, including both institutional and home and community-based care~~, and which~~. Participating access points will provide unbiased information and assistance to individuals needing either public or private resources, to professionals seeking assistance on behalf of their clients, and to individuals planning for their future long-term care needs. Upon receipt of ~~federal funds~~ funding, the department of human services may establish the initial aging and disability resource ~~center~~ link, "no wrong door" model, or it may request bids and award ~~a contract~~ contracts for ~~the provision of this service~~ training and coordination to implement the model utilizing existing community-based access points and for the provision of services. The ~~duties of the aging and disability resource center must include all duties~~ initial model and any subsequent model or variation of the model, as well as any additional locations will provide services consistent with those required ~~to receive federal funds, including~~ by the 2006 amendments to the Older Americans Act [Pub. L. 109-365; 120 Stat. 2522; 42 U.S.C. 3001 et seq.], providing information about the full range of long-term care service and support options available in the state to assure that consumers may make informed decisions about their care. The resource ~~center~~ link's participating access points must be free from a conflict of interest which would inappropriately influence or bias the actions of a contractor, staff member, board member, or volunteer of the ~~resource center~~ access points to limit the information given to a consumer to steer the consumer to services that may also be provided by the ~~resource center~~ access points.

SECTION 22. AMENDMENT. Section 50-24.1-02.6 of the North Dakota Century Code is amended and reenacted as follows:

~~50-24.1-02.6. (Contingent effective date - See note) Medical assistance benefits - Eligibility criteria.~~

~~1. The department shall provide medical assistance benefits to otherwise eligible persons who are:~~

~~a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and~~

~~b. Minors who have countable income that does not exceed an amount determined under subsection 3.~~

~~2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.~~

~~3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law, that provide an income level for all minors born before September 30, 1983, equal to one hundred percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined and that do not exceed legislative appropriations for that purpose.~~

~~4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.~~

~~(Contingent effective date - See note)~~ Medical assistance benefits - Eligibility criteria.

1. The department shall provide medical assistance benefits to otherwise eligible persons who are:

   a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and

   b. Minors who have countable income that does not exceed an amount determined under subsection 3.

2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.

3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law~~, that provide an income level for all individuals from birth through age eighteen equal to one hundred thirty-three percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined~~.

4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.

SECTION 23. AMENDMENT. Section 50-24.1-02.6 of the North Dakota Century Code is amended and reenacted as follows:

~~**50-24.1-02.6. (Contingent effective date - See note) Medical assistance benefits - Eligibility criteria.**~~

~~1. The department shall provide medical assistance benefits to otherwise eligible persons who are:~~

~~a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and~~

~~b. Minors who have countable income that does not exceed an amount determined under subsection 3.~~

~~2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.~~

~~3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law, that provide an income level for all minors born before September 30, 1983, equal to one hundred percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined and that do not exceed legislative appropriations for that purpose.~~

~~4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.~~

~~(Contingent effective date - See note)~~ Medical assistance benefits - Eligibility criteria.

1. The department shall provide medical assistance benefits to otherwise eligible persons who are:

   a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and

   b. Minors who have countable income that does not exceed an amount determined under subsection 3.

2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of ~~subsection~~ subsections 3 and 4, is the greatest income level achievable without exceeding legislative appropriations for that purpose.

3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law~~, that provide an income level for all individuals from birth through age eighteen equal to one hundred thirty-three percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined~~.

4. The department of human services shall establish income levels for pregnant women at an amount, no less than required by federal law, equal

to one hundred sixty-five percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined.

5. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets."

Page 8, after line 21, insert:

"**SECTION 26. REPEAL.** Section 4 of chapter 422 of the 2007 Session Laws is repealed.

SECTION 27. EFFECTIVE DATE. Section 23 of this Act becomes effective on the date the department of human services certifies to the legislative council that the department has received approval to claim federal financial participation to expand medical assistance benefits to pregnant women as provided for in section 1 of this Act, but may not become effective earlier than January 1, 2010.

SECTION 28. EMERGENCY. Sections 2 and 18 of this Act are declared to be an emergency measure."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT - LC 98013.0206 FN 3

A copy of the statement of purpose of amendment is attached.

STATEMENT OF PURPOSE OF AMENDMENT:

House Bill No. 1012 - Summary of Senate Action

	Executive Budget	House Version	Senate Changes	Senate Version
DHS - Management				
Total all funds	$65,842,656	$60,188,970	$6,290,621	$66,479,591
Less estimated income	36,027,838	34,041,261	2,163,521	36,204,782
General fund	$29,814,818	$26,147,709	$4,127,100	$30,274,809
DHS - Program/Policy				
Total all funds	$1,919,716,163	$1,877,716,114	$110,802,718	$1,988,518,832
Less estimated income	1,375,189,679	1,350,082,207	133,936,912	1,484,019,119
General fund	$544,526,484	$527,633,907	($23,134,194)	$504,499,713
DHS - State Hospital				
Total all funds	$70,001,527	$66,911,926	$2,988,802	$69,900,728
Less estimated income	19,563,594	18,511,154	1,048,975	19,560,129
General fund	$50,437,933	$48,400,772	$1,939,827	$50,340,599
DHS - Developmental Center				
Total all funds	$54,015,265	$52,989,719	$1,025,358	$54,015,077
Less estimated income	37,160,672	36,572,644	587,914	37,160,558
General fund	$16,854,593	$16,417,075	$437,444	$16,854,519
DHS - Northwest HSC				
Total all funds	$8,562,127	$8,209,132	$311,162	$8,520,294
Less estimated income	3,680,172	3,471,996	203,790	3,675,786
General fund	$4,881,955	$4,737,136	$107,372	$4,844,508
DHS - North Central HSC				
Total all funds	$20,923,799	$18,917,773	$1,945,777	$20,863,550
Less estimated income	8,825,362	8,416,847	404,642	8,821,489
General fund	$12,098,437	$10,500,926	$1,541,135	$12,042,061
DHS - Lake Region HSC				
Total all funds	$11,011,109	$10,641,067	$329,647	$10,970,714
Less estimated income	4,747,559	4,524,710	218,572	4,743,282
General fund	$6,263,550	$6,116,357	$111,075	$6,227,432
DHS - Northeast HSC				
Total all funds	$26,376,851	$25,616,905	$668,681	$26,285,586
Less estimated income	14,320,535	14,029,163	264,834	14,293,997
General fund	$12,056,316	$11,587,742	$403,847	$11,991,589
DHS - Southeast HSC				
Total all funds	$32,020,964	$29,760,855	$1,671,734	$31,432,589
Less estimated income	15,966,058	15,188,388	494,134	15,682,522
General fund	$16,054,906	$14,572,467	$1,177,600	$15,750,067
DHS - South Central HSC				
Total all funds	$15,913,332	$15,257,320	$527,907	$15,785,227
Less estimated income	6,970,002	6,700,249	266,461	6,966,710
General fund	$8,943,330	$8,557,071	$261,446	$8,818,517
DHS - West Central HSC				
Total all funds	$26,008,933	$24,362,468	$813,893	$25,176,361
Less estimated income	12,693,292	12,254,021	333,558	12,587,579
General fund	$13,315,641	$12,108,447	$480,335	$12,588,782
DHS - Badlands HSC				
Total all funds	$11,694,235	$10,762,996	$927,439	$11,690,435
Less estimated income	5,429,653	5,182,171	222,184	5,404,355
General fund	$6,264,582	$5,580,825	$705,255	$6,286,080
Bill total				
Total all funds	$2,262,086,961	$2,201,335,245	$128,303,739	$2,329,638,984

Less estimated income	1,540,574,416	1,508,974,811	140,145,497	1,649,120,308
General fund	$721,512,545	$692,360,434	($11,841,758)	$680,518,676

House Bill No. 1012 - DHS - Management - Senate Action

	Executive Budget	House Version	Senate Changes[1]	Senate Version
Salaries and wages	$19,303,132	$13,660,900	$5,515,967	$19,176,867
Operating expenses	46,539,524	46,528,070	603,142	47,131,212
Contingent appropriation			171,512	171,512
Total all funds	$65,842,656	$60,188,970	$6,290,621	$66,479,591
Less estimated income	36,027,838	34,041,261	2,163,521	36,204,782
General fund	$29,814,818	$26,147,709	$4,127,100	$30,274,809
FTE	108.35	107.35	0.00	107.35

[1]

Management - Senate changes:	FTE	General Fund	Other Funds	Total
Administration Support Program				
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$131,076	$268,110	$399,186
Restore funding for state employee salary equity adjustments		3,458,506	1,575,064	5,033,570
Provide funding for young adult transition residential services in a human services region to be determined by the department		417,311	171,111	588,421
Restore a portion of the House reduction for department travel		7,128	7,592	14,720
Division of Information Technology Program				
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		27,323	55,888	83,211
Provide a contingent appropriation to expand medical assistance benefits for pregnant women if approved by the federal government		85,756	85,756	171,512
Total Senate changes - Management	0.00	$4,127,100	$2,163,521	$6,290,621

House Bill No. 1012 - DHS - Program/Policy - Senate Action

	Executive Budget	House Version	Senate Changes[1]	Senate Version
Salaries and wages	$44,664,959	$43,963,473	($2,331,287)	$41,632,186
Operating expenses	73,251,082	72,176,081	801,945	72,978,026
Capital assets	13,000	13,000		13,000
Grants	456,965,308	455,130,804	485,000	455,615,804
Grants - Medical assistance	1,344,821,814	1,306,432,756	25,082,856	1,331,515,612
Federal fiscal stimulus funds			84,389,205	84,389,205
Contingent appropriation			2,374,999	2,374,999
Total all funds	$1,919,716,163	$1,877,716,114	$110,802,718	$1,988,518,832
Less estimated income	1,375,189,679	1,350,082,207	133,936,912	1,484,019,119
General fund	$544,526,484	$527,633,907	($23,134,194)	$504,499,713
FTE	363.50	361.00	0.00	361.00

[1]

Program and Policy - Senate changes:	FTE	General Fund	Other Funds	Total
Economic Assistance Policy Program				
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$48,462	$99,126	$147,588
Child Support Program				
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		68,787	140,700	209,487
Medical Services Program				
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		44,010	90,020	134,030
Restore a portion of the House reduction for department travel		10,915	8,653	19,568
Restore funding for medically needy to reflect income levels of 83 percent of the federal poverty level as provided for in the executive budget (The House decreased funding to reflect income levels of 75 percent of the federal poverty level.)		376,947	642,379	1,019,326
Increase funding for rebasing physician payment rates. The Senate version provides $47,700,000, of which $17,639,460 is from the general fund, for rebasing rates to 75 percent of the amount needed to rebase to 100 percent of cost. The House version provided $10,600,000, of which $3,919,880 is from the general fund, for rebasing rates to 20 percent of the amount needed to rebase to 100 percent of cost. The executive budget included funding of $13,250,000, of which $4,899,850 is from the general fund, for rebasing rates to 25 percent of the amount needed to rebase to 100 percent of cost.		10,779,670	18,370,330	29,150,000
Restore funding in the grants - medical assistance line item for rebasing ambulance payment rates to Medicare rates as provided for in the executive budget. The House version provides $1,508,336, of which $557,783 is from the general fund, to provide funding equal to 75 percent of the funding provided in the executive budget.		185,927	316,851	502,778
Restore funding in the grants - medical assistance line item for rebasing dentist payment rates to a minimum of 75 percent of average billed charges as provided for in the executive budget. The House version provides for rebasing dentist		278,333	474,445	752,778

payment rates to a minimum of 70 percent of average billed charges.			
Provide funding in the grants - medical assistance line item for supplemental payments to small, rural critical access hospitals	400,000	0	400,000
Adjust funding for the state children's health insurance program to reflect utilization reprojections and a revised premium amount	(2,832,256)	(8,110,063)	(10,942,319)
Increase funding for the state children's health insurance program to increase eligibility for the program from 160 percent to 200 percent of the federal poverty level in accordance with provisions of House Bill No. 1478	644,873	1,846,237	2,491,110
Restore funding removed by the House in the grants - medical assistance line item for medical services projected caseload/utilization rates	9,600,000	16,359,978	25,959,978
Provide a contingent appropriation to expand medical assistance benefits for pregnant women if approved by the federal government	878,275	1,496,724	2,374,999
Provide funding for an estimated decrease in the state's federal medical assistance percentage (FMAP) for the last seven months of the 2009-11 biennium	9,500,000	(9,500,000)	0
Long-Term Care Program			
Restore funding added in the executive budget and removed by the House for the addition of a third tier of personal care that would allow a maximum of 1,200 units of care per month	1,021,922	1,741,524	2,763,446
Add funding of $7,837,284, of which $2,876,801 is from the general fund, to the amounts provided by the House to provide total funding of $22,576,412, of which $7,927,252 is from the general fund, $1,000,000 is from the health care trust fund, and $13,649,160 is from federal funds, to provide a $1 per hour salary and benefit supplemental payment for all individuals employed by basic care and nursing care facilities except for administrators and directors of nursing	2,976,801	4,860,483	7,837,2
Add funding of $2,709,955, of which $86,807 is from the general fund, to the amounts provided by the House, to provide total funding of $21,639,106, of which $7,086,807 is from the general fund and $14,552,299 is from federal funds, to provide a $1 per hour salary and benefit supplemental payment for all individuals employed by developmental disabilities providers except for administrators	86,807	2,623,148	2,709,955
Add funding to provide a $1 per hour increase for qualified service providers	853,268	963,026	1,816,294
Add funding in the grants - medical assistance line item for developmental disabilities providers who are serving severely medically fragile and behaviorally challenged individuals in addition to the funding added by the House	1,897,465	3,233,594	5,131,059
Restore funding removed by the House in the grants - medical assistance line item for long-term care projected caseload/utilization rates	5,600,000	9,543,320	15,143,320
Restore funding removed by the House in the grants - medical assistance line item for developmental disabilities grants projected caseload/utilization rates	2,476,000	4,219,511	6,695,511
Aging Services Program			
Restore a portion of the House reduction for department travel	1,753	5,232	6,985
Restore funding for salaries and wages for anticipated savings from vacant positions	3,350	6,852	10,20

and employee turnover			
Provide funding for a pilot aging and disability resource link	300,000	0	300,000
Provide funding for a grant for the community of care program	125,000	0	125,000
Children and Family Services Program			
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover	7,754	15,860	23,614
Restore a portion of the House reduction for department travel	527	1,326	1,853
Increase funding for the Healthy Families program by $200,000 from the general fund, from $300,000 from the general fund as provided for the 2007-09 biennium to $500,000 from the general fund for the 2009-11 biennium	200,000	0	200,000
Mental Health and Substance Abuse Program			
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover	7,940	16,241	24,181
Restore a portion of the House reduction for department travel	7,921	22,858	30,779
Add funding in the operating expenses line item for the compulsive gambling services to $650,000, of which $250,000 is from the general fund and $400,000 is from lottery proceeds. The House version provides funding of $550,000, of which $150,000 is from the general fund and $400,000 is from lottery proceeds. The executive budget recommended funding of $700,000, of which $300,000 is from the general fund and $400,000 is from lottery proceeds.	100,000	0	100,000
Add funding in the grants line item for the Governor's Prevention and Advisory Council grants. The House version provides no funding for the Governor's Prevention and Advisory Council grants. The executive budget recommended funding of $200,000 from the general fund for the Governor's Prevention and Advisory Council grants.	10,000	0	10,000
Provide additional funding for the peer support program	300,000	0	300,000
Developmental Disabilities Council			
Restore a portion of the House reduction for department travel	0	2,223	2,223
Developmental Disabilities Division			
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover	3,455	7,067	10,522
Restore a portion of the House reduction for department travel	3,768	16,488	20,256
Vocational Rehabilitation			
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover	2,666	5,453	8,119
Restore a portion of the funding for department travel	8,548	28,121	36,669
Add funding in the grants line item to provide $1,894,539, of which $1,080,958 is from the general fund, for centers for independent living. The House version provides funding of $1,744,539, of which $930,958 is from the general	150,000	0	150,000

fund, for centers for independent living, and the executive budget recommended funding of $2,144,539, of which $1,330,958 is from the general fund, for centers for independent living.				
Federal Stimulus Funding				
Provide for increased funding for supplemental nutrition assistance program benefits and related additional administrative expenses		0	9,874,747	9,874,747
Change the funding source and provide additional funding for child support enforcement activities		(2,763,082)	3,200,000	436,918
Change the funding source for Medicaid, foster care, and adoption payments due to the enhanced FMAP included in the American Recovery and Reinvestment Act of 2009		(66,500,000)	66,500,000	0
Provide funding for elderly nutrition services		0	485,000	485,000
Provide funding for the senior employment program		0	143,288	143,288
Provide funding for older blind services		0	3,170	3,170
Provide for increased funding for developmentally delayed infants aged 0 to 3 to reflect federal funds received for Individuals With Disabilities Education Act - Part C		0	2,140,000	2,140,000
Provide for increased funding for centers for independent living		0	243,000	243,000
Provide for increased funding for vocational rehabilitation services to reflect federal funds received through the American Recovery and Reinvestment Act of 2009		0	1,800,000	1,800,000
Total Senate changes - Program and Policy	0.00	($23,134,194)	$133,936,912	$110,802,718

Other changes affecting Program and Policy programs:

Adds a section of legislative intent regarding Medicaid reimbursement for hospitals, physicians, chiropractors, and ambulances

Adds a section of legislative intent regarding the funding added for provider services for developmental disabilities medically fragile individuals

Adds a section of legislative intent regarding dementia care services provided for in House Bill No. 1043

Adds a section of legislative intent regarding home telemonitoring

Amends NDCC Section 50-06-29 relating to the establishment of aging and disability resource link

Amends NDCC Section 50-24.1-02.6 relating to medical assistance eligibility

Repeals Section 4 of Chapter 422 of the 2007 Session Laws relating to the effective

date of the expansion of medical assistance benefits

Recognizes additional estimated general fund turnback of $30.3 million from the 2007-09 biennium

House Bill No. 1012 - DHS - State Hospital - Senate Action

	Executive Budget	House Version	Senate Changes[1]	Senate Version
State Hospital	$70,001,527	$66,911,926	$2,988,802	$69,900,728
Total all funds	$70,001,527	$66,911,926	$2,988,802	$69,900,728
Less estimated income	19,563,594	18,511,154	1,048,975	19,560,129
General fund	$50,437,933	$48,400,772	$1,939,827	$50,340,599
FTE	472.51	466.51	5.00	471.51

1

State Hospital - Senate changes:	FTE	General Fund	Other Funds	Total
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$511,140	$1,045,510	$1,556,650
Restore a portion of the House reduction for department travel		4,603	3,465	8,068
Restore funding, including 5 new FTE positions, for the global health initiative added in the executive budget but removed by the House	5.00	424,084	0	424,084
Restore one-time funding for extraordinary repairs removed by the House		1,000,000	0	1,000,000
Total Senate changes - State Hospital	5.00	$1,939,827	$1,048,975	$2,988,802

House Bill No. 1012 - DHS - Developmental Center - Senate Action

	Executive Budget	House Version	Senate Changes[1]	Senate Version
Developmental Center	$54,015,265	$52,989,719	$1,025,358	$54,015,077
Total all funds	$54,015,265	$52,989,719	$1,025,358	$54,015,077
Less estimated income	37,160,672	36,572,644	587,914	37,160,558
General fund	$16,854,593	$16,417,075	$437,444	$16,854,519
FTE	445.54	445.54	0.00	445.54

1

Developmental Center - Senate changes:	FTE	General Fund	Other Funds	Total
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$287,370	$587,800	$875,170

Restore a portion of the House reduction for department travel		$74	$114	$188
Restore one-time funding for extraordinary repairs removed by the House		150,000	0	150,000
Total Senate changes - Developmental Center	0.00	$437,444	$587,914	$1,025,358

House Bill No. 1012 - Human Service Centers - General Fund Summary

	Executive Budget	House Version	Senate Changes[1]	Senate Version
DHS - Northwest HSC	4,881,955	4,737,136	107,372	4,844,508
DHS - North Central HSC	12,098,437	10,500,926	1,541,135	12,042,061
DHS - Lake Region HSC	6,263,550	6,116,357	111,075	6,227,432
DHS - Northeast HSC	12,056,316	11,587,742	403,847	11,991,589
DHS - Southeast HSC	16,054,906	14,572,467	1,177,600	15,750,067
DHS - South Central HSC	8,943,330	8,557,071	261,446	8,818,517
DHS - West Central HSC	13,315,641	12,108,447	480,335	12,588,782
DHS - Badlands HSC	6,264,582	5,580,825	705,255	6,286,080
Total general fund	$79,878,717	$73,760,971	$4,788,065	$78,549,036

House Bill No. 1012 - Human Service Centers - Other Funds Summary

	Executive Budget	House Version	Senate Changes[1]	Senate Version
DHS - Northwest HSC	3,680,172	3,471,996	203,790	3,675,786
DHS - North Central HSC	8,825,362	8,416,847	404,642	8,821,489
DHS - Lake Region HSC	4,747,559	4,524,710	218,572	4,743,282
DHS - Northeast HSC	14,320,535	14,029,163	264,834	14,293,997
DHS - Southeast HSC	15,966,058	15,188,388	494,134	15,682,522
DHS - South Central HSC	6,970,002	6,700,249	266,461	6,966,710
DHS - West Central HSC	12,693,292	12,254,021	333,558	12,587,579
DHS - Badlands HSC	5,429,653	5,182,171	222,184	5,404,355
Total other funds	$72,632,633	$69,767,545	$2,408,175	$72,175,720

House Bill No. 1012 - Human Service Centers - All Funds Summary

	Executive Budget	House Version	Senate Changes[1]	Senate Version
DHS - Northwest HSC	8,562,127	8,209,132	311,162	8,520,294
DHS - North Central HSC	20,923,799	18,917,773	1,945,777	20,863,550
DHS - Lake Region HSC	11,011,109	10,641,067	329,647	10,970,714
DHS - Northeast HSC	26,376,851	25,616,905	668,681	26,285,586
DHS - Southeast HSC	32,020,964	29,760,855	1,671,734	31,432,589
DHS - South Central HSC	15,913,332	15,257,320	527,907	15,785,227
DHS - West Central HSC	26,008,933	24,362,468	813,893	25,176,361
DHS - Badlands HSC	11,694,235	10,762,996	927,439	11,690,435
Total all funds	$152,511,350	$143,528,516	$7,196,240	$150,724,756
FTE	847.48	836.48	9.00	845.48

[1]

Northwest Human Service Center - Senate changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$97,561	$199,556	$297,117

Restore a portion of the House reduction for department travel		9,811	4,234	14,045
Total Senate changes - Northwest Human Service Center	0.00	$107,372	$203,790	$311,162

North Central Human Service Center - Senate changes:	FTE	General Fund	Other Funds	Total
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$122,969	$251,527	$374,496
Restore funding for the global health initiative added in the executive budget but removed by the House		1,358,307	100,000	1,458,307
Restore funding and FTE position added in the executive budget but removed by the House for providing additional oversight and monitoring of developmental disabilities cases	1.00	58,793	52,354	111,147
Restore a portion of the House reduction for department travel		1,066	761	1,827
Total Senate changes - North Central Human Service Center	1.00	$1,541,135	$404,642	$1,945,777

Lake Region Human Service Center - Senate changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$104,767	$214,295	$319,062
Restore a portion of the House reduction for department travel		6,308	4,277	10,585
Total Senate changes - Lake Region Human Service Center	0.00	$111,075	$218,572	$329,647

Northeast Human Service Center - Senate changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$63,064	$128,994	$192,058
Restore funding for the global health initiative added in the executive budget but removed by the House		280,663	81,200	361,863
Restore funding and FTE position added in the executive budget but removed by the House for providing additional oversight and monitoring of developmental disabilities cases	1.00	58,793	52,354	111,147
Restore a portion of the House reduction for department travel		1,327	2,286	3,613
Total Senate changes - Northeast Human Service Center	1.00	$403,847	$264,834	$668,681

Southeast Human Service Center - Senate changes:	FTE	General Fund	Other Funds	Total
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$164,349	$336,167	$500,516

Restore funding for the global health initiative added in the executive budget but removed by the House	4.00	953,604	104,906	1,058,510
Restore funding and FTE position added in the executive budget but removed by the House for providing additional oversight and monitoring of developmental disabilities cases	1.00	58,793	52,354	111,147
Restore a portion of the House reduction for department travel		854	707	1,561
Total Senate changes - Southeast Human Service Center	5.00	$1,177,600	$494,134	$1,671,734

South Central Human Service Center - Senate changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$128,661	$263,169	$391,830
Restore funding for the global health initiative added in the executive budget but removed by the House	1.00	127,669	0	127,669
Restore a portion of the House reduction for department travel		5,116	3,292	8,408
Total Senate changes - South Central Human Service Center	1.00	$261,446	$266,461	$527,907

West Central Human Service Center - Senate changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$135,157	$276,456	$411,613
Restore funding for the global health initiative added in the executive budget but removed by the House		279,546	0	279,546
Restore funding and FTE position added in the executive budget but removed by the House for providing additional oversight and monitoring of developmental disabilities cases	1.00	58,793	52,354	111,147
Restore a portion of the House reduction for department travel		6,839	4,748	11,587
Total Senate changes - West Central Human Service Center	1.00	$480,335	$333,558	$813,893

Badlands Human Service Center - Senate changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$40,139	$82,102	$122,241
Restore funding for the global health initiative added in the executive budget but removed by the House		665,000	140,000	805,000
Restore a portion of the House reduction for department travel		116	82	198
Total Senate changes - Badlands Human Service Center	0.00	$705,255	$222,184	$927,439

98013.0207
Title.

Prepared by the Legislative Council staff for
Senator Christmann
April 9, 2009

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

Page 1, line 3, after the semicolon insert "to create and enact a new subsection to section 50-25.1-05 of the North Dakota Century Code, relating to the adoption of rules regarding the recording of interviews in child abuse or neglect cases;"

Page 7, after line 29, insert:

"**SECTION 12.** A new subsection to section 50-25.1-05 of the North Dakota Century Code is created and enacted as follows:

The department shall adopt rules that require all interviews of the alleged abused or neglected child conducted under this section to be audio-recorded or video-recorded, when possible. The rules must provide that a recording may not be disclosed except in accordance with section 50-25.1-11."

Renumber accordingly

Date: 4-10-09
Roll Call Vote #: 1

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1012

Senate **Senate Appropriations** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number .0207 Christmann amendment

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Christmann Seconded By Bowman

Representatives	Yes	No	Representatives	Yes	No
Senator Wardner			Senator Robinson		
Senator Fischer			Senator Lindaas		
V. Chair Bowman			Senator Warner		
Senator Krebsbach			Senator Krauter		
Senator Christmann			Senator Seymour		
Chairman Holmberg			Senator Mathern		
Senator Kilzer					
V. Chair Grindberg					

Total Yes _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

voice vote carried

Prepared by the Legislative Council staff for
Senator Warner
April 9, 2009

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

Page 3, line 3, replace "112,284,910" with "134,430,125" and replace "692,360,434" with "714,505,649"

Page 3, line 4, replace "218,890,181" with "258,985,530" and replace "1,508,974,811" with "1,549,070,160"

Page 3, line 5, replace "331,175,091" with "393,415,655" and replace "2,201,335,245" with "2,263,575,809"

Page 3, after line 6, insert:

"**SECTION 2. APPROPRIATION.** There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $6,277,888, or so much of the sum as may be necessary, and from special funds derived from federal funds, the sum of $9,930,864, or so much of the sum as may be necessary, to the department of human services for the purpose of providing inflationary increases of seven percent for the second year of the biennium for rebased services and seven percent annual increases for all other services, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 3. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $15,867,327, or so much of the sum as may be necessary, and from special funds derived from federal funds, the sum of $30,164,485, or so much of the sum as may be necessary, to the department of human services for the purpose of providing additional funding for a supplemental payment for individuals employed by basic care and nursing home facilities, developmental disabilities service providers, and qualified service providers, for the biennium beginning July 1, 2009, and ending June 30, 2011."

Renumber accordingly

Date: 4-10-09
Roll Call Vote #: 2

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1012

Senate **Senate Appropriations** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number .0208 Warner amend. 7-7-09

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Warner Seconded By Robinson

Representatives	Yes	No	Representatives	Yes	No
Senator Wardner		✓	Senator Robinson	✓	
Senator Fischer		✓	Senator Lindaas	✓	
V. Chair Bowman		✓	Senator Warner	✓	
Senator Krebsbach		✓	Senator Krauter	✓	
Senator Christmann		✓	Senator Seymour	✓	
Chairman Holmberg		✓	Senator Mathern	✓	
Senator Kilzer		✓			
V. Chair Grindberg		✓			

Total Yes 6 No 8

Absent

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Failed

98013.0209
Title.0300
Fiscal No. 4

Prepared by the Legislative Council staff for
Senate Appropriations
April 10, 2009

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

Page 1, line 2, after the first semicolon insert "to provide a contingent appropriation;"

Page 1, line 3, replace the first "and" with "to create and enact a new subsection to section 50-25.1-05 of the North Dakota Century Code, relating to the adoption of rules regarding the recording of interviews in child abuse or neglect cases;" and after "25-04-05" insert ", 50-06-29, 50-24.1-02.6"

Page 1, line 4, after "screenings" insert ", the establishment of an aging and disability resource link, medical assistance eligibility"

Page 1, line 5, after "fund" insert "; and to repeal section 4 of chapter 422 of the 2007 Session Laws, relating to the effective date of the expansion of medical assistance benefits"

Page 1, line 17, replace "2,148,542" with "7,664,509" and replace "13,660,900" with "19,176,867"

Page 1, line 18, replace "(13,582,286)" with "(12,979,144)" and replace "46,528,070" with "47,131,212"

Page 1, line 20, replace "($11,434,02911)" with "($5,314,920)" and replace "60,188,970" with "66,308,079"

Page 1, line 21, replace "(16,622,573)" with "(14,544,808)" and replace "34,041,261" with "36,119,026"

Page 1, line 22, replace "5,188,544" with "9,229,888" and replace "26,147,709" with "30,189,053"

Page 2, line 3, replace "18,552,432" with "16,221,145" and replace "43,963,473" with "41,632,186"

Page 2, line 4, replace "4,364,279" with "6,622,596" and replace "72,176,081" with "74,434,398"

Page 2, line 6, replace "111,111,588" with "111,781,588" and replace "455,130,804" with "455,800,804"

Page 2, line 7, replace "189,244,935" with "214,327,791" and replace "1,306,432,756" with "1,331,515,612"

Page 2, line 10, replace "310,797,543" with "336,477,429" and replace "1,877,716,114" with "1,903,396,000"

Page 2, line 11, replace "223,418,640" with "271,725,995" and replace "1,350,082,207" with "1,398,389,562"

Page 2, line 12, replace "87,378,903" with "64,751,434" and replace "527,633,907" with "505,006,438"

Page 2, line 17, replace "715,235" with "1,026,397" and replace "8,209,132" with "8,520,294"

Page 2, line 18, replace "2,135,169" with "4,080,946" and replace "18,917,773" with "20,863,550"

Page 2, line 19, replace "823,712" with "1,153,359" and replace "10,641,067" with "10,970,714"

Page 2, line 20, replace "3,509,556" with "4,178,237" and replace "25,616,905" with "26,285,586"

Page 2, line 21, replace "3,699,225" with "5,370,959" and replace "29,760,855" with "31,432,589"

Page 2, line 22, replace "573,509" with "1,101,416" and replace "15,257,320" with "15,785,227"

Page 2, line 23, replace "3,675,196" with "4,489,089" and replace "24,362,468" with "25,176,361"

Page 2, line 24, replace "964,207" with "1,891,646" and replace "10,762,996" with "11,690,435"

Page 2, line 25, replace "9,519,982" with "12,508,784" and replace "66,911,926" with "69,900,728"

Page 2, line 26, replace "6,195,786" with "7,221,144" and replace "52,989,719" with "54,015,077"

Page 2, line 27, replace "31,811,577" with "43,021,977" and replace "263,430,161" with "274,640,561"

Page 2, line 28, replace "12,094,114" with "16,139,178" and replace "124,851,343" with "128,896,407"

Page 2, line 29, replace "19,717,463" with "26,882,799" and replace "138,578,818" with "145,744,154"

Page 3, line 3, replace "112,284,910" with "101,828,152" and replace "692,360,434" with "681,903,676"

Page 3, line 4, replace "218,890,181" with "359,292,050" and replace "1,508,974,811" with "1,649,376,680"

Page 3, line 5, replace "331,175,091" with "461,120,202" and replace "2,201,335,245" with "2,331,280,356"

Page 3, after line 6, insert:

"**SECTION 2. APPROPRIATION - FEDERAL FISCAL STIMULUS FUNDS - ADDITIONAL FUNDING APPROVAL.** The funds provided in this section, or so much of the funds as may be necessary, are appropriated from federal funds made available to the state under the federal American Recovery and Reinvestment Act of 2009, not otherwise appropriated, to the department of human services for the period beginning with the effective date of this Act and ending June 30, 2011, as follows:

Federal medical assistance percentage	$66,500,000
Elderly nutrition services	485,000
Child support incentive matching funds	3,200,000
Rehabilitation services and disability assistance and independent living	2,043,000
Individuals With Disabilities Education Act - Part C	2,140,000
Supplemental nutrition assistance program benefits	9,874,747

and administration	
Senior employment program	143,288
Older blind	3,170
Total federal funds	$84,389,205

The department of human services may seek emergency commission and budget section approval under chapter 54-16 for authority to spend any additional federal funds received under the federal American Recovery and Reinvestment Act of 2009 in excess of the amounts appropriated in this section for the period beginning with the effective date of this Act and ending June 30, 2011.

Any federal funds appropriated under this section, except for the funding of $66,500,000 relating to the federal medical assistance percentage and funding of $2,763,082 of child support incentive matching funds, are not a part of the agency's 2011-13 base budget. Any program expenditures made with these funds will not be replaced with state funds after the federal American Recovery and Reinvestment Act funds are no longer available.

SECTION 3. GENERAL FUND TRANSFER TO BUDGET STABILIZATION FUND - EXCEPTION - USE OF GENERAL FUND AMOUNTS. Notwithstanding section 54-27.2-02, the state treasurer and the office of management and budget may not include in the amount used to determine general fund transfers to the budget stabilization fund at the end of the 2007-09 biennium under chapter 54-27.2 any general fund amounts resulting from the increased federal share of medical assistance payments resulting from federal medical assistance percentage changes under the federal American Recovery and Reinvestment Act of 2009. The state treasurer and the office of management and budget shall separately account for these amounts and 2009-11 biennium general fund amounts resulting from federal medical assistance percentage changes under the federal American Recovery and Reinvestment Act of 2009 and use these amounts to defray the expenses of continuing program costs of the department of human services from the general fund for the biennium beginning July 1, 2009, and ending June 30, 2011, as follows:

Inflationary increases for human service providers	$32,564,450
Rate increases for selected medicaid services due to rebasing	21,788,982
Rate increases for nursing homes due to property limit changes	3,000,000
Wage increases for employees of nursing homes, basic care, and developmental disabilities services providers and qualified service providers	15,867,327
Global behavioral health initiative	4,088,873
Salary increases for department of human services employees	18,949,591
Total	$96,259,223

SECTION 4. CONTINGENT APPROPRIATION. If section 23 of this Act becomes effective, there is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $964,031, or so much of the sum as may be necessary, and from special funds derived from federal funds, the sum of $1,582,480, or so much of the sum as may be necessary, to the department of human services for the purpose of defraying the expenses of implementing the expansion of medical assistance benefits for pregnant women as provided for in section 23 of this Act, for the biennium beginning July 1, 2009, and ending June 30, 2011."

Page 3, line 19, replace "2,793,692" with "3,943,692"

Page 3, line 21, replace "3,146,298" with "4,296,298"

Page 4, remove lines 22 through 29

Page 5, line 1, replace "$14,739,128" with "$22,576,412" and replace "$4,950,451" with "$7,927,252"

Page 5, line 2, replace "$8,788,677" with "$13,649,160"

Page 5, line 4, replace "each employee earning a salary that is less than the eightieth" with "employees beginning July 1, 2009. Basic care and skilled nursing care facilities may not use the money received under this section for providing salary and benefit enhancements to administrators or directors of nursing."

Page 5, remove lines 5 and 6

Page 5, line 9, replace "$18,929,151" with "$21,639,106" and replace "$7,000,000" with "$7,086,807"

Page 5, line 10, replace "$11,929,151" with "$14,552,299"

Page 5, line 11, replace "each employee earning a" with "employees beginning July 1, 2009. Developmental disabilities service providers may not use the money received under this section for providing salary and benefit enhancements to administrators."

Page 5, replace lines 12 and 13 with:

"**SECTION 12. LEGISLATIVE INTENT - MEDICAID PROVIDER PAYMENTS.** It is the intent of the legislative assembly that the department of human services establish a goal to set medicaid payments for hospitals, physicians, chiropractors, and ambulances at 100 percent of cost.

SECTION 13. SUPPLEMENTAL PAYMENT - CRITICAL ACCESS HOSPITALS. The grants - medical assistance line item in subdivision 2 of section 1 of this Act includes the sum of $400,000 from the general fund that the department of human services shall use for providing a supplemental payment to eligible critical access hospitals. A critical access hospital is eligible for a payment under this section only if its percentage of medical payments exceeds 25 percent of its total annual revenue in its most recent audited financial statements and is located in a city with a population that does not exceed 1,450. The department shall seek federal medicaid funding to provide a portion of the $400,000 supplement payment. If federal medicaid funding is not available for a portion of the payment, the department may spend the $400,000 from the general fund for making the supplemental payment only if the action will not result in a reduction in federal medicaid funding to the state.

SECTION 14. LEGISLATIVE INTENT - DEVELOPMENTAL DISABILITIES MEDICALLY FRAGILE. It is the intent of the sixty-first legislative assembly that the additional funding for severely medically fragile and behaviorally challenged individuals be provided to the Anne Carlsen center and other similar private providers serving individuals with developmental disabilities in proportion to the respective severity of the critical medical and behavioral needs of each individual served by these providers. The funding is to become part of each provider's annual base budget and is not to reduce each provider's entitlement to additional critical needs staffing in future ratesetting by the department.

SECTION 15. LEGISLATIVE INTENT - DEMENTIA CARE SERVICES. It is the intent of the sixty-first legislative assembly that the department of human services integrate the dementia care services program established in House Bill No. 1043 with the home and community-based care services programs of the department.

SECTION 16. LEGISLATIVE COUNCIL STUDY - RETURNING VETERANS AND THEIR FAMILIES. During the 2009-11 interim, the legislative council shall

consider studying the impact of veterans who are returning from wars and their families on the state's human services system. The study must include an analysis of the estimated cost of providing human service-related services to the returning veterans and their families, including treatment for traumatic brain injury and mental illness. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly.

SECTION 17. LEGISLATIVE INTENT - HOME TELEMONITORING SERVICES. It is the intent of the sixty-first legislative assembly that the department of human services consider the changes necessary to reimburse home telemonitoring services under the medicaid program at the same rate as skilled nursing visits provided in person.

SECTION 18. UNSPENT 2007-09 BIENNIUM - GENERAL FUND APPROPRIATIONS - EXCEPTION. The amount of $270,000 of the $3,100,000 for a sexual offender treatment addition at the state hospital appropriated in subdivision 3 of section 3 of 2007 Senate Bill No. 2012 is not subject to section 54-44.1-11 and may be spent during the 2009-11 biennium for completing roof repair at the state hospital."

Page 7, after line 21, insert:

"**SECTION 20. AMENDMENT.** Section 50-06-29 of the North Dakota Century Code is amended and reenacted as follows:

50-06-29. ~~Application for aging~~ Aging and disability resource ~~center funding~~ link - No wrong door model. ~~No later than December 31, 2007, the~~ The department of human services, within the limits of legislative appropriation, shall ~~seek federal funds for the planning~~ plan and ~~implementation of~~ implement an aging and disability resource ~~center for~~ link, "no wrong door" model, initially in up to two regions of the state. The department also may provide additional services or may provide services in multiple regions as required or allowed by any source providing funds for these purposes. The initial resource ~~center will be a single point of information program at the community level which~~ link model will help people residing in the state make informed decisions about the full range of long-term care service and support options, including both institutional and home and community-based care~~, and which~~. Participating access points will provide unbiased information and assistance to individuals needing either public or private resources, to professionals seeking assistance on behalf of their clients, and to individuals planning for their future long-term care needs. Upon receipt of ~~federal funds~~ funding, the department of human services may establish the initial aging and disability resource ~~center~~ link, "no wrong door" model, or it may request bids and award ~~a contract~~ contracts for ~~the provision of this service~~ training and coordination to implement the model utilizing existing community-based access points and for the provision of services. The ~~duties of the aging and disability resource center must include all duties~~ initial model and any subsequent model or variation of the model, as well as any additional locations will provide services consistent with those required ~~to receive federal funds, including~~ by the 2006 amendments to the Older Americans Act [Pub. L. 109-365; 120 Stat. 2522; 42 U.S.C. 3001 et seq.], providing information about the full range of long-term care service and support options available in the state to assure that consumers may make informed decisions about their care. The resource ~~center~~ link's participating access points must be free from a conflict of interest which would inappropriately influence or bias the actions of a contractor, staff member, board member, or volunteer of the ~~resource center~~ access points to limit the information given to a consumer to steer the consumer to services that may also be provided by the ~~resource center~~ access points.

SECTION 21. AMENDMENT. Section 50-24.1-02.6 of the North Dakota Century Code is amended and reenacted as follows:

~~50-24.1-02.6. (Contingent effective date - See note) Medical assistance benefits - Eligibility criteria.~~

~~1. The department shall provide medical assistance benefits to otherwise eligible persons who are:~~

~~a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and~~

~~b. Minors who have countable income that does not exceed an amount determined under subsection 3.~~

~~2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.~~

~~3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law, that provide an income level for all minors born before September 30, 1983, equal to one hundred percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined and that do not exceed legislative appropriations for that purpose.~~

~~4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.~~

~~(Contingent effective date - See note)~~ Medical assistance benefits - Eligibility criteria.

1. The department shall provide medical assistance benefits to otherwise eligible persons who are:

   a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and

   b. Minors who have countable income that does not exceed an amount determined under subsection 3.

2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.

3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law~~, that provide an income level for all individuals from birth through age eighteen equal to one hundred thirty-three percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined~~.

4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.

SECTION 22. AMENDMENT. Section 50-24.1-02.6 of the North Dakota Century Code is amended and reenacted as follows:

~~**50-24.1-02.6. (Contingent effective date - See note) Medical assistance benefits - Eligibility criteria.**~~

~~1. The department shall provide medical assistance benefits to otherwise eligible persons who are:~~

~~a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and~~

~~b. Minors who have countable income that does not exceed an amount determined under subsection 3.~~

~~2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.~~

~~3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law, that provide an income level for all minors born before September 30, 1983, equal to one hundred percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined and that do not exceed legislative appropriations for that purpose.~~

~~4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.~~

~~(Contingent effective date - See note)~~ Medical assistance benefits - Eligibility criteria.

1. The department shall provide medical assistance benefits to otherwise eligible persons who are:

   a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and

   b. Minors who have countable income that does not exceed an amount determined under subsection 3.

2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of ~~subsection~~ subsections 3 and 4, is the greatest income level achievable without exceeding legislative appropriations for that purpose.

3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law~~, that provide an income level for all individuals from birth through age eighteen equal to one hundred thirty-three percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined~~.

4. The department of human services shall establish income levels for pregnant women at an amount, no less than required by federal law, equal

to one hundred sixty-five percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined.

5. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets."

Page 7, after line 29, insert:

"**SECTION 24.** A new subsection to section 50-25.1-05 of the North Dakota Century Code is created and enacted as follows:

The department shall adopt rules that require all interviews of the alleged abused or neglected child conducted under this section to be audio-recorded or video-recorded, when possible. The rules must provide that a recording may not be disclosed except in accordance with section 50-25.1-11."

Page 8, after line 21, insert:

"**SECTION 26. REPEAL.** Section 4 of chapter 422 of the 2007 Session Laws is repealed.

SECTION 27. EFFECTIVE DATE. Section 23 of this Act becomes effective on the date the department of human services certifies to the legislative council that the department has received approval to claim federal financial participation to expand medical assistance benefits to pregnant women as provided for in section 1 of this Act, but may not become effective earlier than January 1, 2010.

SECTION 28. EMERGENCY. Sections 2 and 18 of this Act are declared to be an emergency measure."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT - LC 98013.0209 FN 4

A copy of the statement of purpose of amendment is attached.

STATEMENT OF PURPOSE OF AMENDMENT:

House Bill No. 1012 - Summary of Senate Action

	Executive Budget	House Version	Senate Changes	Senate Version
DHS - Management				
Total all funds	$65,842,656	$60,188,970	$6,290,621	$66,479,591
Less estimated income	36,027,838	34,041,261	2,163,521	36,204,782
General fund	$29,814,818	$26,147,709	$4,127,100	$30,274,809
DHS - Program/Policy				
Total all funds	$1,919,716,163	$1,877,716,114	$112,444,090	$1,990,160,204
Less estimated income	1,375,189,679	1,350,082,207	134,193,284	1,484,275,491
General fund	$544,526,484	$527,633,907	($21,749,194)	$505,884,713
DHS - State Hospital				
Total all funds	$70,001,527	$66,911,926	$2,988,802	$69,900,728
Less estimated income	19,563,594	18,511,154	1,048,975	19,560,129
General fund	$50,437,933	$48,400,772	$1,939,827	$50,340,599
DHS - Developmental Center				
Total all funds	$54,015,265	$52,989,719	$1,025,358	$54,015,077
Less estimated income	37,160,672	36,572,644	587,914	37,160,558
General fund	$16,854,593	$16,417,075	$437,444	$16,854,519
DHS - Northwest HSC				
Total all funds	$8,562,127	$8,209,132	$311,162	$8,520,294
Less estimated income	3,680,172	3,471,996	203,790	3,675,786
General fund	$4,881,955	$4,737,136	$107,372	$4,844,508
DHS - North Central HSC				
Total all funds	$20,923,799	$18,917,773	$1,945,777	$20,863,550
Less estimated income	8,825,362	8,416,847	404,642	8,821,489
General fund	$12,098,437	$10,500,926	$1,541,135	$12,042,061
DHS - Lake Region HSC				
Total all funds	$11,011,109	$10,641,067	$329,647	$10,970,714
Less estimated income	4,747,559	4,524,710	218,572	4,743,282
General fund	$6,263,550	$6,116,357	$111,075	$6,227,432
DHS - Northeast HSC				
Total all funds	$26,376,851	$25,616,905	$668,681	$26,285,586
Less estimated income	14,320,535	14,029,163	264,834	14,293,997
General fund	$12,056,316	$11,587,742	$403,847	$11,991,589
DHS - Southeast HSC				
Total all funds	$32,020,964	$29,760,855	$1,671,734	$31,432,589
Less estimated income	15,966,058	15,188,388	494,134	15,682,522
General fund	$16,054,906	$14,572,467	$1,177,600	$15,750,067
DHS - South Central HSC				
Total all funds	$15,913,332	$15,257,320	$527,907	$15,785,227
Less estimated income	6,970,002	6,700,249	266,461	6,966,710
General fund	$8,943,330	$8,557,071	$261,446	$8,818,517
DHS - West Central HSC				
Total all funds	$26,008,933	$24,362,468	$813,893	$25,176,361
Less estimated income	12,693,292	12,254,021	333,558	12,587,579
General fund	$13,315,641	$12,108,447	$480,335	$12,588,782
DHS - Badlands HSC				
Total all funds	$11,694,235	$10,762,996	$927,439	$11,690,435
Less estimated income	5,429,653	5,182,171	222,184	5,404,355
General fund	$6,264,582	$5,580,825	$705,255	$6,286,080
Bill total				
Total all funds	$2,262,086,961	$2,201,335,245	$129,945,111	$2,331,280,356

Less estimated income	1,540,574,416	1,508,974,811	140,401,869	1,649,376,680
General fund	$721,512,545	$692,360,434	($10,456,758)	$681,903,676

House Bill No. 1012 - DHS - Management - Senate Action

	Executive Budget	House Version	Senate Changes[1]	Senate Version
Salaries and wages	$19,303,132	$13,660,900	$5,515,967	$19,176,867
Operating expenses	46,539,524	46,528,070	603,142	47,131,212
Contingent appropriation			171,512	171,512
Total all funds	$65,842,656	$60,188,970	$6,290,621	$66,479,591
Less estimated income	36,027,838	34,041,261	2,163,521	36,204,782
General fund	$29,814,818	$26,147,709	$4,127,100	$30,274,809
FTE	108.35	107.35	0.00	107.35

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Management - Senate changes:	FTE	General Fund	Other Funds	Total
Administration Support Program				
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$131,076	$268,110	$399,186
Restore funding for state employee salary equity adjustments		3,458,506	1,575,064	5,033,570
Provide funding for young adult transition residential services in a human services region to be determined by the department		417,311	171,111	588,422
Restore a portion of the House reduction for department travel		7,128	7,592	14,720
Division of Information Technology Program				
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		27,323	55,888	83,211
Provide a contingent appropriation to expand medical assistance benefits for pregnant women if approved by the federal government		85,756	85,756	171,512
Total Senate changes - Management	0.00	$4,127,100	$2,163,521	$6,290,621

House Bill No. 1012 - DHS - Program/Policy - Senate Action

	Executive Budget	House Version	Senate Changes[1]	Senate Version
Salaries and wages	$44,664,959	$43,963,473	($2,331,287)	$41,632,186
Operating expenses	73,251,082	72,176,081	2,258,317	74,434,398
Capital assets	13,000	13,000		13,000
Grants	456,965,308	455,130,804	670,000	455,800,804
Grants - Medical assistance	1,344,821,814	1,306,432,756	25,082,856	1,331,515,612
Federal fiscal stimulus funds			84,389,205	84,389,205
Contingent appropriation			2,374,999	2,374,999
Total all funds	$1,919,716,163	$1,877,716,114	$112,444,090	$1,990,160,204
Less estimated income	1,375,189,679	1,350,082,207	134,193,284	1,484,275,491
General fund	$544,526,484	$527,633,907	($21,749,194)	$505,884,713
FTE	363.50	361.00	0.00	361.00

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Program and Policy - Senate changes:	FTE	General Fund	Other Funds	Total
Economic Assistance Policy Program				
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$48,462	$99,126	$147,588
Child Support Program				
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		68,787	140,700	209,487
Medical Services Program				
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		44,010	90,020	134,030
Restore a portion of the House reduction for department travel		10,915	8,653	19,568
Restore funding for medically needy to reflect income levels of 83 percent of the federal poverty level as provided for in the executive budget (The House decreased funding to reflect income levels of 75 percent of the federal poverty level.)		376,947	642,379	1,019,326
Increase funding for rebasing physician payment rates. The Senate version provides $47,700,000, of which $17,639,460 is from the general fund, for rebasing rates to 75 percent of the amount needed to rebase to 100 percent of cost. The House version provided $10,600,000, of which $3,919,880 is from the general fund, for rebasing rates to 20 percent of the amount needed to rebase to 100 percent of cost. The executive budget included funding of $13,250,000, of which $4,899,850 is from the general fund, for rebasing rates to 25 percent of the amount needed to rebase to 100 percent of cost.		10,779,670	18,370,330	29,150,000
Restore funding in the grants - medical assistance line item for rebasing ambulance payment rates to Medicare rates as provided for in the executive budget. The House version provides $1,508,336, of which $557,783 is from the general fund, to provide funding equal to 75 percent of the funding provided in the executive budget.		185,927	316,851	502,778
Restore funding in the grants - medical assistance line item for rebasing dentist payment rates to a minimum of 75 percent of average billed charges as provided for in the executive budget. The House version provides for rebasing dentist		278,333	474,445	752,778

payment rates to a minimum of 70 percent of average billed charges.			
Provide funding in the grants - medical assistance line item for supplemental payments to small, rural critical access hospitals	400,000	0	400,000
Adjust funding for the state children's health insurance program to reflect utilization reprojections and a revised premium amount	(2,832,256)	(8,110,063)	(10,942,319)
Increase funding for the state children's health insurance program to increase eligibility for the program from 160 percent to 200 percent of the federal poverty level in accordance with provisions of House Bill No. 1478	644,873	1,846,237	2,491,110
Restore funding removed by the House in the grants - medical assistance line item for medical services projected caseload/utilization rates	9,600,000	16,359,978	25,959,978
Provide a contingent appropriation to expand medical assistance benefits for pregnant women if approved by the federal government	878,275	1,496,724	2,374,999
Provide funding for an estimated decrease in the state's federal medical assistance percentage (FMAP) for the last seven months of the 2009-11 biennium	9,500,000	(9,500,000)	0
Long-Term Care Program			
Restore funding added in the executive budget and removed by the House for the addition of a third tier of personal care that would allow a maximum of 1,200 units of care per month	1,021,922	1,741,524	2,763,446
Add funding of $7,837,284, of which $2,876,801 is from the general fund, to the amounts provided by the House to provide total funding of $22,576,412, of which $7,927,252 is from the general fund, $1,000,000 is from the health care trust fund, and $13,649,160 is from federal funds, to provide a $1 per hour salary and benefit supplemental payment for all individuals employed by basic care and nursing care facilities except for administrators and directors of nursing	2,976,801	4,860,483	7,837,284
Add funding of $2,709,955, of which $86,807 is from the general fund, to the amounts provided by the House, to provide total funding of $21,639,106, of which $7,086,807 is from the general fund and $14,552,299 is from federal funds, to provide a $1 per hour salary and benefit supplemental payment for all individuals employed by developmental disabilities providers except for administrators	86,807	2,623,148	2,709,955
Add funding to provide a $1 per hour increase for qualified service providers	853,268	963,026	1,816,294
Add funding in the grants - medical assistance line item for developmental disabilities providers who are serving severely medically fragile and behaviorally challenged individuals in addition to the funding added by the House	1,897,465	3,233,594	5,131,059
Restore funding removed by the House in the grants - medical assistance line item for long-term care projected caseload/utilization rates	5,600,000	9,543,320	15,143,320
Restore funding removed by the House in the grants - medical assistance line item for developmental disabilities grants projected caseload/utilization rates	2,476,000	4,219,511	6,695,511
Aging Services Program			
Restore a portion of the House reduction for department travel	1,753	5,232	6,985
Restore funding for salaries and wages for anticipated savings from vacant positions	3,350	6,852	10,202

and employee turnover			
Provide funding for a pilot aging and disability resource link	300,000	0	300,000
Provide funding for a grant for the community of care program	120,000	0	120,000
Children and Family Services Program			
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover	7,754	15,860	23,614
Restore a portion of the House reduction for department travel	527	1,326	1,853
Increase funding for the Healthy Families program by $200,000 from the general fund, from $300,000 from the general fund as provided for the 2007-09 biennium to $500,000 from the general fund for the 2009-11 biennium	200,000	0	200,000
Add funding for family group conferencing	1,200,000	256,372	1,456,372
Mental Health and Substance Abuse Program			
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover	7,940	16,241	24,181
Restore a portion of the House reduction for department travel	7,921	22,858	30,779
Add funding in the operating expenses line item for the compulsive gambling services to $650,000, of which $250,000 is from the general fund and $400,000 is from lottery proceeds. The House version provides funding of $550,000, of which $150,000 is from the general fund and $400,000 is from lottery proceeds. The executive budget recommended funding of $700,000, of which $300,000 is from the general fund and $400,000 is from lottery proceeds.	100,000	0	100,000
Restore funding in the grants line item for the Governor's Prevention and Advisory Council grants. The House version provides no funding for the Governor's Prevention and Advisory Council grants. The executive budget recommended funding of $200,000 from the general fund for the Governor's Prevention and Advisory Council grants.	200,000	0	200,000
Provide additional funding for the peer support program	300,000	0	300,000
Developmental Disabilities Council			
Restore a portion of the House reduction for department travel	0	2,223	2,223
Developmental Disabilities Division			
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover	3,455	7,067	10,522
Restore a portion of the House reduction for department travel	3,768	16,488	20,256
Vocational Rehabilitation			
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover	2,666	5,453	8,119
Restore a portion of the funding for department travel	8,548	28,121	36,669
Add funding in the grants line item to provide $1,894,539, of which	150,000	0	150,000

$1,080,958 is from the general fund, for centers for independent living. The House version provides funding of $1,744,539, of which $930,958 is from the general fund, for centers for independent living, and the executive budget recommended funding of $2,144,539, of which $1,330,958 is from the general fund, for centers for independent living.

Federal Stimulus Funding				
Provide for increased funding for supplemental nutrition assistance program benefits and related additional administrative expenses		0	9,874,747	9,874,747
Change the funding source and provide additional funding for child support enforcement activities		(2,763,082)	3,200,000	436,918
Change the funding source for Medicaid, foster care, and adoption payments due to the enhanced FMAP included in the American Recovery and Reinvestment Act of 2009		(66,500,000)	66,500,000	0
Provide funding for elderly nutrition services		0	485,000	485,000
Provide funding for the senior employment program		0	143,288	143,288
Provide funding for older blind services		0	3,170	3,170
Provide for increased funding for developmentally delayed infants aged 0 to 3 to reflect federal funds received for Individuals With Disabilities Education Act - Part C		0	2,140,000	2,140,000
Provide for increased funding for centers for independent living		0	243,000	243,000
Provide for increased funding for vocational rehabilitation services to reflect federal funds received through the American Recovery and Reinvestment Act of 2009		0	1,800,000	1,800,000
Total Senate changes - Program and Policy	0.00	($23,134,194)	$133,936,912	$110,802,718

Other changes affecting Program and Policy programs:

Adds a section of legislative intent regarding Medicaid reimbursement for hospitals, physicians, chiropractors, and ambulances

Adds a section of legislative intent regarding the funding added for provider services for developmental disabilities medically fragile individuals

Adds a section of legislative intent regarding dementia care services provided for in House Bill No. 1043

Adds a section of legislative intent regarding home telemonitoring

Amends NDCC Section 50-06-29 relating to the establishment of aging and disability resource link

Amends NDCC Section 50-24.1-02.6 relating to medical assistance eligibility

Creates a new subsection to NDCC Section 50-25.1-05 relating to the adoption of rules regarding the recording of interviews in child abuse or neglect cases

Repeals Section 4 of Chapter 422 of the 2007 Session Laws relating to the effective date of the expansion of medical assistance benefits

Recognizes additional estimated general fund turnback of $30.3 million from the 2007-09 biennium

House Bill No. 1012 - DHS - State Hospital - Senate Action

	Executive Budget	House Version	Senate Changes[1]	Senate Version
State Hospital	$70,001,527	$66,911,926	$2,988,802	$69,900,728
Total all funds	$70,001,527	$66,911,926	$2,988,802	$69,900,728
Less estimated income	19,563,594	18,511,154	1,048,975	19,560,129
General fund	$50,437,933	$48,400,772	$1,939,827	$50,340,599
FTE	472.51	466.51	5.00	471.51

1

State Hospital - Senate changes:	FTE	General Fund	Other Funds	Total
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$511,140	$1,045,510	$1,556,650
Restore a portion of the House reduction for department travel		4,603	3,465	8,068
Restore funding, including 5 new FTE positions, for the global health initiative added in the executive budget but removed by the House	5.00	424,084	0	424,084
Restore one-time funding for extraordinary repairs removed by the House		1,000,000	0	1,000,000
Total Senate changes - State Hospital	5.00	$1,939,827	$1,048,975	$2,988,802

House Bill No. 1012 - DHS - Developmental Center - Senate Action

	Executive Budget	House Version	Senate Changes[1]	Senate Version
Developmental Center	$54,015,265	$52,989,719	$1,025,358	$54,015,077
Total all funds	$54,015,265	$52,989,719	$1,025,358	$54,015,077
Less estimated income	37,160,672	36,572,644	587,914	37,160,558
General fund	$16,854,593	$16,417,075	$437,444	$16,854,519
FTE	445.54	445.54	0.00	445.54

Developmental Center - Senate changes:	FTE	General Fund	Other Funds	Total
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$287,370	$587,800	$875,170
Restore a portion of the House reduction for department travel		$74	$114	$188
Restore one-time funding for extraordinary repairs removed by the House		150,000	0	150,000
Total Senate changes - Developmental Center	0.00	$437,444	$587,914	$1,025,358

House Bill No. 1012 - Human Service Centers - General Fund Summary

	Executive Budget	House Version	Senate Changes[1]	Senate Version
DHS - Northwest HSC	4,881,955	4,737,136	107,372	4,844,508
DHS - North Central HSC	12,098,437	10,500,926	1,541,135	12,042,061
DHS - Lake Region HSC	6,263,550	6,116,357	111,075	6,227,432
DHS - Northeast HSC	12,056,316	11,587,742	403,847	11,991,589
DHS - Southeast HSC	16,054,906	14,572,467	1,177,600	15,750,067
DHS - South Central HSC	8,943,330	8,557,071	261,446	8,818,517
DHS - West Central HSC	13,315,641	12,108,447	480,335	12,588,782
DHS - Badlands HSC	6,264,582	5,580,825	705,255	6,286,080
Total general fund	$79,878,717	$73,760,971	$4,788,065	$78,549,036

House Bill No. 1012 - Human Service Centers - Other Funds Summary

	Executive Budget	House Version	Senate Changes[1]	Senate Version
DHS - Northwest HSC	3,680,172	3,471,996	203,790	3,675,786
DHS - North Central HSC	8,825,362	8,416,847	404,642	8,821,489
DHS - Lake Region HSC	4,747,559	4,524,710	218,572	4,743,282
DHS - Northeast HSC	14,320,535	14,029,163	264,834	14,293,997
DHS - Southeast HSC	15,966,058	15,188,388	494,134	15,682,522
DHS - South Central HSC	6,970,002	6,700,249	266,461	6,966,710
DHS - West Central HSC	12,693,292	12,254,021	333,558	12,587,579
DHS - Badlands HSC	5,429,653	5,182,171	222,184	5,404,355
Total other funds	$72,632,633	$69,767,545	$2,408,175	$72,175,720

House Bill No. 1012 - Human Service Centers - All Funds Summary

	Executive Budget	House Version	Senate Changes[1]	Senate Version
DHS - Northwest HSC	8,562,127	8,209,132	311,162	8,520,294
DHS - North Central HSC	20,923,799	18,917,773	1,945,777	20,863,550
DHS - Lake Region HSC	11,011,109	10,641,067	329,647	10,970,714
DHS - Northeast HSC	26,376,851	25,616,905	668,681	26,285,586
DHS - Southeast HSC	32,020,964	29,760,855	1,671,734	31,432,589
DHS - South Central HSC	15,913,332	15,257,320	527,907	15,785,227
DHS - West Central HSC	26,008,933	24,362,468	813,893	25,176,361
DHS - Badlands HSC	11,694,235	10,762,996	927,439	11,690,435
Total all funds	$152,511,350	$143,528,516	$7,196,240	$150,724,756
FTE	847.48	836.48	9.00	845.48

Northwest Human Service Center - Senate changes:	FTE	General Fund	Other Funds	Total
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$97,561	$199,556	$297,117
Restore a portion of the House reduction for department travel		9,811	4,234	14,045
Total Senate changes - Northwest Human Service Center	0.00	$107,372	$203,790	$311,162

North Central Human Service Center - Senate changes:	FTE	General Fund	Other Funds	Total
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$122,969	$251,527	$374,496
Restore funding for the global health initiative added in the executive budget but removed by the House		1,358,307	100,000	1,458,307
Restore funding and FTE position added in the executive budget but removed by the House for providing additional oversight and monitoring of developmental disabilities cases	1.00	58,793	52,354	111,147
Restore a portion of the House reduction for department travel		1,066	761	1,827
Total Senate changes - North Central Human Service Center	1.00	$1,541,135	$404,642	$1,945,777

Lake Region Human Service Center - Senate changes:	FTE	General Fund	Other Funds	Total
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$104,767	$214,295	$319,062
Restore a portion of the House reduction for department travel		6,308	4,277	10,585
Total Senate changes - Lake Region Human Service Center	0.00	$111,075	$218,572	$329,647

Northeast Human Service Center - Senate changes:	FTE	General Fund	Other Funds	Total
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$63,064	$128,994	$192,058
Restore funding for the global health initiative added in the executive budget but removed by the House		280,663	81,200	361,863
Restore funding and FTE position added in the executive budget but removed by the House for providing additional oversight and monitoring of developmental disabilities cases	1.00	58,793	52,354	111,147
Restore a portion of the House reduction for department travel		1,327	2,286	3,613
Total Senate changes - Northeast Human Service Center	1.00	$403,847	$264,834	$668,681

Southeast Human Service Center - Senate changes:	FTE	General Fund	Other Funds	Total
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$164,349	$336,167	$500,516
Restore funding for the global health initiative added in the executive budget but removed by the House	4.00	953,604	104,906	1,058,510
Restore funding and FTE position added in the executive budget but removed by the House for providing additional oversight and monitoring of developmental disabilities cases	1.00	58,793	52,354	111,147
Restore a portion of the House reduction for department travel		854	707	1,561
Total Senate changes - Southeast Human Service Center	5.00	$1,177,600	$494,134	$1,671,734

South Central Human Service Center - Senate changes:	FTE	General Fund	Other Funds	Total
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$128,661	$263,169	$391,830
Restore funding for the global health initiative added in the executive budget but removed by the House	1.00	127,669	0	127,669
Restore a portion of the House reduction for department travel		5,116	3,292	8,408
Total Senate changes - South Central Human Service Center	1.00	$261,446	$266,461	$527,907

West Central Human Service Center - Senate changes:	FTE	General Fund	Other Funds	Total
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$135,157	$276,456	$411,613
Restore funding for the global health initiative added in the executive budget but removed by the House		279,546	0	279,546
Restore funding and FTE position added in the executive budget but removed by the House for providing additional oversight and monitoring of developmental disabilities cases	1.00	58,793	52,354	111,147
Restore a portion of the House reduction for department travel		6,839	4,748	11,587
Total Senate changes - West Central Human Service Center	1.00	$480,335	$333,558	$813,893

Badlands Human Service Center - Senate changes:	FTE	General Fund	Other Funds	Total
Restore funding for salaries and wages for anticipated savings from vacant positions and employee turnover		$40,139	$82,102	$122,241
Restore funding for the global health initiative added in the executive budget but		665,000	140,000	805,000

removed by the House				
Restore a portion of the House reduction for department travel		116	82	198
Total Senate changes - Badlands Human Service Center	0.00	$705,255	$222,184	$927,439

Date: 4-10-09
Roll Call Vote #: 3

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1012

Senate **Senate Appropriations** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☒ Amended

Motion Made By Warner Seconded By Kilzer

Representatives	Yes	No	Representatives	Yes	No
Senator Krebsbach	✓		Senator Seymour	✓	
Senator Fischer	✓		Senator Lindaas	✓	
Senator Wardner	✓		Senator Robinson	✓	
Senator Kilzer	✓		Senator Warner	✓	
V. Chair Bowman	✓		Senator Krauter	✓	
Senator Christmann	✓		Senator Mathern	✓	
V. Chair Grindberg	✓				
Chairman Holmberg	✓				

Total Yes 14 No 0

Absent 0

Floor Assignment Kilzer

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1012, as engrossed: Appropriations Committee (Sen. Holmberg, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1012 was placed on the Sixth order on the calendar.

Page 1, line 2, after the first semicolon insert "to provide a contingent appropriation;"

Page 1, line 3, replace the first "and" with "to create and enact a new subsection to section 50-25.1-05 of the North Dakota Century Code, relating to the adoption of rules regarding the recording of interviews in child abuse or neglect cases;" and after "25-04-05" insert ", 50-06-29, 50-24.1-02.6"

Page 1, line 4, after "screenings" insert ", the establishment of an aging and disability resource link, medical assistance eligibility"

Page 1, line 5, after "fund" insert "; and to repeal section 4 of chapter 422 of the 2007 Session Laws, relating to the effective date of the expansion of medical assistance benefits"

Page 1, line 17, replace "2,148,542" with "7,664,509" and replace "13,660,900" with "19,176,867"

Page 1, line 18, replace "(13,582,286)" with "(12,979,144)" and replace "46,528,070" with "47,131,212"

Page 1, line 20, replace "($11,434,02911)" with "($5,314,920)" and replace "60,188,970" with "66,308,079"

Page 1, line 21, replace "(16,622,573)" with "(14,544,808)" and replace "34,041,261" with "36,119,026"

Page 1, line 22, replace "5,188,544" with "9,229,888" and replace "26,147,709" with "30,189,053"

Page 2, line 3, replace "18,552,432" with "16,221,145" and replace "43,963,473" with "41,632,186"

Page 2, line 4, replace "4,364,279" with "6,622,596" and replace "72,176,081" with "74,434,398"

Page 2, line 6, replace "111,111,588" with "111,781,588" and replace "455,130,804" with "455,800,804"

Page 2, line 7, replace "189,244,935" with "214,327,791" and replace "1,306,432,756" with "1,331,515,612"

Page 2, line 10, replace "310,797,543" with "336,477,429" and replace "1,877,716,114" with "1,903,396,000"

Page 2, line 11, replace "223,418,640" with "271,725,995" and replace "1,350,082,207" with "1,398,389,562"

Page 2, line 12, replace "87,378,903" with "64,751,434" and replace "527,633,907" with "505,006,438"

Page 2, line 17, replace "715,235" with "1,026,397" and replace "8,209,132" with "8,520,294"

Page 2, line 18, replace "2,135,169" with "4,080,946" and replace "18,917,773" with "20,863,550"

Page 2, line 19, replace "823,712" with "1,153,359" and replace "10,641,067" with "10,970,714"

Page 2, line 20, replace "3,509,556" with "4,178,237" and replace "25,616,905" with "26,285,586"

Page 2, line 21, replace "3,699,225" with "5,370,959" and replace "29,760,855" with "31,432,589"

Page 2, line 22, replace "573,509" with "1,101,416" and replace "15,257,320" with "15,785,227"

Page 2, line 23, replace "3,675,196" with "4,489,089" and replace "24,362,468" with "25,176,361"

Page 2, line 24, replace "964,207" with "1,891,646" and replace "10,762,996" with "11,690,435"

Page 2, line 25, replace "9,519,982" with "12,508,784" and replace "66,911,926" with "69,900,728"

Page 2, line 26, replace "6,195,786" with "7,221,144" and replace "52,989,719" with "54,015,077"

Page 2, line 27, replace "31,811,577" with "43,021,977" and replace "263,430,161" with "274,640,561"

Page 2, line 28, replace "12,094,114" with "16,139,178" and replace "124,851,343" with "128,896,407"

Page 2, line 29, replace "19,717,463" with "26,882,799" and replace "138,578,818" with "145,744,154"

Page 3, line 3, replace "112,284,910" with "101,828,152" and replace "692,360,434" with "681,903,676"

Page 3, line 4, replace "218,890,181" with "359,292,050" and replace "1,508,974,811" with "1,649,376,680"

Page 3, line 5, replace "331,175,091" with "461,120,202" and replace "2,201,335,245" with "2,331,280,356"

Page 3, after line 6, insert:

"**SECTION 2. APPROPRIATION - FEDERAL FISCAL STIMULUS FUNDS - ADDITIONAL FUNDING APPROVAL.** The funds provided in this section, or so much of the funds as may be necessary, are appropriated from federal funds made available to the state under the federal American Recovery and Reinvestment Act of 2009, not otherwise appropriated, to the department of human services for the period beginning with the effective date of this Act and ending June 30, 2011, as follows:

Federal medical assistance percentage	$66,500,000
Elderly nutrition services	485,000

Child support incentive matching funds	3,200,000
Rehabilitation services and disability assistance and independent living	2,043,000
Individuals With Disabilities Education Act - Part C	2,140,000
Supplemental nutrition assistance program benefits and administration	9,874,747
Senior employment program	143,288
Older blind	3,170
Total federal funds	$84,389,205

The department of human services may seek emergency commission and budget section approval under chapter 54-16 for authority to spend any additional federal funds received under the federal American Recovery and Reinvestment Act of 2009 in excess of the amounts appropriated in this section for the period beginning with the effective date of this Act and ending June 30, 2011.

Any federal funds appropriated under this section, except for the funding of $66,500,000 relating to the federal medical assistance percentage and funding of $2,763,082 of child support incentive matching funds, are not a part of the agency's 2011-13 base budget. Any program expenditures made with these funds will not be replaced with state funds after the federal American Recovery and Reinvestment Act funds are no longer available.

SECTION 3. GENERAL FUND TRANSFER TO BUDGET STABILIZATION FUND - EXCEPTION - USE OF GENERAL FUND AMOUNTS. Notwithstanding section 54-27.2-02, the state treasurer and the office of management and budget may not include in the amount used to determine general fund transfers to the budget stabilization fund at the end of the 2007-09 biennium under chapter 54-27.2 any general fund amounts resulting from the increased federal share of medical assistance payments resulting from federal medical assistance percentage changes under the federal American Recovery and Reinvestment Act of 2009. The state treasurer and the office of management and budget shall separately account for these amounts and 2009-11 biennium general fund amounts resulting from federal medical assistance percentage changes under the federal American Recovery and Reinvestment Act of 2009 and use these amounts to defray the expenses of continuing program costs of the department of human services from the general fund for the biennium beginning July 1, 2009, and ending June 30, 2011, as follows:

Inflationary increases for human service providers	$32,564,450
Rate increases for selected medicaid services due to rebasing	21,788,982
Rate increases for nursing homes due to property limit changes	3,000,000
Wage increases for employees of nursing homes, basic care, and developmental disabilities services providers and qualified service providers	15,867,327
Global behavioral health initiative	4,088,873
Salary increases for department of human services employees	18,949,591
Total	$96,259,223

SECTION 4. CONTINGENT APPROPRIATION. If section 23 of this Act becomes effective, there is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $964,031, or so much of the sum as may be necessary, and from special funds derived from federal funds, the sum of $1,582,480, or so much of the sum as may be necessary, to the department of human services for the purpose of defraying the expenses of implementing the expansion of medical assistance benefits for pregnant women as provided for in section 23 of this Act, for the biennium beginning July 1, 2009, and ending June 30, 2011."

Page 3, line 19, replace "2,793,692" with "3,943,692"

Page 3, line 21, replace "3,146,298" with "4,296,298"

Page 4, remove lines 22 through 29

Page 5, line 1, replace "$14,739,128" with "$22,576,412" and replace "$4,950,451" with "$7,927,252"

Page 5, line 2, replace "$8,788,677" with "$13,649,160"

Page 5, line 4, replace "each employee earning a salary that is less than the eightieth" with "employees beginning July 1, 2009. Basic care and skilled nursing care facilities may not use the money received under this section for providing salary and benefit enhancements to administrators or directors of nursing."

Page 5, remove lines 5 and 6

Page 5, line 9, replace "$18,929,151" with "$21,639,106" and replace "$7,000,000" with "$7,086,807"

Page 5, line 10, replace "$11,929,151" with "$14,552,299"

Page 5, line 11, replace "each employee earning a" with "employees beginning July 1, 2009. Developmental disabilities service providers may not use the money received under this section for providing salary and benefit enhancements to administrators."

Page 5, replace lines 12 and 13 with:

"**SECTION 12. LEGISLATIVE INTENT - MEDICAID PROVIDER PAYMENTS.** It is the intent of the legislative assembly that the department of human services establish a goal to set medicaid payments for hospitals, physicians, chiropractors, and ambulances at 100 percent of cost.

SECTION 13. SUPPLEMENTAL PAYMENT - CRITICAL ACCESS HOSPITALS. The grants - medical assistance line item in subdivision 2 of section 1 of this Act includes the sum of $400,000 from the general fund that the department of human services shall use for providing a supplemental payment to eligible critical access hospitals. A critical access hospital is eligible for a payment under this section only if its percentage of medical payments exceeds 25 percent of its total annual revenue in its most recent audited financial statements and is located in a city with a population that does not exceed 1,450. The department shall seek federal medicaid funding to provide a portion of the $400,000 supplement payment. If federal medicaid funding is not available for a portion of the payment, the department may spend the $400,000 from the general fund for making the supplemental payment only if the action will not result in a reduction in federal medicaid funding to the state.

SECTION 14. LEGISLATIVE INTENT - DEVELOPMENTAL DISABILITIES MEDICALLY FRAGILE. It is the intent of the sixty-first legislative assembly that the additional funding for severely medically fragile and behaviorally challenged individuals be provided to the Anne Carlsen center and other similar private providers serving individuals with developmental disabilities in proportion to the respective severity of the critical medical and behavioral needs of each individual served by these providers. The funding is to become part of each provider's annual base budget and is not to reduce each provider's entitlement to additional critical needs staffing in future ratesetting by the department.

SECTION 15. LEGISLATIVE INTENT - DEMENTIA CARE SERVICES. It is the intent of the sixty-first legislative assembly that the department of human services integrate the dementia care services program established in House Bill No. 1043 with the home and community-based care services programs of the department.

SECTION 16. LEGISLATIVE COUNCIL STUDY - RETURNING VETERANS AND THEIR FAMILIES. During the 2009-11 interim, the legislative council shall consider studying the impact of veterans who are returning from wars and their families on the state's human services system. The study must include an analysis of the estimated cost of providing human service-related services to the returning veterans and their families, including treatment for traumatic brain injury and mental illness. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly.

SECTION 17. LEGISLATIVE INTENT - HOME TELEMONITORING SERVICES. It is the intent of the sixty-first legislative assembly that the department of human services consider the changes necessary to reimburse home telemonitoring services under the medicaid program at the same rate as skilled nursing visits provided in person.

SECTION 18. UNSPENT 2007-09 BIENNIUM - GENERAL FUND APPROPRIATIONS - EXCEPTION. The amount of $270,000 of the $3,100,000 for a sexual offender treatment addition at the state hospital appropriated in subdivision 3 of section 3 of 2007 Senate Bill No. 2012 is not subject to section 54-44.1-11 and may be spent during the 2009-11 biennium for completing roof repair at the state hospital."

Page 7, after line 21, insert:

"**SECTION 20. AMENDMENT.** Section 50-06-29 of the North Dakota Century Code is amended and reenacted as follows:

50-06-29. ~~Application for aging~~ Aging and disability resource ~~center funding~~ link - No wrong door model. ~~No later than December 31, 2007, the~~ The department of human services, within the limits of legislative appropriation, shall ~~seek federal funds for the planning~~ plan and ~~implementation of~~ implement an aging and disability resource ~~center for~~ link, "no wrong door" model, initially in up to two regions of the state. The department also may provide additional services or may provide services in multiple regions as required or allowed by any source providing funds for these purposes. The initial resource ~~center will be a single point of information program at the community level which~~ link model will help people residing in the state make informed decisions about the full range of long-term care service and support options, including both institutional and home and community-based care~~, and which~~. Participating access points will provide unbiased information and assistance to individuals needing either public or private resources, to professionals seeking assistance on behalf of their clients, and to individuals planning for their future long-term care needs. Upon receipt of ~~federal funds~~ funding, the department of human services may establish the initial aging and disability resource ~~center~~ link, "no wrong door" model, or it may request bids and award ~~a contract~~ contracts for ~~the provision of this service~~ training and coordination to implement the model utilizing existing community-based access points and for the provision of services. The ~~duties of the aging and disability resource center must include all duties~~ initial model and any subsequent model or variation of the model, as well as any additional locations will provide services consistent with those required ~~to receive federal funds, including~~ by the 2006 amendments to the Older Americans Act [Pub. L. 109-365; 120 Stat. 2522; 42 U.S.C. 3001 et seq.], providing information about the full range of long-term care service and support options available in the state to assure that consumers may make

informed decisions about their care. The resource ~~center~~ link's participating access points must be free from a conflict of interest which would inappropriately influence or bias the actions of a contractor, staff member, board member, or volunteer of the ~~resource center~~ access points to limit the information given to a consumer to steer the consumer to services that may also be provided by the ~~resource center~~ access points.

SECTION 21. AMENDMENT. Section 50-24.1-02.6 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-02.6. ~~(Contingent effective date - See note) Medical assistance benefits - Eligibility criteria.~~

~~1. The department shall provide medical assistance benefits to otherwise eligible persons who are:~~

~~a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and~~

~~b. Minors who have countable income that does not exceed an amount determined under subsection 3.~~

~~2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.~~

~~3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law, that provide an income level for all minors born before September 30, 1983, equal to one hundred percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined and that do not exceed legislative appropriations for that purpose.~~

~~4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.~~

~~(Contingent effective date - See note)~~ Medical assistance benefits - Eligibility criteria.

1. The department shall provide medical assistance benefits to otherwise eligible persons who are:

   a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and

   b. Minors who have countable income that does not exceed an amount determined under subsection 3.

2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.

3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law~~, that provide an income level for all individuals from birth through age eighteen equal to one hundred thirty-three percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined~~.

4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.

SECTION 22. AMENDMENT. Section 50-24.1-02.6 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-02.6. ~~(Contingent effective date - See note) Medical assistance benefits - Eligibility criteria.~~

~~1. The department shall provide medical assistance benefits to otherwise eligible persons who are:~~

~~a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and~~

~~b. Minors who have countable income that does not exceed an amount determined under subsection 3.~~

~~2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.~~

~~3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law, that provide an income level for all minors born before September 30, 1983, equal to one hundred percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined and that do not exceed legislative appropriations for that purpose.~~

~~4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.~~

~~(Contingent effective date - See note)~~ Medical assistance benefits - Eligibility criteria.

1. The department shall provide medical assistance benefits to otherwise eligible persons who are:

   a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and

   b. Minors who have countable income that does not exceed an amount determined under subsection 3.

2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of ~~subsection~~ subsections 3 and 4, is the greatest income level achievable without exceeding legislative appropriations for that purpose.

3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law~~, that provide an income level for all individuals from birth through age eighteen equal to one hundred thirty-three percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined~~.

4. The department of human services shall establish income levels for pregnant women at an amount, no less than required by federal law, equal to one hundred sixty-five percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined.

5. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets."

Page 7, after line 29, insert:

"**SECTION 24.** A new subsection to section 50-25.1-05 of the North Dakota Century Code is created and enacted as follows:

The department shall adopt rules that require all interviews of the alleged abused or neglected child conducted under this section to be audio-recorded or video-recorded, when possible. The rules must provide that a recording may not be disclosed except in accordance with section 50-25.1-11."

Page 8, after line 21, insert:

"**SECTION 26. REPEAL.** Section 4 of chapter 422 of the 2007 Session Laws is repealed.

SECTION 27. EFFECTIVE DATE. Section 23 of this Act becomes effective on the date the department of human services certifies to the legislative council that the department has received approval to claim federal financial participation to expand medical assistance benefits to pregnant women as provided for in section 1 of this Act, but may not become effective earlier than January 1, 2010.

SECTION 28. EMERGENCY. Sections 2 and 18 of this Act are declared to be an emergency measure."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT - LC 98013.0209 FN 4

A copy of the statement of purpose of amendment is on file in the Legislative Council Office.

2009 HOUSE APPROPRIATIONS

CONFERENCE COMMITTEE

HB 1012

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☒ Check here for Conference Committee

Hearing Date: 4/21/09

Recorder Job Number: 12036

Committee Clerk Signature Mary Ann Rehwaldt

Minutes:

Chairman Pollert: Called the meeting to order and took roll call. We will start discussions on HB 1012. If I could ask for someone to go through amendments? How would you like to do this?

Senator Kilzer: The way I carried it on the floor is that I followed the amendments .0209. It did take me an hour to do it. You are quite knowledgeable and you went through the bill as you did. There are some parts I can skip over or omit. If you do have questions ask them right away. If we can start on the fiscal part of .0209. I took the sections and when we come to that part we can have our discussion as we go through them. If we start on page 3 of the fiscal note, what we did was to restore salaries for funding and wages for anticipated savings from vacant positions and employee turnover. What we did was put the vacancies and turnovers back in. This amounted to a general fund of about $2 million and a total put back of about $6 million. The same thing for the child support program and also for the medical services program. The next one was the travel part. I know you on the house side had removed half of the travel. What we did was to restore half of what you removed. The thinking there was while gas prices have gone down to $4 a gallon to over $2 there was airline factors and others that have not went down. We felt that part of that should be restored.

Representative Bellew: We just removed half of the increase not half of the travel.

Senator Kilzer: The next part was restoring funding of the medically needy to reflect needs of 83% which you had taken down to 75%. On checking with the department we felt that it was best to restore that back up to the executive budget level and that is what you did. The next item is the increase funding of rebasing physician payment rates. I can take a moment to talk about what we felt about rebasing. As you know during the last interim the department did spend a lot of energy and time on rebasing hospitals, physicians, chiropractors, ambulance. The studies that were done were reviewed and placed in the executive budget where there were certain rates. Their rebased value positions were placed at 25% and others at various percentages. The rebasing wasn't calculated in the end on actual costs back. In some cases they had done surveys. In the case of ambulances they had gone at the Medicare level and dentists ended up at 75% of average bill charges. In the end I think they came pretty close or as close as they could be. In the area of physicians prior to the rebasing they were being reimbursed at 51% of the actual costs. The Governor's executive budget in reality by going to 25% of the rebased costs had raised that to about 64% of the actual costs. The house in reducing it to 20% of the rebased actually made it at 60% of the actual cost. They reduced it to 20% of the rebased which made it at 60% of the actual cost. Like I mentioned before, the actual payment was 51% executive budget would have brought it to 64%. There is not a direct parallel of rebased percentages and actual costs. The Senate changed the physician reimbursement to bring it up to 75% of the rebased cost. That actually puts it at about 88 or 89% of the actual cost.

Chairman Pollert: In y our discussions about the 75% of the physicians were there any discussions about staying close to the Governor's budget as far as lowering the rebasing to hospitals to fund the $10.8 million that 75% rebasing does. Did you look at it all as far as going

to equal it out?

Senator Kilzer: We did look at that in detail. What we determined was that in some providers like hospitals had been rebased more frequently than others. Some of those hadn't been rebased in about 17 years. The intent is another paragraph here is to eventually get this up to 100% of rebase. It is rather discouraging from the providers to have them fill this with more and more patients and to expect the providers to provide the service at a loss. The intent is to eventually get all of the providers up to 100% of the rebase. There was discussion on having it 75-80% across the board. It would have been very shocking to the required dollars to do that. This is why we attempted to put most providers at 75% and to keep hospitals at 100%. That takes me to the next page.

Chairman Pollert: On the rebasing of ambulances the governor's budget was at 75%. Did you put that at 100% of cost reports?

Senator Warner: As I recall the ambulance rate was 100% of Medicare. The Medicare rate was what it was targeted to.

Roxanne Woeste: The executive budget did rebase the ambulance rates to Meritcare rates. The house action was to provide 75% of that amount. The senate amendments returned back to the governor's budget.

Senator Kilzer: On the top of page 4 the first full item there is the Rolla situation. Rolla hospital is on the verge of closing. They have a Medicaid percentage of 31% of their revenues. The next is 16%. Rolla is the only one that has 25% of its revenues that comes from Medicaid. The federal law says they can't be reimbursed for outpatient lab and anesthesia services. That puts them $400,000 in the hole. We are putting $400,000 to keep their doors open. They are a critical access hospital.

Representative Bellew: Is this going to be an ongoing thing? Is this just a mandate approach? I'm assuming by what you just described that the $400,000 is going to happen almost every biennium.

Senator Kilzer: That was one of my concerns also. I am reassured that it won't be at temporary solution. They are going to be asking for continuing appropriation. In the past there has been discretionary payments made to hospitals, probably not in this situation. They do have this necessity to cost shift. Other third party payers are also wanting to be cost shifted to. The state becomes the last resort to keep it open.

Chairman Pollert: Wasn't there $1 million that was put to the rural hospitals. This is a furtherance that we are having with Rolla. If Rolla has a problem it would shift over to Devils Lake. We didn't have the discussion in the house but I thought it would happen in the Senate. I knew there was talk about it.

Senator Kilzer: The next item is to bring up funding for the state children's health insurance program to reflect utilization reprojections and a revised premium amount. The revised premium amount meant that when the budget was put together it was anticipated that it would cost $243.93 per child. Later revisions by Blue Cross Blue Shield which successfully bid for the CHIPS program placed it at $228.71. That is a little over $15 a month difference. This brings up the number of added kids at 200% of poverty to 158.

Senator Fischer: Not other than the fact that we can go to 200% for the same amount of money or less before the reprojections as well as the premium increase. At the percent of the money it was in at the house at 160.

Chairman Pollert: Could we get a spreadsheet as far as the number of enrollees and how that came about.

Senator Fischer: You certainly can. That is addressed in the other house bill.

Chairman Pollert: In other words did the policy change happen in the other house bill that came forward? Did HB 1478 change as well?

Senator Fischer: They changed the policy and the reflections were made in that bill as well as the budget.

Chairman Pollert: So if we could get the numbers that would be great.

Senator Kilzer: The next item is the increase funding for the state children's health insurance program funding to increase eligibility from 160 to 200%. The next item is restoring funding and remove for the house grants medical assistance line item for medical services projected case load utilization reports. The house had taken out the general fund money for that.

Chairman Pollert: On the case loads for the 3 figures that the house did and you restored, we will go through on how you got those numbers. That can be a discussion for a future meeting.

Senator Kilzer: The total on this had been $132.2 million in general funds. The house had reduced $9.6 million out of that. The next fund is a contingent appropriation to expand medical assistance benefits for pregnant women if approved by the federal government. This is to increase the poverty line of 133 to 165% of poverty. If I recall that would have made 387 more women eligible a year.

Chairman Pollert: That was defeated on the house side so the Senate just added it into the DHS budget?

Senator Kilzer: That is correct. The next one is to provide funding for the medical assistance percentage for the last 7 months of the 2009 -11 biennium. As you recall the stimulus package and the FMAP component to that is $66.5 million but it expires at the end of the calendar year 2010. There will be the first six months of the year 2011 that the FMAP will revert back down so the state will have to kick in the $9.5 million.

Chairman Pollert: I would suspect that you would have language in here about the federal stimulus dollars because there is $30 some million that will come from the AARA.

Senator Kilzer: Yes we do. The FMAP is $66.5 million designated for that. The next item is starting in the long term care program restoring funding added in the executive budget and the removal of the house for the addition of a third tier personal care which would allow units of 1,200 units of care per month. That is the increase of personal care per day from 8-10 hours. The idea there is that if you have personal care you can get both morning and evening so the patient can stay in their own home longer. We put that back in. The next one is add funding of $7.1 million of which $2.8 million is from the general fund of the amounts provided to the house to provide total funding of $22.5 million of which $7.9 is from general fund, $1 million from health care trust fund and $13.6 is from federal funds to provide a $1 salary benefit to all employees employed by basic care and nursing facilities except for administrators and directors of nursing. The thing about that was the house had said if you are above the 80 or 90th percentile you didn't get it. This is restoring for all benefits for the workers below the 80 or 90 percentile.

Chairman Pollert: One if the issues was that there was $1 million in IGT funds that the house had allocated for this particular section which was taken out by the Senate. We will have a discussion as far as the amount of money the house had appropriated over was $2.9 million less. I think our ideas on the house side was that the discretion would go to giving authority between DHS and the administrators to go up to $1 and I think you guys are going to make sure everyone gets that. We have a language difference and dollars amounts to talk about.

Senator Kilzer: That paragraph was related to the IGT funds and the people who work in long term care nursing homes. The next is that the DD providers at the 90th percentile and the one line was the QSP's. The next one is adding funding and grants to the medical assistance line

item for development disabilities providers who are serving medically fragile and behaviorally challenged. When you see that phrase you immediately think of the Anne Carlsen Center.

Chairman Pollert: Can I back you up. The $1 increase for the QSP's, I take it that was done to get them in line with the dollar for long term care and DD providers. Was that a figure provided to you by DHS? Does that include the QSP's in the agencies, there are two different categories.

Senator Kilzer: The next one is to restore funding removed by the house and grants medical assistance line item for long term care projected case load utilization rates. This is for long term care nursing homes and home and community based services. The executive budget it was $194.8 million and the house they removed $5.6. These are general funds and we restored that. The last item is to restore funding removed by the house in then grants medical assistance line item for developmental disabilities grants projected case load utilization. That is for DD's only. The executive budget would be $118.9 million. The house had taken out $2.4 million. We restored that. That brings us to aging services.

Chairman Pollert: With that we will go for an hour next time and be in recess until tomorrow.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☒ Check here for Conference Committee

Hearing Date: 4/22/09

Recorder Job Number: 12103

Committee Clerk Signature

Minutes:

Chairman Pollert: Called the meeting to order and verified that every member was present.

Senator Kilzer: We were going through the amendments that the Senate had made to HB 1012. I was at the bottom of page 4 to the attachment of .0209 on the fiscal part where it said aging services. I have talked about the travel and the vacant positions on the beginning. I haven't gone through each one. That takes us over to the next page 5. The next item is providing funding for the aging and disability resource link. The house had removed $600,000 of that and this had also been in HB 1476 which had been killed. I think we put back $300,000 or half of that as I remember.

Chairman Pollert: The idea of the $300,000, what was that? Were you going to let DHS bring forward a plan? What was the idea?

Senator Kilzer: It was to have 2 of the pilot projects and we thought that one would be appropriate to start with. The next item is to provide funding for the community care program of $120,000. This was not in the executive budget or house budget, it was put in the Senate. This was to have a community care program based out of the nursing home in Arthur, ND. It involves the word as it is described where you have more volunteers and more people involved with outside services to allow people to not have to go to a nursing home at an early stage.

This would have very good benefits not only for the welfare of the patients but also for the expenses.

Chairman Pollert: The $120,000 was that in the house or Senate bill?? I don't remember anything about that. Was it something that just came in on the Senate side during the second half? Is this kind of like a similar program to the pilot project that was put back in with the $300,000?

Senator Fischer: It is much like the one above it. It's a program that has been ongoing or started. I don't think it was that many years ago. They would like to expand it to supplement or replace the pilot aging disability. It is for the same thing. As far is it being alike there are some things in both proposals that are unique. However they do have the same overall purpose. That is to assist aging population in providing the right services, getting people information or services. I think one of the two is going to have a distinct change in funding because it will keep people out of nursing homes prematurely.

Chairman Pollert: I can't speak for the whole house but I will speak for our side of the HR section, two years ago there was testimony to have this in 53 counties. We had trouble with that with the one stop centers. The one in Arthur, is it one of the deals where you see it spreading through the whole state? What would the plan be if that was accepted the $120,000.

Senator Fischer: I don't see it as a state wide program now. Whether they decide to expand that would be. Right now I'm sure it's regional. We talked to them about what the cost would be to expand it to a region. Right now this is just a regional program. They didn't talk anything about expanding it.

Chairman Pollert: We on the house side are having considerable discussions that appropriations is getting into policy. This looks like one of them. I know we have to look at that. For myself I would like to see more information on community care like who they have

employed and what they are doing. That is why I want some more information to say we can know what is going on.

Senator Fischer: I would be more than happy. There are those of us who don't agree that social services is doing a good job. The fact is that over the years I have heard from constituents and others that the problem with getting information on programs that aren't necessarily in social services is a telephone call and it ends there. The idea is to supply information to constituents on where they actually do go and we don't provide the services.

Representative Bellew: I think most of the questions were answered but mine was who was going to get the money and how was it going to be spent? You have $120,000 in there, what is that for?

Senator Fischer: We will get all of that to break it down.

Representative Bellew: Is there a specific organization that this is directed to?

Representative Ekstrom: I have always been a fan of single point of entry. I think it's an important program. I don't' know if we really have a decent model yet as to what this would look like. In terms of where I might sit in terms of this particular item, I was really bothered and would like to see the funding going to getting the meals out there, getting them dealt with, transportation issues, things like that. I really do believe that the legislature needs to address the single point of entry notion. I haven't seen a model yet that lets me do this. You have this long term care that is already in there. We have this in terms of meals and transportation would be my priority at the moment until I saw a model.

Senator Kilzer: The next item under children and family services programs was to increase funding for health families by $200,000 from the general fund. Going up from $300,000 to $500,000. Then the last one under children and family services is the village family services of $1.2 million. The Governor had $250,000. The house did not change that. The question is on

the amount of federal funds that would be available for that. It is a very large expansion on an excellent program.

Chairman Pollert: You are on the add funding for family group counseling right?

Senator Kilzer: Yes.

Chairman Pollert: You mentioned something about the village. Is that what you are talking about? What is family group conferencing? We had the one Senate bill that had health families in it, part of this family and group conferencing. Are you saying that you are just picking out one particular item or is this kind of all encompassing of SB 2396? If it is you are adding more money because there was health families included in that original SB 2396.

Senator Kilzer: I'm not sure on this. I don't call exactly why.

Chairman Pollert: What we could do is get the old 2396 but I remember there were 4 items in there. One was family resource centers which is through the NDSU extension service which was $250,000. Once SB 2396 was killed on the house floor the house appropriations education and environment section put $125,000 in it. I'm wondering how much of a double up we are going to have. Wasn't there something on family group conferencing.

Senator Fischer: This is to help families resolve issues as they end up in foster care. They have been doing this for quite some time.

Representative Ekstrom: Is this related to the project at all in terms of the model they might be using? A group of folks from here went out to Pennsylvania and saw how they were handling foster care. Is that SB 2396?

Chairman Pollert: SB 2396 was an abbreviated form of the project when it came forward it wasn't an OAR. That is what it was. It is being pieced back together by amendments. Maybe what we will have to do when we get to this point is add the question and bring someone from DHS to talk about the family group conferencing.

Senator Kilzer: The next is compulsive gambling. This puts $400,000 from the lottery into this program. The executive budget added $300,000 for a total of $700,000. The house reduced $150,000. That was down to $550,000. It came to us in the Senate and we added $100,000 to bring it back to $650,000.

Chairman Pollert: It's a net reduction of $50,000?

Senator Kilzer: The next is to restore funding in the grants line item for the Governor's prevention and advisory council on grants. This is mainly for students against bad decisions and underage drinking and things like that. There was $100,000 in the present biennium for the community health trust fund. There was $200,000 in the executive budget. The house removed all of that and the Senate restored the $200,000. That is where it stands at the moment.

Chairman Pollert: The net amount into prevention and advisory grants is not the $100,000 from last biennium. It's actually $100,000 increase from last biennium.

Senator Kilzer: Correct it would be doubled. The next one is to provide additional funding for the peer support program.

Representative Ekstrom: On the OAR sheet for the peer support there were federal dollars available. On OAR it was $2.3 million general funds. Is there any federal funds that would come from that if we put that money in? I

Senator Kilzer: The Senate had put in $300,000 for that program and you will see it won't be in the executive or house version.

Chairman Pollert: It was an OAR.

Senator Kilzer: Federal stimulus funding is all federal funds. The first one is the SNAP program which is the old food stamp program of $9.8 million of all federal money. There are $31,000 people in ND receiving that benefit. The next one is the child support enforcement

activities. As you noticed it is $2.7 million with parentheses around it with a general fund of $33.2 million federal funds. There is the fact that there is $400,000 in the current budget that can't be replaced with the new stimulus. That is why it's listed there. $3.2 is the maximum available for federal funds. The biggest one of all is the FMAP. I'm sure you are all familiar with what that is. The FMAP is reduced down to $60 something from 63 from the period of October 2008 through the end of December 2010. In the first quarter of the next biennium the FMAP again reverts back so the state has to pay a higher percentage again and that amounts to $9.6 million that you will have to pay out of general funds to make up for the ending of the FMAP. The elderly nutrition services is $495,000 which is over and above the regular amount and I don't have that in front of me. The senior employment program is $143,000. There is $3,000 for older services and there is something like $480,000 in their account which I'm not sure is the present biennium. They do have an account and this would add to that. The developmentally delayed infant's age 0-3 is part of the disability education act part C.

Representative Bellew: Would that include kids who can't hear?

Senator Kilzer: I think part C is a category by itself and I'm not too sure what is all included in that. The disability certainly does include infants who have hearing problems. There is a total of $4.1 million all federal funds in this biennium already. This would be adding to that amount. The increased funding for centers for independent living $243,000. Their basic amount is $2.1 million. The house had $400,000 and the Senate had restored $150,000 of that other. That is basically a 1.85 million prior to the stimulus money.

Chairman Pollert: Could I look at it another way. The original budget request was for $800,000 and the house had taken out $400,000. You added back in $150,000 plus the $243,000 which gets you close to $800,000. Could you look at it that way as well? Is that your thought process?

Senator Kilzer: Yes. That is if you put it together with the next thing which is location rehabilitation services.

Chairman Pollert: Was this listing of the federal stimulus money exactly the same as it came in the Legislative Council sheets? Is that a correct assumption. I know in the health department and all of that we just had lists in there saying the AAR funds.

Roxanne Woeste: It is very close. I think there was one number that the department was able to give us an updated number. I think it was the elderly nutrition services perhaps in their earlier memo completed by our office was at the $500,000. That has been reduced to $485,000 with the new estimate that has been received.

Senator Kilzer: I will move on to page 7. The talk about some of the things on the state hospital. There had been the 5 FTE's for the global health initiative that were in the executive budget that had been removed by the house. Six of the departments said they can get along without the sixth one. They need to find a pharmacy person for the DOCR unit at the state hospital. That was restored on page 7.

Chairman Pollert: Then you put back the $1 million that the house had reduced. We had asked for a priority list from the state hospital. Then we took up that list and came up with the $1 million. It was items 15 or less on their priority list and you restored all of the extraordinary repairs they had requested.

Senator Kilzer: We had a list but I don't recall that the roof was on there at that time. On the next page, page 8 in addition to the vacant positions with employee turnover and travel. There was 150,000 dollars on the developmental center. There was a lot of $10,000 on that list also that should have attention so we put that in. On page 9 it talks about the global health initiatives. There is really 2 situations there that are involved on the next page and that page.

Chairman Pollert: Global health initiative, I know DHS and I can see what they are thinking. I didn't like that. Do you have your hands around what that means? Should have it been a statewide health initiative. Should it be something else that should be friendlier? Did you get a good idea of what you thought global health was?

Senator Kilzer: I had the advantage of talking to Brenda 1 on 1. I can give you my perception that I was left with after talking to her. There is two components. There is the inpatient and outpatient. Inpatient means you are institutionalized in the hospital. The state hospital has been more than full at times. The overload goes to the 5 hospitals in the state that take inpatient psychiatric patients. That is one of the components of the expenses of global health initiative. The other one is mostly on the outpatient part where it is talking about the human health service centers and the person that is outpatient. The main item there is the case management load. The Feds are saying the case managers are spread too thin and we should have more of them. That is the other part of the global health initiate that we feel needs addressing. That is what it amounts to.

Chairman Pollert: The inpatient is kind of a rebasing of the hospital contracts, is that what that is? It must be negotiated rates with Trinity, St. A's, Medcenter One, etc. There has been renegotiated contracts and those contracts have gone up. I probably have that information somewhere.

Senator Kilzer: That is most of it. One part is to bring the non Medicaid patient reimbursement up to the Medicaid reimbursement levels. There is a difference there. That is one problem that is being addressed here.

Chairman Pollert: I'd like to see what that rebasing cost was. It's simpler because I have this organized. We have the figures for the state hospital for their employees plus what you want for the human service center.

Senator Kilzer: At the state hospital they do staff at 85% of capacity. When they get to be over 100% they are really quite understaffed. That is one of the reasons they have to send out patients when they are full.

Chairman Pollert: What I struggle with is in the DOCR budget and how you continue the DOCR system is full. Yet they want more employees. I could sit and say the same thing for the state hospital. They are full but we are going to add more employees. I just struggle with that. I know it is a simple statement and I know it's a complex situation. I just struggle with that.

Representative Ekstrom: Can the department provide us with a handout in terms of the individuals coming to both the human service centers as well as to the state hospitals, how many are more severely ill than what we have seen in the past. That was my rational for saying we did need to expand and get more employees. They are handling more difficult cases. It's very much like administrative segregation that we have at DOCR. We are expanding that and having a much more difficult type of prisoner. If they could provide us with a handout in terms of the case load as well as how severally ill these people are. We saw that with the human service centers particularly. They have tough characters to deal with.

Senator Kilzer: I have covered the field overall.

Chairman Pollert: Did we put back in some at risk programs? I have a little handout that says human service centers have funding for young adult transition services.

Senator Warner: That is originally the 2 centers if I recall one in Fargo and Bismarck. They had people transitioning out of them. It is targeted at younger age homeless. There were people transitioning out of foster care. They need more structure. We funded 1 of those centers at the discretion of the agencies to determine which city would receive the center. They require 24/7 presence of staff.

Chairman Pollert: I would ask that we have the total amount of rebasing contracts on global health and I don't want to add up all the service centers for global health if I could get that as one figure. I don't want to add it all up when I'm going through this. Was there any amendments done as far as studies? Maybe we didn't discuss this but I know there were some amendments passed on the Senate floor. Could you discuss them?

Senator Kilzer: There were 2 floor amendments that were offered and passed. One had to do with the raising to $95 the personal care allowances. I think it is presently at $60 a month. We raised it to $75. There was a floor amendment on the Senate floor that raised it up to $95 a month. It does have a fiscal affect. The other floor amendment was on the salary for DD providers QSP's and nursing home personnel raising the 6,6 and 1 up to 7&7 and 1.

Representative Bellew: Explain the 7,7,and 1.

Senator Warner: The 7&7 relates to the rate of inflation that was built into the structure. It is an overall cost of which salaries are only a part. It's part of the overall inflation.

Representative Bellew: What is the 1?

Senator Warner: The $1 an hour salary increase of employees at the local level of administration. That was on the house side as well.

Chairman Pollert: You are talking about the $1 an hour for long term care, the DD providers. And you also added the $1 for QSP's. So the 7&7 is department wide for hospitals, etc.?

Senator Warner: Just those 3 categories of long term care, DD, and QSP's. The other providers are handled separately at 6%. Some of them are rebased to 100% of the recommended rebase rate.

Roxanne Woeste: The amendment that passed on the floor is the 7&7 for everyone. I believe the rebased services would be 0&7. All other services would be a 7% annual increased.

Chairman Pollert: So it is departmental wide?

Roxanne Woeste: Right. It returns to the Governor's budget.

Chairman Pollert: Could we go if there was any language added on the Senate side as far as sections to 1012?

Representative Bellew: I would like to discuss the 75 and 95 personal need allowance.

Chairman Pollert: was the 75 added as an extra by the house or was that going to the Governor's level? Was the amendment made in the HR section? Was the Governor's budget at 65 and we added that to it?

Roxanne Woeste: I believe the Governor's budget was at 60. The house increased it to 75% and the Senate increased it to 95%.

Representative Bellew: I have a couple questions on the dollars. On page 2 of the breakout of the dollar amount it says the total general fund reduction of $10,456,000. I would like to know how that figure was derived. I can get it later.

Chairman Pollert: I will go one step further it seems to me that we have taken federal stimulus dollars that are one time funding and are funding them on ongoing programs. I would like to have Legislative Council or someone from DHS tell me how much the dollar figures are. I have concerns about funding ongoing programs with one time funding. I would like to have that prepared for us too.

Roxanne Woeste: We can put something together. I think the largest is the FMAP. They are going to get additional funding source dollars and it is going to decrease the amount of general fund dollars we will need to make for the FMAP related expenditures.

Chairman Pollert: I understand that. Maybe we need a better breakout.

Roxanne Woeste: There are only two areas in this budget where we are replacing stimulus for general fund dollars. The one area is the FMAP and the other area is the child support.

Chairman Pollert: Somewhere in the budget I am going to use approximate numbers here of $29 million off the DHS budget. The federal stimulus dollars came in and those were roughly $30 million and some odd dollars for the 07-09 biennium which will go back as general fund turn back with the other $20 million. My guess is that DHS is going to have a $50 million general turn back in 07-09. Then in 09-11 there is $66 million. Of the $66 million on the Senate side it was added that the approximate is $58 million. The $58 million, it means there is roughly a $29 million increase over the Governor's budget. Somewhere in there it is either federal stimulus dollars or one time funding or ongoing through general funds. Somehow I want to get a hand on that. I want some more accurate figures.

Roxanne Woeste: That is correct. The Senators provided you with those increases. Those are the increases we just mentioned in all of these amendments. We are going off of HB .0500.

Senator Kilzer: I'm still a strong supporter on .0209 is showing the changes if you want the bill as it is now you go to .0500.

Chairman Pollert: We will go through .0209.

Senator Kilzer: Section 2 on page 2 does talk about the stimulus funds. The next page talks about some of the rebasing and some of the property limit changes and the wage increases that were in the bill, and also the global health initiative. Going over to page 4 number 12 it is the intent of the legislative assembly that the human services department establish a goal to set Medicaid payments for hospitals, physicians, chiropractors at 100% of cost. It doesn't say when but that is the reason.

Representative Bellew: Is that of cost of Medicare or Medicaid?

Senator Kilzer: It is rebasing that is not on Medicare or anything else except the actual cost to provide the service. That is what rebasing means. It's not bill charges or the Medicare feel schedule. It's the actual cost of providing the services. Sometimes as was done in this case

you can't determine the costs precisely. They do regional surveys and things like that. They go to Medicare as the last resort. The definition is to come up with the actual cost.

Chairman Pollert: So it could be looked at both from the house and senate as far as the rebasing that is being done in HB 1012 is one step towards that. You are going another level higher most definitely.

Senator Kilzer: They did the rebasing during the interim. That is all done already. The next thing to do is to apply it. This is why you do the study, to reach 100%. Section 13 is the Rolla situation. This is what was being done in K-12 education. 14 is the Ann Carlsen Center. It is the severely challenged children.

Chairman Pollert: In the numbers you provided there is $400,000 some thousand in general funds. Plus the study of what you had in Section 16. You enhanced it more than what the houses 2 options were. Does anyone in the house side remember? Was there a third level or did they do it at the second level? We can get that answered next time.

Representative Ekstrom: I know this is after the fact but we moved a number of people to other facilities. There is additional cost incurred by the facilities to receive these people. How are we going to get reimbursed for the additional cost?

Senator Kilzer: I have not heard the answer to that question. It's a little more widespread. We also have the same problem with the Veteran's Hospital. I have not heard. Moving on with section15 concerns HB 1043. That was the dementia services particularly providing that were borderline that need to be institutionalized .The reason it is close to home and community based services is because the institutions have a good network of social workers and people like that to assist people. It is the ones that are receiving home and community based care services or aren't receiving any services that should be soon. Number 16 is to have a study

about returning veteran's from the current war that have traumatic brain injury and mental illness to kind of get an idea of what the severity of the problem holds.

Chairman Pollert: SB 2198 deals with TBI. Part of that bill is a little discussion on how the veterans would be impacted on SB 2198. Should this be a little more broader to talk about TBI for veterans. SB 2198, I have some questions on as far as how much that funding should be. It's currently at 40 and that is a high figure.

Senator Fischer: SB 2198 is TBI alone. It doesn't necessarily tell you veterans.

Chairman Pollert: Correct but it might. I'm trying to find out that information too.

Senator Fischer: Maybe it should be included?

Chairman Pollert: That is what I'm wondering. I'm not talking all of SB 2198 it's a matter of should the funding be in there as well or through here and have the study broader?

Senator Kilzer: Section 17 is home tele-monitoring. That section wants to consider changes to reimburse home tele-monitoring services at the same level of skilled nursing. This is becoming a very widely accepted type of medical follow up. I think it certainly has its place. Section 18 refers to the fact that the fifth unit at the state hospital for dangerous sexual offender treatment was not built. The last ones I didn't make good notes on.

Chairman Pollert: What we will do is stop here. We will continue when we are rescheduled.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☒ Check here for Conference Committee

Hearing Date: 4/23/09

Recorder Job Number: 12177

Committee Clerk Signature

Minutes:

Chairman Pollert: Called the meeting to order. Let the record show all members are present. We will only be able to go until about five to five. I will tell you really quick that we will meet between 9 and 10 and go through the case load utilization and Saturday morning between 8 and 9. Because of our time table is short I asked for information on the project because the Senate added in health steps. I asked if Tara could come down and give us a quick rundown that the committee would like as far as SB 2396 and see if there are questions on the Senate amendments.

Tara Lea Muhlhauser: I am the director of children and family services division. My understanding is you wanted me to address SB 2396 as some have been referring to as the Allegheny county bill. Senator Lee was the sponsor. There was a study group that went to Allegheny county Pennsylvania to look at improvements they have made in their system specifically improvements that were in regard to preventing placement of children and foster care and other kind of what we call front end programs or projects to keep them out of the formal child welfare system. The end result of this was SB 2396 that had 4 funding components in it. If you would like to run through the 4 components I can do that and talk

about the various ways. We believe that most of them have been in fact funded in other budget amendments or proposals. If you want me to walk through all four of those I could.

Chairman Pollert: If you could do that in a condensed form.

Tara Lea Muhlhauser: Parent resource centers were placed in SB 2396 for a cost of $250,000. I could tell you that the department has been supporting parent resource centers through some community based child abuse and neglect federal money for the last biennium. . We have increased our amount of funding in the proposed CFS budget for about $100,000. We are about $150,000 under what was requested in SB 2396.

Chairman Pollert: If you increase it $100, 000 the Senate added back in $125,000.

Tara Lea Muhlhauser: That was an additional amount over and above their appropriation last biennium.

Chairman Pollert: After the defeat of SB 2396. The education put that in the bill. So you are saying that the CFS had an extra $100,000 put in it.

Tara Lea Muhlhauser: Yes. Healthy Families program expansion you will see it reads here $385,000. That was an early amount that you heard testimony from people saying they no longer needed $385,000 because the Minot expansion project was not going to happen this biennium. They lowered their request $200,000 to allow for the expansion of Burleigh/Morton County. You have included that within the amendments for the current budget. We also have $300,000 included for the Grand Forks site. The family team decision making pilot programs Senator Lee and I talked about having some opportunity to have a slightly different model of family group decision making. I can tell you in the CFS budget now we have about $1.7 million in there.

Chairman Pollert: What was that on?

Tara Lea Muhlhauser: The family team decision making pilot programs. The short answer for

us is that we also believe that it is funded. We have an already existing amount of $1.7 million, in the CFS budget part of which goes to in home family services. Part of that is going to fund 3 family group decision making positions in the village. I also understand with the Senate amendment there was some additional money that was added into family group decision making.

Chairman Pollert: So the family group decision making, is that the $1.2 million. That is the family group conferencing?

Tara Lea Muhlhauser: Yes.

Chairman Pollert: Can we get a worksheet on what you are telling us about?

Tara Lea Muhlhauser: The thing to remember about the $1.7 is that it actually divided between intensive in home that the family offers and intensive family group decision making. We do it as part of one RFP because for folks that are cross trained. In that $1.7 there are 3.37 FTE's dedicated to family group decision making. The last amount was a safety and permanent funds enhancement. These are dollars that counties have access to provide flexible funds for families to prevent the removal of children for the placement of children and foster care. Our CFS budget for the next biennium has a fund of $100,000 for those funds. We feel this has essentially been funded as well.

Chairman Pollert: You are saying between the 07-09 budget that it was an enhancement of $100,000?

Tara Lea Muhlhauser; Correct. My offer to you today is that we have really essentially funded the items in SB 2396. At your request I can put the detail in a worksheet form.

Chairman Pollert: As far as the amendments we are still through the discovery phase. Then we will start hopefully making decisions unless we agree with the Senate. On the $1.2 that the Senate put in, is that the exact same thing as family team decision making?

Tara Lea Muhlhauser: Essentially it is. There are a couple different models out there. I think we have been a little lacks about using the terms interchangeably. Family group decision making is usually a shorter process that happens early on in the case. Family group conferencing typically is a longer more involved process that brings more people together and later in a case. From our terms family group conferencing is sometimes a greater cost than family team decision making per meeting. The village uses both models although the majority of their work is falling in the family group conferencing area. There are similar concepts and results that they can offer.

Chairman Pollert: I take it these go out in grants to the Village?

Tara Lea Muhlhauser: Correct. They go out in FTE form and people do the work.

Chairman Pollert: Any questions? I had asked for information on the community of care. If something is added into the budget I need to know what it is about.

Jane Strummen: Thank you for allowing me to be here for a few minutes so I can briefly explain the work of community of care. Community of care is a new member based nonprofit organization. It began as a pilot project of a Good Samaritan society based out of the nursing home in Arthur. It has a mission of assuring older adults have access to health, human, and spiritual services essential to their well being, particularly in rural Cass County as a service area. It was really created to address the significant challenges that rural communities have experienced over the past decades and the negative impact on older adults. The idea of the pilot project was conceived by the former good Samaritan society doctor Judy Ryan, Dr. Klayton Jenson, Shelly Peterson, and myself. Since it initiated it has evolved into an independent 501c3 nonprofit organization. It is governed by a 10 member board of directors, it has 200 plus members, and a number of services have been developed based on needs that have been identified in rural Cass County. Some include information referral assistance, care

giver support and education, state health insurance counseling, a volunteer program, health promotion, and education and aging issues. Last year we served 600 unduplicated persons and that number has been increasing each year. We partnered with 40 plus trained community volunteers, parish nurses, civic service clubs, area use, and other service providers. The formal inter agency agreement with the major service providers in the Fargo metro area. The purpose is to streamline access for those individuals needing some assistance. We are trying to make the process as simple as possible. Community of care is really working to improve the long term care system in incremental, practical, common sense ways. At the same time it will perhaps develop a model that other rural communities can use. The handout that you have talks about some of the benefits on the first side. We are hoping by adding more resources in our local community that it will help delay institutional care and provide the most use of cost effective services. We have a strong volunteer component that is part of our program that has been key by providing knowledge and education. It is helping people access the current services that are available. I think the key for us is that we haven't duplicated any services, we have just addressed the gaps we have maybe identified and brought more resources to a rural area. Community of care has a budget of $175,000. Currently about 1/3 of it comes from foundation grants, 1/3 from charitable contributions, and a remainder from government contracts, a grant, and united way allocation. We are requesting $120,000 during the next biennium so that we can use our experience and knowledge that we have leered to fully develop this model and we can conduct an evaluation whether this is a cost effective model that would be appropriate for the rural communities. On the back side I have given more detail on the pilot project and the outcome objectives that we hope to accomplish.

Chairman Pollert: For the $120,000 that the Senate added into 1012 are you looking to outreach from Cass County and what is the difference between your project and the one stop centers that the DHS has been advocating for.

Jane Strummen: Your second question, community of care is a local project. We have developed services which is the difference in the ADRC. We have filled in the gaps and developed resources we need in our rural communities. I think that is a key difference. We do provide information and education. We also provide the services that are lacking in that area.

Chairman Pollert: What do you mean services that are lacking?

Jane Strummen: Transportation is a critical one. Our residents need to go into Fargo for the most part for their medical services. Transportation is a key that we have been providing. If people don't have transportation access to health care it is difficult for them to remain in our rural communities. That is just one of the services we are providing.

Representative Ekstrom: Have you got a geographic boundary you are working with?

Jane Strummen: Yes. It is rural Cass County. It is a large geographic area. Our program is still new. We are still evolving and serving more people. We would like to have more of a presence in some of our outlying communities like Kindred and Buffalo. We have offices located in Casselton and Arthur. As of any new program it takes awhile for people to understand what we do and what we provide. We are making roads to letting people know more about our services. We are still evolving and growing.

Representative Ekstrom: This $120,000 you would be doing an expansion. This would be in addition to the $175,000 budget that you now have or would we be replacing some of those funds?

Jane Strummen: It is our budget for 2009. Part of that includes grants we are participating. That also includes charitable donations that we have raised and we do fundraising events on a

regular basis. The $175,000 is what we need. We have work to do to get that before the end of the year.

Chairman Pollert: I am going to run out of time. This is almost like one of the bill that is put in with an amendment we don't know anything about. I would ask you get your testimony distributed to the members of the conference committee. The discussion with some of us on the house side has been that it seems like the services are available and are already being offered. Is there a different way of doing it? You are bringing that forward through a Senate amendments and the bill had failed in the house side for the one stop centers. Whatever information you can provide, we have a couple more minutes unless someone has more questions. These normally aren't time for testimony.

Representative Ekstrom: Your program is the pilot we have been talking about in terms of how that one stop might work. I think if you could provide the committee information about the step by step process and what kind of outcome you have had. Give us some data that says this individual came to us, and were on the verge of going to a nursing facility. By doing this we managed to keep that individual in the community at a lesser cost.

Jane Strummen: I could give you one good example. He is my age, severely diabetic and on dialysis four times a week. Before we were serving him he was in and out of the hospital for months on end. We have provided him with transportation 4 days a week at 6 hours a day for the volunteer to take him to and back to his home. We have worked very closely with Cass County social services because he is on Medicaid. We have worked with public health because he needs a care coordination because of his cognitive issues. He needs a caring network to be able to keep him in his home. I know that if he didn't have that caring network he would have to be in supportive environment. Being in a rural community with dialysis is very difficult to stay in your home.

Chairman Pollert: Did you have this form of a bill or anything in the house or senate this session?

Jane Strummen: I didn't. We really were following the ADRC legislation on the house side to see where that evolved to see if community of care might be appropriate to be a Pilot project even though we are different and very distinct. We are doing some of those functions by providing the education and information to individuals. We didn't have a separate bill.

Chairman Pollert: I would appreciate that when you give us that information that you give us the difference between your plan and what the DHS is. What I'm going to do tomorrow is give DHS an opportunity to share their $300,000 plan because I have to be fair to them as well. We will be in recess until tomorrow morning at 9.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☑ Check here for Conference Committee

Hearing Date: 4/24/09

Recorder Job Number: 12187

Committee Clerk Signature Morgan Pearce

Minutes:

Chairman Pollert: Called the conference committee to order and let the record show that all members are present. With that we will start from where we left off. My plan is for this hour to have the department come up and talk about the one stop centers. Then I will ask Brenda to come forward to distribute out the information. I asked for some information on the global health. Then we will get into the case load utilizations that the house did and see how we got into those calculations. Hopefully that gets us there.

Carol Olson: The department is here this morning to give its support over to the community of care and support their efforts in continuing their no wrong door approach. They have proven to be successful in their efforts and we feel there is no reason to continue a whole different system in state government. We would like to support what they have in place right now. We would like to make it easier for everyone concerned and to go back to where we originally started would take me a half hour to explain. They were originally in our plan to begin with when they started with the house. We got derailed and took a different approach. They support the community of care. I just wanted to let you know that.

Representative Ekstrom: One of the things I would like to see the department develop with the community of care are benchmarks so we have the ability to look at this pilot program in

two years and see how they are doing. You have established benchmarks as far as numbers of people served. We would like to see the care they are providing and see what you all think in terms of anything we can do to tighten it up and make sure as we take this model forward we can see progress.

Carol Olson: We see this as really the beginning of a very beneficial public partnership. Like I said before this is something we had envisioned with community of care. They are very worthy. They do have a record and we support it. We will be working with them there is no question about it. We will be working with them in the future for years to come.

Chairman Pollert: I would ask that either through Jane and the department that we get information. There are probably still two of us who aren't quite there yet. Some of us are slow learners. I'm not saying who the two are but there are two are. I think there might be two. Whatever information you or Jane can give us, I would appreciate. We do listen to the Senate intently.

Brenda Weisz: Attachment A. When Tara Muhlhauser talked about that yesterday the request was made if we could put it in a worksheet as to how much is in the budget now, what is in the Governor's budget, where we are today with the funding for the four services and a definition of the four services. This is a one page cheat sheet for you to define what parent resources and health family group conferencing decision making and a safety permanent fund. It will also show you what is in your current budget we are wrapping up right now, any bills or amendments added to those amounts. The only reason I asked that is because it doesn't relate to our bill. I figured that could be filled in later but I didn't know at this time. This is the funding that is included as it relates to the services outlined in SB 2396

Chairman Pollert: Maybe I should ask Roxanne or Lori if either of you do extension. I know it was in there before it went into conference committee for $125,000 for the parent resource centers.

Representative Bellew: Is this all general fund money?

Brenda Weisz: No there is a blend of money in that.

Representative Bellew: Do you have a breakout or approximation?

Brenda Weisz: Yes. I know some but not all of it.

Senator Kilzer: Are they face to face meetings in all of these?

Brenda Weisz: On the family group conferencing? I don't know the answer for sure.

Lori Laschkewitsch: It's not on that topic but the $125,000 for the parent resource center is still in that budget. It hasn't been dissolved yet.

Chairman Pollert: Did that answer your question?

Senator Fischer: Yes.

Chairman Pollert: That has been a topic of what they have been putting in that budget.

Brenda Weisz: We can only put general funds and I will give that to the clerk tomorrow morning. Handout testimony (Attachment B). You had asked for a one pager. As far as addressing these issues with two things in mind, inpatient and outpatient, the front lays out by center so you can identify by region what you have included in the budget. The first one is north central.

Representative Ekstrom: Before we start I have another paper on this that would tie in the numbers. (Attachment C)

Brenda Weisz: If you want to put these side by side the numbers detail by region what we are really trying to accomplish with this funding. The white paper talks about the community capacity issues. I mentioned the two components. First the inpatient component relates to the

state hospital and how we had them staffed at 85% occupancy. That is how the budget has always been prepared. Our occupancy has averaged 90-100%. To deal with that issue part of handling the community capacity issues, part of this funding relates to 5 FTE's at the hospital. When you look at the number sheet that is the very last item before the total where we have right now in the budget before you 5 of the 6 initially requested positions. Secondly another important component of the capacity issues on the inpatient side is we do have clients at the human service center that sometimes do need inpatient hospitalization for short term stabilization. You will find that the hospitals included in receiving that rate increase that nears the rate increase that is reflected in the Medicaid budget that is approved at 100% rebasing. This takes the non Medicaid client at the human service center that will go to the same hospital and ensure that it is provided the same rate of reimbursement. The hospitals affected are Trinity, Altru, Meritcare, Medcenter One, and St. A's . That is the other inpatient component of this. When you go through and look at the outpatient component it deals with the capacity issues of trying to keep people in the community so they aren't institutionalized. To reach that goal we included two residential facilities. One of them is in Minot. Minot is the only region of our large centers that does not have a crisis residential unit. This would put an 8 bed unit there. In Dickinson this would include a 16 bed residential facility. A lot of that is tied to the fact that St. Joe's closed down the behavioral health unit on their hospital. This would help in that regard. Finally there is enhancing the existing community support in Grand Forks. That is to increase their social detox program and also a contract that we have with an entity providing case aid. Collectively that is the breakout. On the one page sheet the front is by region. The first part is increasing the hospital contract at Trinity so that the payment we made to them will work with the payment received from Medicaid at the rebased amount. There is the 8 bed transitional facility and the cost for that. The Altru contract increase is first reflected. What I first

mentioned about strengthening the supports. At southeast increasing the inpatient contract and that would be to Meritcare. This would be to reflect what we pay on the Medicaid side. It also adds staff to Southeast. This is due to Cooperhouse. These are staff that are going to be needed at the human service center which is 4 FTE. Southcentral has the addition of 1 FTE as an addiction services case aid. West central, the cost you see there is to reflect the newly rebased rates so that the non Medicaid client that goes into the hospital will be reimbursed at the hospital at the same rate as Medicaid. At badlands we decreased the contract amount there and put the payment for both Medcenter One and St. A.'s in the west central region. The 16 bed residential facility that I mentioned earlier.

Senator Warner: First of all could you describe a little better, the FTE's, and the level of profession that we are talking about.

Brenda Weisz: Yes. 1 is an RN.

Senator Warner: Is the case manager a social worker.

Brenda Weisz: Yes.

Senator Warner: Is the 16 bed residential treatment in Dickinson the old psychiatric unit?

Brenda Weisz: It's not the old psychiatric unit. It's a residential facility in the community. It would have 16 beds for those individuals that are bouncing in and out of the community. It would allow stabilization for them in the community to remain in the community.

Senator Warner: The Dickinson and Minot facility are contracting with providers, is that how it is done?

Brenda Weisz: We will not be building buildings. If everything remains in the budget we will do it and select a private provider that would have space that could provide the services .

Representative Ekstrom: Typical stay at these residential facilities is longer than a 72 hour home?

Brenda Weisz: It's not beyond a few months but a few days to a week coming out of the hospital.

Senator Warner: Elsewhere in this budget I seem to recall discussion about the peer group. Is that part of the global?

Brenda Weisz: Although there is capacity issues and different initiatives that are included in OAR's in our budget this was one specific general area that we noticed there was some community capacity issues related to behavioral health that was impacting both the regions and the state hospital. Peer support is an initiative different from this.

Senator Warner: But it does relate to behavioral health?

Brenda Weisz: That is correct. On the backside what we did was provided a description by category. So if you wanted to know the amount of this funding area that is attributed to the hospital contracts so that the payment they receive from a non Medicaid client will equal that of the rebased amount of Medicaid. The cost of that is $1.3 million. The residential facilities, the cost of that is $1.6 million. The community supports at Northeast $207,000 and the staffing is broken out for you independently as well, along with the state hospital staff. It gives it to you by region on the front and by category on the back.

Chairman Pollert: What is peer support?

Brenda Weisz: An OAR that had been submitted by the department. What was added on the Senate side was $300,000 of general fund.

Chairman Pollert: You said it was behavioral?

Brenda Weisz: It is. It is SMI for the seriously mentally ill.

Chairman Pollert: I noticed something on non global health behavioral that the Cooper house is always in there.

Brenda Weisz: That is what you left in there for the house side.

Chairman Pollert: Any other questions?

Senator Fischer: Cooper House, could you give me a description of it? Is it residential treatment.

Chairman Pollert: We did the contracted program assistant to have someone man the door at Cooper house. We man the door but we need the 4 FTE's to manage the occupants?

Brenda Weisz: They will actually be staff of the human service center. For those who will need the services with medication monitoring, that is what the FTE's are for.

Chairman Pollert: I understand that. We have the Cooperhouse there and we have people to man the door. So what do we do to the people that we are manning the door with? That is kind of what is happening here with the four FTE's. I will have one more question about the state hospital too.

Nancy McKenzie: With the other 4 FTE's are about that are related to Cooper?

Chairman Pollert: We are going to have the cooper house and have someone man the door. What are we going to do with the occupants of the cooper house?

Nancy McKenzie: As I mentioned before in testimony we know these individuals tend to be folks with trouble with chronic homelessness or at risk of homeless. They tend to be folks that have a lot of trouble with mental illness and substance abuse. Each of the human service centers for example right now has a homeless case manager. They are out in shelters and under the bridge and everywhere trying to hook people up when they need services. The housing first will get people into housing. Research has shown that if we get them there we have a better chance of keeping services wrapped around them and keeping them more stable and not in and out of the state hospital. I think they explained it really well when we were doing the budget and they explained that the addition to the Cooperhouse and that 41 units and people that live there and increased expectations on Southeast for an already high demand

area. It tips it over the edge with that we would definitely have to add a nurse and do a little more case management. We already have wait times on case management and southeast and other regions don't have. It tips it to normal capacity. It's not that the 4 FTE's. They will be working with anyone that comes to the door. The four positions are the case manager, my case aid, a nurse, and an addiction counselor. They are all professional level positions but not psychiatry and psychology.

Chairman Pollert: Just so we don't get it confused because these four are different than the other 4 case DD management positions in northcentral, northeast, and southeast.

Nancy McKenzie: Yes.

Chairman Pollert: One more question I have. With the state hospital you mentioned in your testimony that 90-100%. What was your occupancy per percentage last biennium?

Alex Schweitzer: The last two biennium's the occupancy has been running 90-100%. Prior to that we were always staffed at 85 because we didn't reach anything above that level. Within the last 4 years is when we started seeing the increase in occupancy at the state hospital. In the last biennium we actually added beds at the hospital because of the increased occupancy but did not add staff. That is why we are coming forward now. Plus in the mean time acuity has gone up. Individuals coming in are much sicker, multiple psychiatric diagnosis, multiple medical diagnosis.

Chairman Pollert: So you are telling me that the severity of the cases have gotten worse in the last 5 years.

Alex Schweitzer: People coming in are a lot sicker than they are in the past. They are being managed pretty much in certain residential sites..They require an inpatient setting. We are seeing an increase in acuity. Our data we benchmark for the region shows that.

Chairman Pollert: One question brings up another. You mentioned that they have been in a residency program somewhere else and then they come here?

Alex Schweitzer: They are in residential settings either in their home or a residential program we talked about today at the human service centers that a provider that serves that. At times they made an inpatient setting. When we are seeing them they are ill. They would maintain them in the community. They are not sent to us unless they actually need a hospitalization. What we are seeing is people coming in with multiple diagnosis. If you look at the hospital now compared to 5-10 years ago you can really see the difference between elderly people and people in wheelchairs. Acuity is increasing, occupancy is increasing and when that happens we have held off for a few biennium's in terms of increasing staff. We decreased that over the years. We now feel a need to be able to deal with this problem. That is the reason for that.

Chairman Pollert: That brings up another question. If they have been in a residential setting or in a peer group setting, wouldn't the dollar's drop as savings if they are coming into the state hospital but we don't see that?

Alex Schweitzer: I can't answer the question in terms of community. I can tell you what is going on with the state hospital.

Chairman Pollert: Any other questions?

Senator Fischer: At the present time, what is the rate of intake and releases from the hospital and not from the severely mentally ill but for the people coming in and moving out over a period of time.

Alex Schweitzer: We are seeing an increased average population and increased admissions with the hospital. We are seeing an increased length of stay because they are more ill. We are probably, if you look at the inpatient unit, there is a time when we were running 5 years ago, about 5-600 admissions . We are looking at about 800 with probably as many discharges.

Senator Fischer: Are you finding that across the board?

Alex Schweitzer: Yes. In 2008 40% of our admissions were first time admissions and we have never seen them before. Some of that is dealt with the issue of drugs, meth, and that is a significant number. Those individuals that come in have demonstrated that a lot of them are first identified and diagnosed with a severe mental illness. The acuity levels are up. They are difficult to deal with.

Senator Fischer: How close do you think you are with today's problems with today's solutions with the hospital?

Alex Schweitzer: I'm not sure.

Senator Fischer: You have seen things change over the years. You have seen severe mental illness. Are you able to keep the problems at your door?

Alex Schweitzer: I think we are. It is important to remember that the hospital is smaller than it was back then. We aren't seeing as many inpatients because of Tompkins. If you look at our costs over the 12 year period it hasn't increased much. We have a small core group of mentally ill individuals that are requiring a lot more intense care. Between working with the human service centers, we are dealing with their illness and return them to productive. This shows we are doing very well.

Chairman Pollert: Let's move to case load utilization. I would like to start with the 9.6 and go down the line to the 5.6 and the 2.476. What you are going to have to have is the utilization numbers. Representative Bellew I'm going to let you take over.

Representative Bellew: We are on traditional medical services on inpatient hospital. Just so the Senators know we disagree with the utilization rates the department has submitted. That is how we got our figures. As you can see the department budget has 662 units at 887 per month for the inpatient hospital . When we did our calculations it was from March 08-November 08. It

was the last 10 months and we thought it would be a good trend line. There was November 07-June 08 and they skipped February 08 because it was a low month

Chairman Pollert: If you see the shaded area it is what they used for case load utilization. Our average was $54.60.

Representative Bellew: We thought that was too high and 54.60 was too low. We split the difference and put 6,000 units in there. If you multiply that out, that is 682 less units times 887.70 times 24 months times the general fund amount of .37 which is the general fund amount that we have to pay. It comes to $5.367 million on that one.

Chairman Pollert: You could look at the numbers and get a different number every time.

Representative Bellew: These are arbitrary numbers we picked. We tried to split the differences and we don't think the growth is going to be as great as the department said it is. That is where we come up with these figures. The last five months shows an average of $87,283 units. The bottom figures is $5.376 million. The department used the stuff in the gray. The trend line looked like it was going down on us. Basically they used $137,000 to figure their budget. We reduced that by about 8,000 units. If you take 8201 times 1924 times 24 months times .37 it is $1.4 million.

Chairman Pollert: I have kind of a column there. If we used November 07, skipped May of 08, and through November of 08. I show $129,200 so that gets us pretty close to the number you were using.

Senator Warner : Why did you exclude outliers but include the little ones?

Chairman Pollert: We took out the high outlier just like the department of human services did on May of 08. We use November of 07 at the $158,771 and we use all the gray. If I'm correct we didn't use May of 2008 but we used October and November of 2008. In that case we took out the high.

Representative Ekstrom: If I remember correctly the department swayed the highs and lows. Things came in the following month. That is why we took those out.

Representative Bellew: The next one is physicians. The department used 167,000 units. We used $165,000. That is a difference of 11,059 units times 1761 times 24 times .37 which equals $1.7 million.

Chairman Pollert: If I'm correct I thought we used November of 07 which is in the gray area and went through November of 08, excluding January of 08.

Representative Bellew: That is correct.

Chairman Pollert: Just so you know that Representative Ekstrom and her group went through these. It wasn't just Representative Bellew and myself that went through this. It was the 5 on our side of the aisle. It wasn't us two only.

Senator Kilzer: When you were looking at these did you make sure they were the same? Inaudible.

Chairman Pollert: I can agree with you on that. If you want to get that information you can ask the department. I sure don't want to open this up. This took us just a day or two of going through the numbers. If you want to get them, we did this last year. We did not hit it as hard as the numbers. We used the numbers but did not agree with them completely. As an example the $17.61, we used different numbers last year as far as the cost. We did not do that this time. We accepted the cost of what DHS told us. I thought our numbers came out fairly well. If you take a look of the numbers of what they had we would see they are fair and we would see a deficiency appropriation if they were way off.

Senator Fischer: Let's for the moment presume that these are on the button as far as the figuring is concerned. As I said last session and I was wrong or partially wrong. The thing I was

concerned with was all of the things we went through is that trend lines are exactly that. This in the past, how do we know what we are facing with in the future. If the numbers come out we can take a look at hose. I have no doubt that Representative Bellew has the numbers close to the methodologies to do this. My question of this is how do we provide for the dollars to continue services if the trend line goes up and we have a larger case load?

Representative Bellew: The department does have the ability to move funds within their budget to cover if something happens they also have a general fund turn back of over $20 million. There is money in the budget to service the people in the state. We need to make sure we aren't short changing the citizens of the state one bit.

Chairman Pollert: We could be right and we could be wrong.

Senator Fischer: The only concern I have is the change in the world around us. If these people have nowhere else to go how do we deal with this as legislators. There is always the unknown

Chairman Pollert: It was a very uncomfortable feeling for us last session because this was about the first time that the HR section ever really did it this way. We were nervous too but we took some bad heat because of what we did and we were right. I have a lot of faith in DHS.

Senator Fisher: I'm not asking you to put the money back in. We came over to have this dialogue.

Chairman Pollert: Yes you and I had the discussion and I knew you were going to do that and I had no problem with it. At that time I said we will gladly show you what we did with that. Representative Bellew will gladly go through more. You can see how we did it. That is the biggest hit.

Representative Ekstrom: We have a pretty health budget as far as DHS goes. My concern right now after sitting through SB 2012 last night on the DOT is that you and I both know what

happens is this budget takes a hit. I would like to see a little insulation on this budget because of the competing interest across the board with all the budgets. Within the conversation that means that we are going to really have to go out and find this money. That concerns me. We did as good of a job as we could but we don't know.

Senator Warner: I have a question on the cost per unit. Is this a rebased plus 6 or 7?

Representative Bellew: It is a rebase plus 7. When we did the budget it was a rebased plus 7.

Chairman Pollert: You were right but when we did the amendments to go to 6 then we would have adjusted for the 6. The amendments to go to 6 would have been a dollar value off the bottom line when we did the 7.

Representative Bellew: The figures that the DHS gave us were the rebasing plus 7.

Chairman Pollert: We are using the costs of the $87.70 and those were using the 7&7. When we would have gotten done and adopted the 6&6 the department or Legislative Council would have came forward with the dollars amounts of what the 6&6 does. That is when it would have shown up. We originally did use the 7&7.

Representative Bellew: The next one is premiums. PRTF is psychiatric residential treatment facilities of . The next one is dental services that I have is.

Chairman Pollert: What number did you use?

Representative Bellew: 11.641 units. We rounded it up to 9.6.

Chairman Pollert: We are going to recess until tomorrow morning at 8:00. We could start going through the bill on our own.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☑ Check here for Conference Committee

Hearing Date: 4/25/09

Recorder Job Number: 12245

Committee Clerk Signature

Minutes:

Chairman Pollert: Called the meeting to order. Let the record show that all conference committee members are present. First thing I would like to say is have an addition to what was said yesterday. Senator Fischer and I talked about case load utilizations and we talked about the last biennium. Then you had said something to the effect that maybe we might have been a little right. We were also a little wrong. We were wrong on the costs of what we did last biennium. I thought we were fairly right on the case loads. We were wrong on them. We aren't always right. Do you want any further discussion on case load utilization? Or do you want time to swallow that for another day? Would you rather have Representative Bellew give you the numbers? He can give you the totals for the traditional medical services. That was by far the biggest with the $9.6 million. We still have the $5.6 million under long term care and the $2.476 under DD's. That is up to you if you want those numbers.

Senator Warner: I don't think we need to get that deep into the detail at this point.

Chairman Pollert: Once we start that, I would hope that what we could do is as an example go through the condensed version on what was done on the Senate side and go down the list. We don't know how the Senate does it but as an example we would look at the equity. Instead of having paper with the motion we would just vote on it like we do in our section. The easier

one is to restore the salary equity funding. I would ask that be stricken from the bill. Instead of getting it in paper copy I would ask for a voice vote. If we get two on your side and two on our side. If you want it all on paper we could. If I get people to say that from our side to take out the salary equity then I would just do that.

Senator Fischer: The way we have gone through it is to accede from the house amendment that takes it out.

Chairman Pollert: Yeah but do you want to make the motion right away?

Senator Fischer: I don't know.

Chairman Pollert: After we get some point on Tuesday or Wednesday we would ask for that official motion about receding from the amendments and further amend. Then we would have Legislative Council have everything in front of us as a final for what we have done. Is that ok from the Senate side? Is that ok for the conference committee? I know we could take what we have done. I understand we have to have 2 votes for that. I had asked for this information from Jane Strummen. The other information coming around was the general funds on the SB 2396 the Allegheny project. If there is any discussion on that particular one now is the time. Handout Attachment A, B. With that I would like to take us to discussion on vacant FTE's. The house side had removed $2 million on the vacant FTE's. The Senate had restored it. I would just like to have a little discussion on that this morning.

Senator Kilzer: My memory says 58 FTE's for 24 months?

Chairman Pollert: At the very beginning like page 2 of the amendments on .0209 the statement of purpose, about halfway in they are going to be scattered through the budget from anticipated savings from vacant FTE's and employee turnover. That particular one for administrative support is $131,000. The house had taken out $2 million of general funds and there were federal funds in there. This also might relate to SB 2311. I don't know if the Senate

has worked on that bill or not. There were amendments coming out of the house about the roll up of vacant FTE's. I understand that it might see its demise on the Senate side. If it does we have to have the discussion as far as FTE's. Basically what the house did was ask and we had gotten list of the vacant FTE's at the beginning of the session. At that time and I may have to ask Brenda to come up, there were 114 vacant FTE's at the beginning of the biennium. Then on January 20th, there were 40 taken off or filled but there were still 74 unfilled positions. Our side looked at the average numbers. I will give you how we came up with this. What was done on the house side was a $6.1 million general fund. We just took that $6.1 divided by the $114.33 and took that number times the 74 unfilled FTE's. They come up with a number of $2.136 million. With 74 unfilled that left open up $3.987 million if I'm correct. On the house side we took half of those dollars. That is how the $2 million came up. I have a form from here dated 2/27 vacant positions. At that point there are 91.68 vacant FTE's. Out of that it comes out of $5.13 million. Where are your vacant FTE's at now do you have an idea? This report was handed out at the end of February 2009.

Brenda Weisz: No I'm not sure where we are at with our vacant FTE's. We have others who vacate at the same time. If you compare the December to February some will be the same because we do have trouble filling some of them. You will also find some that are gone, and we will have people leave. I'm not sure where we are at right now. The thing that we did, it doesn't take into account what the state hospital came up with for the same vacancies. In a way that was doubled up. The first vacancy list has all the state hospital vacancies in it.

Chairman Pollert: Let's say that at the beginning of the biennium at 91, as of January 20th for 74, we use that figure and come out with that. We got to the $4 million and took half of that. Could it not be said that the $5.3 million. If you take away the $1.3 million from the state

hospital that leaves $1.3 on the table. Still leaving you half of the vacant FTE dollars if you understand my math.

Brenda Weisz: You are looking at $1.3 million instead of $2 million.

Chairman Pollert: Do you understand how I'm coming up with that number?

Senator Warner: When you are over the agency budgets that the unfilled FTE funding is the funding that is used for retirements and the severance package, is that relevant to this discussion?

Brenda Weisz: When we prepare our budget there will be retirements and people that leave that you don't plan for. You can't build that in as a separate line item. You have to pay that out. When a position vacates for that reason, let's take an accountant, agencies do have to leave that position for 2 more months to cover the payout of the annual leave. We don't have money elsewhere in the budget to do that. I believe there is only about $22,000. What you do is try to manage that. If you have planned retirements you try to propose that within your budget. Otherwise agencies do have to accommodate that within their salary dollars.

Chairman Pollert: Is there any other discussions before we start looking at the list of what we might agree on and what we won't? I'm looking at amendments .0209 and starting at the statement of purpose on page 2. When we go some of these are spread through the whole budget in the sections. Starting on page 2 it says restore the funding for salaries and wages for anticipated savings. I'm not ready to bring that forward I would like the Senate to think about that for the next couple of days and see if we can act on that Monday or Tuesday. The next one is to restore the funding for state employee salary equity adjustments of the $3.458 million. I would ask for discussion on that. I think everyone is aware of what is happening with that. Would it be appropriate that we have voice votes or roll call votes to see if we get the two on the house and senate sides, is that how you do it? That is how amendments get adopted.

Roxanne Woeste: That is correct. A roll call vote would be fine.

Chairman Pollert: Is there any discussions? I think the salary equity is supposed to go on the Office of Management and Budget. I would ask that this be the first one about pulling the equity on HB 1012. Took the roll call vote and we have two votes from each side. We are going to skip over some of these. The next one would be to provide funding for young adult transition residential services and the human services region. That is one of the facilities that the Senate added the amendment to do one of the adult transition facilities services if I'm correct.

Senator Warner: I would move that we accede to the Senate position and fund the one.

Chairman Pollert: Is there any discussion? I'm going to have Brenda or Maggie come up one more time to tell us what this youth transition center is once again.

Representative Ekstrom: What I'm remembering is that these are individuals that have aged out of the foster care system. They need a little bit more help to transition and being on their own. The alternative is that they are going to be homeless.

Chairman Pollert: What did they do before?

Representative Ekstrom: They were on their own and getting themselves into some trouble.

Senator Warner: This is a population that they weren't allowed to do anything. They weren't allowed to drive because the insurance between their foster parents wouldn't assume the responsibility for insuring a child that was not their own. Many of them haven't owned a car, many of them haven't worked. Many of them haven't had a checking account because they have had no income. Many of them haven't had discretionary income because they haven't managed a budget. I would love to see at least two of these and maybe more. I think the fact that we are releasing has to do with one of them. We are going to be turn an 8 bed unit 4 times in a biennium, maybe 32 kids.

Chairman Pollert: This discussion should be in the human service part of the budget and not here. I wonder why this is in this part of the section. It doesn't really matter.

Representative Bellew: This was an OAR I presume. There were 2 of them as OAR's. If I remember right it was $800,000 or two of them. The one OAR of young adult transition service south east. If you go to the OAR list it is $184,000 general funds and $213,000 federal. I would like the Senate to explain to me where the general/federal came in.

Chairman Pollert: Are these the transition services in Minot and one in badlands? This is different.

Senator Kilzer: In the executive budget it was $834,000 general funds. The house took it all out and in the Senate we felt that one unit or sight could be built with half of that. That is where the $417,000 comes from.

Representative Bellew: My point is that in the governor's budget there were $650 and $184 in the funds. That does leave $417,000. If it goes to southeast I think it is overly funded. If it goes to west central it might be under funded.

Senator Kilzer: We didn't make that decision as to which would receive and which would not.

Roxanne Woeste: I was going to try to clarify something. You see this in the division under management. That is where I put it at the time we were drafting amendments. They wanted the department to decide which human service center would be most appropriate. I didn't have an indication as to where the funding would go. That is why you see it here instead of under human service centers.

Senator Warner: Part of the discussion seems to be that is this an OAR or in the executive budget? Was this approved by the Governor?

Representative Bellew: Yes it was in the executive budget. But it was an OAR that was approved.

Chairman Pollert: You will see it. There are OAR's that the Senate put in as amendments that weren't approved in the Governor's budget and this is one of the OAR's that was submitted before. Did you get a list of the OAR on the senate side? We will call the roll. It fails to get 2 from each side. I would rather do this all at one for the travel expenses. The Senate added back half of the travel reduction passed by the house.

Senator Warner: It is the nature of the motion to deal with that all across the budget and not division by division.

Chairman Pollert: I'd rather have it done all as one. If it's ok with you instead of being formal we will just ask the clerk to call the roll to see if we get two from each side. Then we will ask for the official amendment at the end.

Senator Warner: That is ok I just wanted to be clear on what we were voting on.

Chairman Pollert: And I hope we don't have a problem voting on this as a whole instead of section by section. It will be as a whole of the department to accept the Senate's amendment about half of the travel reduction passed by the house. A lot of these amendments were done by Representative Bellew. Does that number look accurate?

Representative Bellew: Yes it does. If we do this would we be going $76,000 back? It removes $76,000 right?

Chairman Pollert: That is correct. This is what is happening.

Senator Kilzer: I would like to be clear that if we have a yes vote we are at the Senate version of adding half of that back.

Chairman Pollert: Took roll call and the motion passes. On page 2 of that report we are talking about the vacant positions so we won't have a discussion on that. I need to ask the question on the next one on the page which is the expand assistance for pregnant women in approved by the government.

Roxanne Woeste: There are two adjustments that deal with that. One is on page 2. The appropriation is split between benefits which is the amount listen on page 4 and the amount listed on page 2 of that is the amount needed to make the necessary IT changes. That is why you see two adjustments related to the same item.

Chairman Pollert: I know that is a bill that failed on the house side. I would ask anyone to speak up on that particular amendment that was added.

Senator Kilzer: The $85,000 of general funds was added back in because going up to 165% of the poverty level we will have an increased eligibility level and the IT system changes will have to be made in order to accommodate that change in eligibility and benefits.

Chairman Pollert: I would ask that the committee would look at this as a whole. On page 4 of the amendments about halfway down would have to be added on to the $85,756. We should talk about the two in conjunction together. It sounds like you can't do one without the other.

Senator Warner: This is one of the primary pro life initiatives in the Senate that was an effort to address prenatal needs for women. This would be for those whose incomes simply don't allow for the kind of prenatal care which the middle and upper classes take for granted. I think it is pro life and a proactive approach to for stalling future medical problems that would come from premature births. We would have to look at the Ann Carlsen center to see the devastating impact of premature birth and inadequate health care during that prenatal period. That was the primary prolife initiative. The Senate will defend this.

Representative Ekstrom: In terms of abortions as well, this enters the heart for people carrying healthy children to term and not being forced into a situation of saying I can't carry this baby to term because I can't access health care for myself. One of the heart burns I heard was this would extend medical insurance to an individual but it would include anything that would happen during the time of her pregnancy so if she would break her arm she would still have

access. I would really say that this is an alternative to abortion, it is pro life, and it is absolutely talking about the health of children who otherwise might wind up at Ann Carlsen.

Chairman Pollert: We can say that at about every segment of our population. I understand that and the Senate put it back in when it failed on the house side.

Representative Bellew: Aren't these ladies eligible for Medicaid?

Maggie Anderson: Today ND is at the federal minimum which is 133% of poverty for pregnant women. This amendment would take that to 165. The individuals between 133 and 165 are not currently eligible for Medicaid.

Senator Kilzer: My numbers as I recall is about 385 women per year.

Maggie Anderson: Yes that sounds right.

Senator Warner: When this bill was introduced the Senate was at 200% of poverty. The Senate reduced it to 165%.

Representative Ekstrom: The other aspect of this that I find stunning is there are very simple things that women can do in a very early part of their pregnancy like simply adding niacin at the very beginning of conception can avoid diseases.

Representative Bellew: I don't think anyone here can answer this question but are the records available to indicate how many women at this income level do have abortions? Basically how many of those 385 would carry them to full term and how many abort their baby.

Senator Warner: I think that is an unfortunate analogy. I don't think anyone in the Senate would say that unless they are aborted that it is irrelevant. There are obviously implications to the prenatal care like a simple vitamin. That would have a huge impact on the lives of these children. We would never make that kind of a determination as to well if it's going to be aborted than its ok.

Chairman Pollert: You will find that Representative Bellew is pretty strong prolife. We will stop there.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☒ Check here for Conference Committee

Hearing Date: 4/27/09

Recorder Job Number: 12279

Committee Clerk Signature Meagan Pearce

Minutes:

Chairman Pollert: Called the meeting to order and noted that every member was present. Handout A. I will give you a little protocol. At some point someone is going to have to bring forward the motion to have the Senate recede from their amendments. As we are going through the points of what was done at the Senate side if there is an item that we don't want to have discussed quite yet we have to make sure we make that apparent that it will get settled down the road. I did talk to Legislative Council about the procedure this morning and it is fine. If we would ask for a motion from the Senate to recede from their amendments they would be doing everything. We are basically going to pick at the bottom of the tree for awhile. That is what it means. I wanted to clarify that. Just so we work that way. I invited Representative Kreidt to sit in because there will be a point where he will be in on the conference committee. I would like for him to explain the house side as far as on the long term care salary and supplemental payments on the 80th percentile. If it's ok with the conference committee I would like to have him go through the version. He made the motion and is more familiar with the subject. If it's ok I will have him give us a brief description.

Representative Kreidt: If you can remember when 1012 came over to the Senate and the amendments that were included in there in regards to the dollar amount that would have

provided a pass through for nursing home employees and basic care employees we were using a percentile at that time. It came over with the 80th percentile and we did adjust that to a 90th. In visiting with the department we became aware that the percentage figure wasn't going to work. They just couldn't get the numbers to come out and get the correct amount of dollars to the facilities to do the pat through. We continued to talk about the dollar salary increase for those individuals. We did exclude the administrators and the directors of nursing and the upper category of staff at the facilities. The dollar mounts that did come out of the house over to the Senate did not include the dollar amount that everyone under the director of nursing and administrators would receive that. The amount was meant to go to the lower percent of the employees. The dollar amount there the administrator had the discretion of using those dollars for salary increases and fringe benefits. If the administrator went and felt that he had an employee that deserved more than $1 amount raise. If they wanted to go ahead and give them a 50 cent raise that would be appropriate. The concern I have now of using the $1 per hour and I see that with the amendment coming back from the Senate and I'm looking at two different numbers I have seen one is $2.9 and one is $2.8 million. I'm not quite sure if that is an error. I'm anticipating that the extra dollars that are included in that amount would bring the dollar amount up to what the senate anticipated and fully fund those individuals to $1 an hour. My concern is that using the dollar per hour figure I would just as soon see the dollar amount that is mentioned removed and just using the flat dollar amount through negotiations of conference committee. I feel that for facilities to have the advantage of using this money where they feel is most needed in regards to their employees and not tying them to the $1/hour. What usually happens is the staff out there is aware what is going on. When it comes to salaries and dollars they are pretty up to par. The administration of the facilities will keep them up to par with what is happening in regards to their salaries. We keep the dollar amount in there. The

staff come in and say that we passed it out and they want it. For some facilities it becomes a problem. They would like to be able to have the discretion and not be locked into that. They will survey the facilities and make the proper appropriation and dollars of not having it tied to the dollar per hour in each of the basic care family and nursing facilities in ND. That was the logic as it came from the house to the Senate. Hopefully conference committee could look at it favorably and move forward with that recommendation.

Chairman Pollert: Are there any questions?

Senator Warner: We talked briefly about the administrators and the directors of nursing. I understand that the dollar per hours don't come from that direction. Is it true that they will grant them money for the position? These people aren't cut out of raises but just aren't covered for that one dollar per hour. Is my understanding correct?

Representative Kreidt: That is correct. The last time back in 2001 if you remember there was a direct pass through going into facilities. There were some follow up by the department through the service process to see that the dollars were used for raises and benefits so they weren't spent on capital expenditures or supplies. These dollars will be going to employees and as I mentioned for giving administration and boards the prerogative for using the dollars and not locking them into the dollar and having the discretion for doing what is best for the employees. If you really have a problem to maintain the CNA staff and attracting new individuals and recruitment, they may plug in a considerable amount of money to staffing the facility. If you have a facility that has a 60-70% turnover they might want to use the majority of that money to maintain that. That is where the critical part of operation is with your hands on people and personal care. That would give them that flexibility.

Senator Kilzer: In your presentation right now you did not mention what I considered the greatest problem of all which is compression. Can you tell us how that was thought of when

you made the house amendments? Did you consider that problem at all?

Representative Kreidt: That discussion really wasn't discussed. Every facility out there is run and is operated under the case mix and equalization of rates. Compression and facilities when you are talking about that, is never discussed. I have never heard that discussion from the industry at any point that I can recall. That has never been a topic of discussion in the industry.

Senator Kilzer: Compression can get to be so bad that new hires receive more reimbursement than 10 year veteran employees. I'm very disappointed to hear that it wasn't discussed.

Representative Kreidt: I can only reference two facilities that I have been associated with. We have never experienced like we do with our state employees, a serious problem with compression.

Chairman Pollert: Are there any other questions? With that we will turn back to what we were working on here the other day. I have invited Representative Kreidt to be here but if he is going to come into this thing on Wednesday because I don't want to bring someone in here cold turkey. We were on the .0209 on page 3 of the statement of purpose. Like I said we are going to pick the lower apples and fruit on the tree that aren't quite as contentious. With that when we had stopped we were just getting to the point and we might want a little further discussion on the items. We were at the where the Senate restored the funding for the medically needy to reflect the income levels at 83% of the poverty level. We can sure have discussion on this part before we move to the next subject.

Senator Warner: The question is that my understanding is 83% of poverty is the threshold for SSI. If we were looking at the continuity of care and the state would pick it up, if we established it at a 75% we are maintaining a gap between the two, is that correct?

Maggie Anderson: The 83% was picked because it was the closest level to SSI. Individuals who receive SSI are considered categorically eligible for Medicaid with no recipient liability. These are individuals who are not receiving SSI.

Senator Warner: If we establish that we would cover the continuum without a gap?

Maggie Anderson: The coverage would be comparable. At 83% the individuals not receiving SSI would have little or no recipient liability comparable to the people who are categorically eligible and SSI with no recipient liability.

Chairman Pollert: On the house side, didn't we have a discussion on a family of 2 and the monthly rates that were fairly comparable with the 80% when we looked at the 75.

Senator Kilzer: At 75% one person could receive up to $650 a month and 2 people could receive up to $875 a month.

Representative Bellew: I would like a clarification on that. Maybe I'm wrong but my notes say $750 for one and $875 for two. If someone could clarify that it would be appreciated.

Maggie Anderson: At 83% of poverty a family of one is $720 and 2 is $969. At SSI it is $637 and $956. That comparison is most accurate and close between those two. I am looking for my additional thing we did on the Senate testimony. At 75% of poverty a family of 1 is $650 and 2 is $875.

Representative Ekstrom: Remind me when the last time we raised this was?

Maggie Anderson: January of 2003. It was frozen January of 2003.

Chairman Pollert: This takes 2 from both sides. Is there still concern? Do we need to have any discussion on the rebasing of the physician payments rate?

Representative Bellew: I would like to have the senate explain this to me. I think we need a discussion. This is one of the big things but not the low hanging apples.

Chairman Pollert: I think we need to have a little more discussion. I understand what the Governor did at 100% for hospitals. The physicians were at 25%. I'm not going to remember the other ones as well.

Senator Kilzer: The Senate did make major changes in the budget. We did a pretty thorough study before we received approval of the whole Senate on this. Rebasing in some areas is done very regularly every 4-5 years. In other areas it's not done for long periods of time like greater than 10 years. The biggest gap between what is reimbursed by Medicaid and the rebasing is in physician services. The department did have a major undertaking in the last interim. The projected rebasing was done up between June 30th of 2010. In some of the budgets you will see an increase above the amount. That is the explanation. If I could focus on hospitals and physicians, hospitals were put in the executive budget at 100% of the rebasing. That was kept in by the Senate. Physicians were completely changed. The physician's base was last done 17 years ago. The physician's reimbursement is 51% of actual cost. It has been chronically that way for a long time. To bring it up to 100% of actual cost would be quite expensive and therefore we kind of look at all of these outside hospitals to bringing them up to 75% of the rebased value. That doesn't mean it is 75% of costs. It means that it would bring it up to 75% of the rebased figure. The Governor had it at 25%. The house reduced it to 20%. In reality, previously they have been rebased at 515 of the actual cost. The Governor's budget would have brought it up to 64% of actual cost. The house takes it back to 60%. If we would go with what the Senate says at 75% of the rebased value that would bring it up to around 88 or 89% of actual cost. It is a parallel situation but not the exact situation when you talk about rebasing or just raw actual cost. That is the background of how and why the Senate went to the 75% of the rebased cost which would bring it up to 88 or 89% of the actual cost.

Chairman Pollert: Any comments or questions? I have one. It's not that I don't' agree with you because I can agree with you. My only concern is when you add another $10.7 million to the budget I have concerns about the cost to continue. I struggle with why the executive budget was 100% for hospitals and 25% for physicians. I have concerns as far as the costs to continue. Not saying that in future biennium's that this is a priority. There is no doubt about that. It is a small comment I have.

Senator Kilzer: I would respond with a reality treatment. Just because someone has been under funded for a long time doesn't meant they should continue that into the future. It looks like the legislature is not appreciative when they are getting all this free care under cost and they add additional people and patients to the whole situation. That is why the intent was put in the bill to work toward what they release. They spent a lot of money on and they spent a lot of money on the rebasing. If you aren't going to follow the results, why did you do the study? I think with those basic tenants that we should be working and have a true goal of getting up to what we discovered in the rebasing.

Chairman Pollert: Could it not be said that the executive budget was working in that direction. We could also say that physicians were put at 25%. I have no idea but couldn't you say we were working in that direction?

Senator Kilzer; I have inquired as to why there were such large discrepancies. It looked to me like there was a compromise on the budget. It would have been too expensive to put everyone up where they truly belong. They put up the less expensive categories. The more expensive ones, they left them in a chronic state of underfunding. That is my conclusion and only my conclusion. That is the best answer I could find after working with the various providers.

Chairman Pollert: That gets to my point that I understand from what the executive budget did and what the senate did. It is costly. I'm not saying it's not right. The $10.7 is a big arm to chew

as far as general funds. I don't know how we are going to resolve that. That is one issue we are going to have to talk about later down the road. This is a related. When you did a study related on the senate side about legislative intent language when we need to go to costs, there is a section or two added to 1012 about the legislative intent to get to cost. Could we have a discussion there? I don't' remember what sections it is.

Senator Kilzer: It is in this bill that the intention is to fully implement the results of the rebased studies. I mentioned before about increasing the eligibility so we will have more people on the wagon. If you are going to keep doing that you will certainly need the legislative intent. Otherwise we will slip back to the way we are right now.

Senator Fischer: I believe that amendment set a goal to 100% by making it very clear it was the first step to getting hospitals, physicians, dentists to getting them to the appropriate care. They spent a lot of time going through the rebasing. If we aren't going to use rebasing why spend the money to do it. Then we can offer them whatever they feel. How long are we going to have hospitals and how long are they going to stay? I believe that in the larger cities there are struggles with the Medicaid population and it is a lot less of the percentage of the total business they do. If we don't address this now when are we going to do it?

Chairman Pollert: I appreciate that and members from the Senate side but how big of steps do you take? It's not that we shouldn't have that as a goal. I just have concerns because every time we add a new program on to DHS that is a cause of concern.

Senator Fischer: When we add those programs they will be analyzed at the rates that we set now. Maybe some of those programs will have different eligibilities. We have gone over the programs that are in place now. You are absolutely right. The cost is going to be greater for the program because of what we do here. Do we keep throwing people in the wagon at this rate? You are going to have hospitals that won't survive.

Chairman Pollert: Could it be said that from your statement that with what we are doing with hospitals, would it be more of a concern that the physician's arena might have trouble surviving or are they correlated?

Senator Fischer: I didn't mean it that way. I'm surprised that some of the hospitals remaining open are open. They are having problems. Would we have the situation in Rolla if the reimbursement were higher? If we are paying the hospitals to survive rather than the reimbursing them at an appropriate rate, are they going to survive on their own?

Senator Kilzer: You kind of implied that the physician service and hospital service are inter-connected. That is not true. It is reimbursement and it should and hopefully does go based upon the services provided. The cost shifting that has gone on in the past, and I can remember when part of the negotiation of blue cross when they used to have that was how much free care was provided by the hospital. That would figure into the negotiation factors. In the modern days bill charges don't mean anything at all. Everything is based upon the fee schedule of the hospital. Third party payers, whether they are workers comp or commercial insurance, they all have their own fee schedules. There is no provisions for cost shifting for other third party payers like Medicaid that don't pay the necessary bottom to continue the service. That part has changed over the last decade, I would be glad to answer questions about that. I hope it's understood what we are talking about and how the third party payers pay off of their fee schedules.

Senator Warner: This is a small point and the distinction needs to be made. The hospitals under ND law can't turn anyone away. The physician's can and I don't think they will go away if we can't cover them at costs. We are going to have diminished access if we don't compensate physicians at the level that they deserve to be. We are going to start seeing the problem. I think we will see it in psychiatry as well. It will appear in the specialty fields before general

practice. It's an issue that needs to be addressed. If we don't do it now when we have the resources to do it I don't think we will make a strong effort in the future.

Chairman Pollert: I think we needed to have this discussion. We will go down to the next line. Basically the ambulances were put back to the executive budget and same way with dentists. Did the house side work or do anything on chiropractors. I might need an explanation about that. What was the Governor's budget?

Representative Bellew: I do have the amendments that we did pass out for chiropractors. It says the executive budget includes funding for $416,000 of which $153,000 is from the general fund. We are rebasing chiropractor payment rates at 100% of the costs. We amended that to reduce the funding for rebasing to 75% of the cost report.

Chairman Pollert: That wasn't addressed on the Senate amendments?

Representative Bellew: I didn't see that.

Chairman Pollert: I just wanted to make sure I didn't miss them.

Senator Kilzer: On the chiropractic issue and some of the smaller ones, is where I mentioned that he did not reduce the smaller items. You had put it at 75% and that is where we left it. We really chose to try to put all of the non hospital providers to 75%.

Chairman Pollert: And you changed the ambulances but ambulances were based off of Medicare rates. I am moving to page 4. At the top of that page it says provide funding in the grants medical assistance line item for supplemental payments of small rural critical access hospitals. I would suspect that there is probably language in one of the sections in HB 1012.

Roxanne Woeste: That is section 13 if you look in the legal version of the amendment .0209 on page 4. Section 13 refers to the supplemental payment to critical access hospitals.

Chairman Pollert: Does anyone here have an objection? Would you want to wait with this or rather have the discussion now?

Representative Bellew: Let's discuss this now.

Chairman Pollert: I will ask for a brief description.

Senator Kilzer: This is the Rolla hospital situation where they have 31% of their revenue coming from Medicaid. The next highest is 16% of revenue from Medicaid. This hospital was getting into trouble largely because Medicare and Medicaid was not allowing reimbursement for outpatient lab and anesthesia services. They had no alternative except to seriously thinking of closing their doors and come to the legislature to get funding. That is what this is.

Chairman Pollert: I will attempt one vote. That is agreed upon 6-0-0.

Senator Warner: We had some discussion on our committee that this is not to become a new budget line item but a onetime thing. It will be a temporary mandate with a more systematic solution. It is to give them breathing space and to stop that temporarily. It is understood and needs to be addressed.

Roxanne Woeste: I can clearly indicate that if you would so like me to do that the $400,000 is one time funding.

Chairman Pollert: On the Senate side do you think there will be a federal fix coming to this?

Senator Warner: We heard there was a dispute in the way they interpreted it. In some places in the country it is a covered service. In others it is not. It may be a small distinction. It may take something at the congressional level to address the issue.

Representative Bellew: Do we need an emergency clause?

Senator Fischer: We didn't hear any discussion. They are under an order to close if they haven't been able to resolve this. The fact that it has been addressed here will lift that. The other thing is that the 100% reimbursement they feel is that amount will help them with their financial situation if that happens.

Chairman Pollert: I know we are going back two years but I think we added $1 million to critical access hospitals last biennium. I think it was thought at that time it was going to help that situation. I take it that it didn't help them as much as they hoped. Does anyone recollect?

Senator Fischer: Their Medicaid population increased. The other thing is that the issue that Senator Warner addressed also is as big a problem.

Chairman Pollert: We are going to move on. We won't discuss the next two items and I don't have to explain why. It will come up on the house floor again today possibly.

Representative Ekstrom: I think if we wanted to that we could possibly discuss where we would like to see that bill in terms of number. I heard there was movement over the weekend.

Chairman Pollert: It is not for us to set policy. Let's see what happens before we go there.

Representative Ekstrom: The thought was that perhaps it would survive better on the floor in here than as a standalone. That is purely procedural.

Chairman Pollert: We decided to wait on the medical assistance for pregnant women which was killed on the house floor. Does anyone have what the vote was for that bill? We will move over to the long term care area. I would like a further explanation of the third tier personal care. I know what it does but is there savings to the state on that? If someone can't answer that I would ask DHS to come forward.

Representative Ekstrom: When I did the calculations on this there was an indication that some 200 people that came out, with the addition of the 2 extra hours, I took the average rate of nursing home care right now and over the biennium it saves about $ 1million.

Chairman Pollert: I'm trying to have you convince me about this. Why would be spend $2.7 million to save $ 1million. To me that sounds negative.

Representative Ekstrom: It goes on. We keep those folks out longer. Less people will go into long term care.

Maggie Anderson: I can't speak to all the spending and saving. We do know that for example about 10 of the clients we are working with would be able to move out of nursing facilities and back to the community if they would have that extra 2 hours a day of personal care. What this is about is providing a continuum of care that offers choice to clients about where they reside. If they find themselves in a situation where they meet nursing home level of care and want to remain in the community and receive the services to remain in the community, this is what this option is about is those individuals who can stay in the community with 8 hours of care but can't stay in the community if they need 8.5 or 10 hours. There only choice is to go to a situational setting. This is about consumer directed choices about long term care options. Long term, if you can keep those individuals in the community, first of all that is their choice. That is where they want to be. Second of all long term it will save dollars because community care is less expensive than institutional care.

Chairman Pollert: So this is not a onetime appropriation but an ongoing expenditure that we are going to have.

Maggie Anderson: That is correct. This would be a modification to our state plan service called personal care. It would revise our limits which would be revised to 10 hours of care versus the 8.

Chairman Pollert: There has to be savings somewhere.

Maggie Anderson: That is the savings that there is maybe 10 people out there. If you leave this in and we implement it there are 5 people that would otherwise go into a nursing home. Because they now can access 2 additional hours of care in their home every day they can stay in their home. Where you are going to see the savings is in fewer long term care expenditures.

Chairman Pollert: We will continue that discussion later. The house vote was 44-49 against. We will be in recess until tomorrow morning.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☒ Check here for Conference Committee

Hearing Date: 4/28/09

Recorder Job Number: 12322

Committee Clerk Signature Morgan Pettit

Minutes:

Chairman Pollert: Called the meeting to order and let the record show every member is present. It's going to be a short one this morning but we are lined up for an hour this afternoon. With that we left off yesterday on the third tier of personal care. Was there any further discussion on that?

Representative Bellew: I personally don't have a problem with the third tier level of care. I think there should be a rate of reduction for the nursing home budget. If this keeps people out of nursing homes there should be an offset somewhere.

Senator Warner: I sort of understood that there are people in nursing homes that could leave. I also assume there would be a population that could stay out of the nursing home all together for at least a longer period. That is the level of mathematics I never achieved. Did we address both sides of that equation before? I only recall the conversation of the 20 or so people that could leave the nursing homes and be able to live in their own homes. I don't recall the ones that could be remain in the communities longer if they had this third tier.

Chairman Pollert: Are you asking that someone come forward from DHS to clear your mind a little bit? It always clears mine.

Maggie Anderson: Specifically with the personal tier piece again it is about providing the

continuum of care for individuals that start out with basic care services in a basic care facility. It is a state funded SPED program. This third tier offers one more choice for clients to have so they can decide to remain in their home and receive the services in their home. It is about client choice and providing those choices. Institutional care is not the only alternative if they would need a bit more care in their home on a daily basis.

Chairman Pollert: What about Representative Bellew's question as far as the case load utilization for long term care drop?

Maggie Anderson: I think long term you will see decline in the utilization of nursing home facility beds. Are you going to see it one for one? Yesterday we talked about one of the services the department estimated for January 1, 2010 implementation date for. S assuming CMS approval we implement on January 1, we aren't going to have 30 clients on day 1 receiving personal care tier 3 and on that same day 30 clients who didn't go into the nursing home that come out of the nursing home. It's overtime where there is a client that is currently on the Medicaid state plan personal care who is getting along with 8 hours of care. Something is going to happen with their health/environmental condition in the next 3 months that they are going to need extra care. If this isn't in place or I choose to go into the nursing home. It's not a one for one. Some of the clients are already on the program and will need the additional hours as their health care needs increase. Others are in the nursing home that we have identified through our money follows the person project who we believe will come out. It's not a one for one exchange.

Representative Bellew: Did I hear you say that you have to get CMS approval for this so there is no guarantee of it?

Maggie Anderson: We do need CMS approval for this. Both appropriation committees have discussed that it will required CMS approval. We have what we call a state plan with them.

Many of the things that will be discussed and brought forward will need CMS approval. I don't expect any problems with that. Until we get into that process we aren't sure what het specific concerns might be.

Chairman Pollert: I want to wait on this. I might be looking for favorably but am not 100% there yet. We had a discussion from Representative Kreidt yesterday. I want to skip over that. What my intent would be is to look at the 7&7 that was put on the Senate floor and also this 2.9 I would want to take up all in one shot when we do that. I don't want to say that will happen tomorrow. We will have that discussion all at once. We know what the dollar does for the DD. Is there any discussion for the QSP's for the buck?

Representative Bellew: I see there is $853,000 but only $963,000 in federal. It seems it's not the 63 37 match. Could we have that explained?

Brenda Weisz: The reason we don't have as much federal funds is that the QSP's often serve the state only programs.

Chairman Pollert: I want to have a little discussion on the medically fragile and behaviorally challenged. I think the house side had $400,000 or some in there. We introduced the language from an independent firm. I want a little more discussion as far as why the Senate put in the 1.9 and 3.2 if someone could address that please. I'm probably wrong but I think we had 2 options in front of us. There was another one in there. I didn't think it was this high. I thought it was lower than that.

Representative Bellew: We had 2 proposals in that. The one was $1.168 million of general and $1.990 of federal. We called that alternate A. That one failed in our subcommittee. The one that passed was to increase payments by $538,900 of general funds and $747,957 of federal funds.

Chairman Pollert: Then I would ask the Senate how they came up with the $1.897 if those were the two unless that particular group of DD providers came to you with a different set of figures.

Senator Fischer: If I'm not mistaken there are two line items. There was $1,897,000.

Chairman Pollert: Was this on an OAR listing for the total dollar amounts? I'm wondering if that correlates out.

Roxanne Woeste: If you add the amount added by the Senate to the house, it equals what the OAR was.

Senator Fischer: One of them passed by the house was not an OAR? It was just combined?

Roxanne Woeste: I believe a good description would be that the house funded a portion of the OAR and the Senate funded the rest for a total.

Chairman Pollert: What I'm bringing up is just a curiosity sake why when we had an option a and b. I didn't know if you had that option. I don't know if that happened in y our discussions or not?

Senator Fischer: When we dealt with it, these apparently are together with the house and the difference of the OAR. That comes out to the total. That is the one that we support.

Chairman Pollert: And the study language was proposed in the house side? That is still probably 500? So you didn't play with the language on that?

Senator Fischer: Not that I recall, no.

Chairman Pollert: There is also a $100,000 fiscal note on that too.

Roxanne Woeste: I believe the study and the funding for the study was in HB 1556. That bill has been passed and signed.

Representative Bellew: If I have the right OAR on the back page of the OAR's it says DD staffing to meet critical needs, is that what we are talking about?

Roxanne Woeste: Yes I believe that is correct.

Chairman Pollert: If I was to vote on this today I wouldn't vote for the $1.897.

Senator Warner: Is there some other number that would be agreeable?

Chairman Pollert: There is and you will hear it later.

Senator Kilzer: May I ask why you wouldn't?

Chairman Pollert: We have a study coming in. I know there was an OAR out there. Why would we jump in with all feet when we don't know what the study is going to say? That is my opinion.

Representative Bellew: The Governor didn't fund this in his budget either. That is one of the things that I look upon. I would like to know that if the Governor didn't fund it and didn't think it was worthwhile?

Senator Kilzer: I would hope that each of us on the committee looks at the needs of whether or not it was funded in another budget. I pointed out to yesterday on the medical providers how terribly underfunded this had been for such a long time. I almost got the consensus that you think because something has been underfunded terribly for a long time that it shouldn't be properly funded. I hate to see that attitude.

Chairman Pollert: I understand your concerns and we struggle with this every biennium. We are also appropriators at the same time. We have people thinking we are funding too much. We struggle with that. I don't agree with that philosophy. That is my opinion. Going to page 5 of the amendments .0209 we already know about the $300,000. Does anyone want to discuss the healthy families? If I'm correct SB 2396 which is the Allegheny project, I think they were trying to get $350,000 some thousand. The Senate added $200,000 that had failed on the

house side. I want to look at that $200,000 in conjunction with. I will give you my personal opinion. The $200,000 I'm kind of nodding. The $1.2 is too hefty.

Representative Ekstrom: How are you feeling about the Arthur project of community care? That is in conjunction with this as well.

Chairman Pollert: It is related but it's not related. I look at that $120,000 of community of care. That is more of an all encompassing. That's not just the Allegheny project.

Representative Ekstrom: What I'm suggesting is that it might give us direction. We could let the $1.2 go at the moment. I think the Arthur project and some of the other programs will give us a better direction of where we are going with foster care. Foster Care is getting to be a pretty hefty expense.

Chairman Pollert: We will have a discussion on the community of care. We will take some votes on that and healthy families. Id' like to have the Senate give some thought on where they might be. With that there is a few of us that have meetings. We will be in recess until 3 this afternoon.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☒ Check here for Conference Committee

Hearing Date: 4/28/09

Recorder Job Number: 12350

Committee Clerk Signature

Minutes:

Chairman Pollert: Called the meeting back to order and let the record show that all conference committee members are present. We are on page 5 of the amendments .0209 on the statements of purpose. On that we were talking about healthy families in conjunction with the Allegheny project and also the family group counseling. So I'd like to have a little discussion to see if we have any common ground on what we might like to do. Healthy families and family group conferencing, I'd like to have a discussion. I myself am uncomfortable with the $1.2 million. I would like to have a little discussion about that.

Representative Ekstrom: Do you have a number in mind?

Chairman Pollert: Would you like to hear what I would like to bring forward? If you remember SB 2396 which is the Allegheny project, that bill was defeated in the house. There are certain items that I wouldn't mind seeing. I would look favorably upon healthy families for $200,000. I have a little pain in my side about the $1.2 million. I would be tempted to have a discussion about on the $1.2, remembering there is $125,000 in the NDSU extension budget for the parent resource center. If you remember SB 2396 there are four areas, parent resource areas, healthy families, and family team decision making pilot programs, and a safety and permanency funds enhancement. What I would like to see is to fund the $200,000 in healthy

families. I would like to see the $1.2 drop down to $200,000 and put $100,000 in the safety and permanency funds. I would be open to discussion on if you would like to keep the family group conferencing for 100 or put it in the family decision pilot programs or are those one in the same?

Representative Ekstrom: If counsel or Office of Management and Budget could tell us if we reduced that to $200,000 what would the federal match be at that point? We have $256,000 as the federal funds.

Chairman Pollert: When I look at SB 2396 it is all general funds.

Representative Ekstrom: on page 5 to add funding for family group conferencing.

Brenda Weisz: The federal funds were added when we did the Senate amendment. Since that time we have found out that there shouldn't be federal funds with that. The OAR had federal funds. It contained two types of services. Upon further review and having information it's not available for group conferencing there are only general funds available for that. If one of our grants would go up we would tap the federal funds if available. At this point there are no federal funds to go along with it.

Chairman Pollert: If you remember SB 2396 the family team decision making, is that the same thing or something different?

Brenda Weisz: It's the same thing.

Chairman Pollert: I would have to make it two different motions because the $200,000 is separate from the $1.2. We would have to break that out to $100,000 for the safety and permanency funds. What are safety and permanency funds?

Brenda Weisz: Payments we make out to the counties to assist families to keep their child at home, keep them out of placement, and do things for them to be able to keep them at home.

Chairman Pollert: Let's try a roll call on dropping the $1.2 million down to $200,000 with the $100,000 to the family group conferencing and $100,000 to the safety and permanency funds enhancement. It passes 6-0-0.

Representative Bellew: Give me a brief explanation on healthy families again? Is that foster care too?

Chairman Pollert: I would probably want to have someone talk on that. I think that it is when they would try to recognize or target families that would be having trouble. They would try to counsel them to keep them in the family. That was a project started in Grand Forks County and I think they got a grant for Burleigh and Morton. Now they are trying to go into Ward.

Brenda Weisz: It's parent support early intervention, a national model. They have expanded into Bismarck and Mandan and they want to in Minot. They got their start in Grand Forks.

Chairman Pollert: Any other discussion? I am in support of this amendment. We will take the roll. That is 6-0-0. I would like a little discussion on the providing funding for the grant for the community care program. Any discussion?

Representative Ekstrom: As I said the other day, this could serve as a pilot for us with the single point of entry. That is a goal in terms of getting people to access care and the levels of care and not be put through a lot of bureaucracy. This is a small step to get us some data. I know with the folks with Alzheimer's need this.

Chairman Pollert: We will see what happens with the $120,000 for the community of care. We would have to have a vote on the $300,000 for the next one above.

Senator Kilzer: This community of care is what is being done in Arthur, ND. I'm not sure what Representative Ekstrom was talking about? Were you talking about the example in Arthur?

Representative Ekstrom: I think that the Arthur program isn't the wrong door. Some of the things they are doing would give us data and let us see how they are getting people get

hooked up with services. It is really good information. It's not precisely where I want to go with the aging and disability resource list. I always wanted that. This is a setup that is already run and already has the boots on the ground. They provide us with a good model.

Senator Kilzer: I agree with that. The community of care is just that. It's involvement with the whole community. It's not just making sure that the person on SPED or some other program. This community of care is just as Representative Ekstrom pointed out, to be helpful to keep that person at the best level of activity in their own location of choice. I certainly do support the model.

Chairman Pollert: Any other discussion?

Senator Fischer: To get the ball rolling I would make a motion to eliminate the $300,000 to provide funding for a pilot aging and disability resource link.

Senator Kilzer: I second that.

Chairman Pollert: That would be throwing $300,000 out of that program.

Senator Warner: Would we be open to some consideration to have the same organization initiate the second pilot in the west?

Chairman Pollert: My input on that is that it is a pilot project. The house side has had some real reluctance about the one stop centers. I would like to see how this goes. If it's true that there are savings, I would like to see that before we go anymore. That is my impression. That passes 6-0-0. Now I want to bring up discussion for the community of care program.

Senator Warner: I would move that we fund that with $120,000.

Senator Fischer: I second that.

Representative Ekstrom: I would like to further amend. I would like to put an additional $10,000 to allow them to study the opportunity. What would it take to expand into another location? That is just purely pulled out of air. We asked for accountability on this one. We

wanted to see the same benchmarks and to hear from you if it was working. Just one more step further to talk about what a statewide system would look like. Just a little money to get that started.

Senator Warner: I second that.

Chairman Pollert: So this would be $130,000? Any discussion? What are you hoping to have accomplished?

Representative Ekstrom: Perhaps I have looked at the ADRC. One of the reasons that I had some misgivings was that we didn't really know what it was going to look like. We know what the Community of Care looks like. All I'm saying is that giving it to the dept. with the notion that it would start working out to get this done everywhere without duplication of services. The ultimate goal is to keep people in their homes and communities.

Chairman Pollert: Are you saying it would be for them to come back with accountability and what the savings might be with the programs. The $120,000 is going to go to the community of care program. Do you want $10,000 more to see what they bring forward?

Carol Olson: You aren't going to hear me say this very often but I'm not so sure we need an appropriation to do such a thing as this. The department's goal in this is to work with the community of care and follow what they do with their expansion and take their results and work with them to come up with the data. Jane already has data. We can report on that and work with them and move it forward. We can come back in the next legislative session and maybe during the interim and bring some information forth. I don't feel we would need an appropriation to pass along the information.

Chairman Pollert: We agreed on almost everything 100%. I would just ask if there is anyone that would want to recede from their motions.

Representative Ekstrom: I will recede from my motion.

Senator Warner: As will I.

Chairman Pollert: Any other discussion? That passes 6-0-0. Let's go down a little further. I think we went from the top of page 5. We will talk about the vacant FTE's later. We will move on to gambling. I have to remind myself what we did with that. The original recommendation from the executive budget was $300,000. The Senate adds another $100,000 to get it to $650,000. There is $400,000 from the Attorney General. Do we want any discussion on that? What the house did was an increase of $300,000. The house cut that down by half to $150,000. The Senate restored $100,000.

Senator Fischer: What is the source of the funds?

Chairman Pollert: The funds are general. Currently of the $250,000 that was added in, those are general funds.

Representative Ekstrom: I'm looking at our original sheet of amendments that we had. What I'm seeing is a decrease of $200,000. It looks like what the Senate did was put half of that back.

Senator Kilzer: In statute $400,000 comes from the attorney general's lottery fund. The Governor added $300,000 in the executive budget which made a total of $700,000. Was it $150,000 that was reduced by the house? One of the other things was to check how much tribes or reservation gambling is contributing to this compulsive gambling. It doesn't amount to very much. This is the major funding source for compulsive gambling.

Representative Bellew: My understanding is that the extra $100,000 the Senate put in would be for an advertising campaign so people know the programs are available and try to get them in treatment.

Senator Warner: Why doesn't all of this come out of the lottery proceeds? They are general fund rather than letting it get into the general fund to change its identity. It is all the same.

Chairman Pollert: It's a general fund appropriation out of the Attorney General's office as it was a general fund appropriation out of ours. It's not coming from the lottery proceeds because the lottery proceeds are those general funds.

Lori Laschkewitsch: The lottery proceeds are transferred to the general funds. If you are taking the money out of the lottery proceeds it will be transferred to the general funds.

Chairman Pollert: Indirectly it is a general fund. It's just a one stop spot before it gets there. You could say that in the health department budget about the EMS grants. The EMS grants are taken out of the insurance tax distribution fund or the insurance distribution fund. It is a similar way as they do the lottery compulsive gambling. It's the same way. It's a step before the general fund but it is a general fund direct effect. Is the other $150,000 for services or marketing? I don't have a problem if it's services but I do start having one if it is marketing. On compulsive gambling, the $400,000 comes from where? Is it going directly to services? You could tell me if it's for services or marketing?

JoeAnne Hoesel: It's for treatment. We had it allocated $450,000 for treatment. We had a small amount for travel and some for media. I'm not sure how it was reflected with all the changes that had gone on. We know there is a need for increased treatment. We also know if we don't do media that treatment is available. We certainly have a goal of increasing treatment so people know where to find that. We know when we run the media campaigns that our calls to the treatment center do increase. There is a balance with that.

Chairman Pollert: The original recommendation of the $300,000 do you have an idea how much is going to be program and how much is going to be marketing?

JoeAnne Hoesel: I can tell you of the $700,000 that $450,000 was treatment.

Chairman Pollert: So what you are telling me is that it was a proposal to spend $250,000 on marketing. Of the $700,000 after the Senate amendments that would be $650,000 total dollars

of which $450,000 would be for treatment which means if we take off the $150,000 for house. Here is my question. I have a problem with marketing. That is $200,000 for marketing. I have a problem with that. I'm just wondering if there is some kind of ground here or other. Of the $450,000 what are you doing for marketing now? It was originally $400,000 before this budget.

JoeAnne Hoesel: We did a small media campaign in 2007. We haven't done any of that since. I can get you the amount. What we have found is that if we don't do any marketing which is a website and radio spots, people don't' know how to access it. I will offer to you that it's a matter of putting it into grants and operating. I believe we do need to have some media to do this so people know how to access that. Certainly there is flexibility in terms of how that money is split into the allocation. We would abide with the wishes of the community.

Senator Warner: How would you anticipate the funding stream being used? Obviously the more you spend on marketing, the higher interest so it will eventually balance out. You anticipate the gross amount that will balance both sides of the equation.

Al Stenehjem: I do serve on the advisory committee with the Department of Human Services and the compulsive gambling group. I am involved in some of that discussion. It has always been our goal to make sure those services from gambling addiction are throughout the state. The funding we have put in place covers most of that when we have people that aren't working full time because the funding isn't available. We are looking to increasing that to full time for some of the people in Fargo and Grand Forks. The problem is that we can have all of the infrastructure and services available but if people do not know that they are available and the treatment is effective we just spend that money for nothing. I don't like to say its marketing. It's more of education, letting people know what is available if they have a problem with gambling so there is treatment available and in most cases it is successful. We need to get that message out and as we have done that we spent $60,000 last biennium just on education. It's

not very much money. We had to focus it in a 3-4 month period so we could utilize those dollars. What we are looking for is a little more comprehensive.

Senator Warner: Is there a number smaller than $700,000 that you think would do that job?

Al Stenejhem: When we first looked at it we were looking at $1.2 million. We put the services needed together and the education, training, and the marketing. We are down to $700,000. I think about $200,000 throughout the biennium is for marketing. The rest will go for services.

JoeAnne Hoesel: If I can clarify and give you more details. It was $534,000 for treatment. It was $160,000 for awareness outcomes and media, $820 for travel, and $5,180 for resource material. That totals $700,000.

Chairman Pollert: So currently the Senate version is at $650,000? What do you want to do committee?

Senator Warner: I would move that the conference adopt the Senate position on this at $650,000. We see this problem pop up all over the place. In the rural areas it seems to be the number 1 reason for embezzlement for our financial institutions. It seems to be linked to several cases that I know of for embezzlement for school boards, business managers, it's not just the down and out to get caught up with this. Quite frankly it seems the most people are women given the relatively small number of women who commit other types of crime. The number of women who commit crimes of this nature seem to be proportionally large. They are sweet little old ladies but the money still disappears. I think in the long run we would be better off putting it in this position. The Senate's number is pretty close to the number which had been approved.

Representative Ekstrom: I second that.

Chairman Pollert: When was the $400,000 first instituted?

Brenda Weisz: When the lottery went through there was $350,000 put in for treatment. I believe the last year Delzer was on the committee. It has stayed at $400,000.

Chairman Pollert: We will call the roll. The next one down the list is when the Senate added in $200,000 dollars. That is stated wrong. The Senate amendments restored the $200,000 that the house had taken out. The executive budget was at $200,000. The history on that was the last biennium there was $100,000 given. This is what it's about. This would be an increase of $100,000.

Representative Bellew: If the committee remembers that money comes from the community health trust fund. This is all general fund money.

Senator Kilzer: This is one of the focuses of the present governor and first lady. ND really has the worst problem in the nation with underage drinking. This needs to be continued with additional attention. That is why we want to get a better handle on the problem and not give us the dishonor of being the worst state in the nation in this category.

Chairman Pollert: I would be in support of $100,000 of what we did last biennium. I don't know about $200,000. That is just my position right now. Should we just wait for a later date?

Senator Kilzer: I appreciate your comment and I to fret a little that the community health trust fund is being used the way it is. When you look at the list of the good projects that it funded and how it can no longer fund the projects. It is going to be difficult. We may end up doing not as the Senate wanted to do.

Representative Ekstrom: Fargo has the worst record of all in terms of binge drinking. I would like to have the $200,000 I think they have to have some level of funding. If we can get it back to the $100,000, I'm not thrilled, but we may need to go there.

Senator Kilzer: I am suggesting and requesting to go to $100,000 in recognition of the problems of the community health trust fund.

Chairman Pollert: If I understand the discussion it would be to have $100,000 go into the governor's advisory council and $100,000 would be reduced but there would be $100,000 in the program. Any other discussion?

Senator Kilzer: Because of the community trust fund I have to make the motion that we put $100,000 into the biennium for this.

Representative Ekstrom: I second that.

Chairman Pollert: I have the same worries as well as far as what is going on. It has been a real struggle for us as to trying to figure out and get more money into Women's Way, etc. Here on this conference committee we will be addressing this. This motion would reduce the Senate amendment by $100,000. This one passes 6-0-0. I want to have a little discussion but not vote on this, the peer support. I don't want to vote on this today. I would like to have someone step forward.

Representative Ekstrom: I'm sure most of the committee remember that peer support is coming out of the mental health community. It matches up people who have had severely mental illness. They have a buddy system. It allows them to buddy up with someone who is experiencing difficulty. We have heard testimony from people who have not been out of their houses. We want to get them up and out and back into the community again. We talked a long time about the difficulties we are having at the state hospital and the fact they are taking care of people with greater acuity and cases where they are certainly mentally ill. These folks are back but aren't doing so well. This one person keeps people from falling into the well and winding up at the state hospital. I would be willing to negotiate how much this would be but I do think some additional funding is really needed.

Representative Bellew: This is an OAR? There were also some federal funds with that. Could the department explain this?

Brenda Weisz: When we developed the OAR in the summer we did have a state plan with CMS to add peer support for a state plan. We were told subsequent to that to remove that from our state plan. There will be no Medicaid funds available. At the time the amendment passed it would be all general funds at this point.

Chairman Pollert: Can you give me a brief description on peer support.

JoeAnne Hoesel: Peer support is a program and there are different levels. Our initial OAR is a funnel service through Medicaid. However this amount that we are looking at right now of $300,000 represents a lower tiered peer support program for individuals that have a mental illness that are in recovery are trained to provide peer support. They are really an extension of case management. What they do provide to people currently in treatment and receiving services for their mental illness is hope. Hope we know by research and our day to day experience with service delivery is one of the major factors is the difference of someone maintaining and going in and out of hospitalization and having longer periods of recovery and stabilization. We have individuals are doing things that they never thought themselves to be able to do like have employment, own their own homes, go out of their homes, go to a church function. It is a difference between recovery that is minimal to recovery that is robust and brings them more in line and involved in their community.

Chairman Pollert: What was the budget the previous biennium on peer support?

JoeAnne Hoesel: There has been a small program pieced together through western sunrise and Northwest Human Service Center. Western Sunrise is a contract through that through their psycho social rehab center. It's an extension of that.

Chairman Pollert: Is it like 30,40,50,000?

JoeAnne Hoesel: What it does is it actually hires individuals that are having stable mental health recovery. They come in and match them with a person in treatment. It's all driven by a treatment plan and they are supervised to go towards the right direction.

Chairman Pollert: Handout A. This is a breakdown of the amount of money for the Centers of Independent Living. I asked the department for a current budget for grants to independent living. As you see the current budget in 07-09 is $1.344 million. You will see the general breakdown. The Governor's budget was for $800,000 of general funds. The house reduced that. What is in front of us today is we are going from a $530,958 general fund balance to $1.080. It's about 100% increase. Then the federal funds stay pretty steady the way this looks. With that, this will be coming up tomorrow so you had some information. We are lined up for 2 meetings tomorrow for an hour long each.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☒ Check here for Conference Committee

Hearing Date: 4/29/09

Recorder Job Number: 12371

Committee Clerk Signature

Minutes:

Chairman Pollert: Called the meeting to order and let the record show that every member was present and that Representative Bellew was replaced by Representative Kreidt. With that is going to be the long term care hour. When I say long term care if we go back to page 4 that is not what I'm talking about. I don't want to discuss the third tier personal care yet. I want to have a discussion on the 7&7 and the Senate floor amendments to move from 75 to 95 on the Senate floor. I want to talk about the funding for the long term care. I would like to talk about the dollar increase for the QSP's and also the dollar on the DD. With that I would start with a discussion of the Senate amendments on the floor. In your packets they are numbered the 02-11. Senator Warner I think that was your amendment .0213.

Senator Warner: This is a number that was bedded by the department of human service but by the executive branch with the recommendation coming out of the Governor's office. We felt that it was appropriate given the rate of inflation in years where it was below the rate of inflation. This was a good time to do the single one time catch up rate for those agencies affected by this.

Chairman Pollert: I never really did officially welcome you to the conference committee. Usually it was Senator Mathern. You might regret this move. Just to do that discussion back in

the first it was 7&7. It is easier to say the discretionary dollars. The amendments on the house side were to add the pass through money and that is why we went to the 6&6 because of the pass through of the dollars. You had mentioned the inflation. All I did was simple math. I'm able to hit a plus and minus. I had asked the department as far as the inflationary as compared to the consumer price index from the year 1997-2008. When we did that it was kind of interesting. It showed the legislature's average has been $2.075. The average for the CPI was $2.84. There was a gap there. What I did was I went and used the same numbers and did a 7&7 and also a 6&6. When I did a 5&5 the average comes out to $2.943. We had a number for CPI that was $2.1. That is a number I used for 09-10. That comes up to $2.49 basis a CPI of 2.735. When I did a 6&6 it came out to $2.63 for the 636 and it came out to a 2.735 again so within a tenth. When you do a 7&7 and the Legislature goes to 2.78 and the CPI is 2.735. When I did the averages I thought the 6&6 was a fair figure.

Representative Kreidt: On the house side when we started looking at the budget for 1012 the Governor had put in the 7&7. You have to remember there was an optional request and that was for a salary pass through that was not approved by the Governor. As we begin our discussion we did realize that there are some problems in facilities in turnovers and some nursing staff positions. We felt that a salary pass through and we had much discussion on that in regards to what we can use for a dollar amount. The final amount that we arrived at, we did use the health care trust fund. We did take $1 million out of there. The general fund of about $14 million to go forward with a pass through to the negotiations to secure that amount. We did reduce the 7 to 6. We felt that was a rather generous amount of dollars with the 6&6 and pass through because that pass through will go directly to staff members on July 1. They will receive that on January 1. This gives them some upfront money to make the salary adjustments. We did put in on the house side and came to you. That was a pretty good package in my eyes.

Having been involved for over 30 years with the long term care facilities, that is a pretty nice package.

Representative Ekstrom: In my research in terms of where this needs to go, we look at this budget in aggregate. I decided I'm going to go to the 5 corners of the state and see where individual numbers are going. I know we have to deal with this as an aggregate number. At valley elder care the food cost went up by 11.38% and the overall went up by 8.85%. It is sort of my center point. The homes in Fargo sent me numbers with regard to food. If you go to Valley City they have a turnover rate of 36%. They spent 35% more because of the turnover they have there. The St. Gerard's in Hankinson the turnover rate was only 25%. Blue Cross Blue Shield went up 12% in the 08-09 period. Advertising because of the high turnover rate spent 55% trying to refill the position. It's maybe easier to look at this in aggregate. These are substantial numbers.

Senator Kilzer: The Senate did with all due respect with Senator Warner a reasonably close vote to bring it to 7&7 and 1. I think a lot of us were satisfied with the 6&6 and 1 with 100% coverage for the workers in order to avoid the compression that I spoke about a couple of days ago. Things aren't as rosy as they were when the Governor put his budget together. I do have employees in my district outside of the medical field that frequently tell me they aren't getting any raise and don't anticipate a raise in the next couple of years. I still do favor the 6&6 and 1. I also would like the 1 to be a 1 for all of the non administrators even if they are already at the 80th percentile. It's a reasonable figure that might seem high to some folks. In some of the other areas it has been so low for so long. That is the way I would like to see this go.

Senator Warner: I think the will of the Senate favors the $1 pass through. That is where we would take our stand. I want to yield on the 7. I hope we do give some consideration for the money we would be saying to make some commitments. Our action of backing away to the

and back to the 6&6 plus 1 in exchange for the other programs, I would hope that it would be the honor of the committee to get into consideration of things as they do come up.

Representative Kreidt: Just to reiterate that when 1012 did come before our committee in the house, there was no pass through at all just the 7&7. We could have stated the 7&7 and not used any general fund money or used any money out of the health care trust fund to bring that forward. We did realize that we were having difficulties maintaining staff and securing staff and turnover that we felt it was a pretty fair amount of dollars. The federal dollars that are attracted by it. That is up for discussion. I personally felt that it was more than a fair amount of money the $15 million that we had applied. Would you consider a motion in regards to the 6&6?

Chairman Pollert: The amendment stressed the 7&7 in .0213. Would our action have to be to recede from the amendments in .0213? Would that be correct? Is that how we would have to do since it was off the Senate floor?

Roxanne Woeste: That would be fine if you wanted to state the Senate recedes from .0213

.**Chairman Pollert**: Dose the Senate have to make that motion?

Roxanne Woeste: It could come from any side.

Chairman Pollert: Before we make that motion.

Senator Warner: I would prefer to just consider this as part of the total package.

Chairman Pollert: Are you saying that you would just not like to take a vote right now.

As far as the $2.9 that is in the care portion of the statement of purpose. I still have repercussions about that. I'm in support of the house version. I don't want to be sitting here and making deals on the floor. You stated that. If my vote is reflective on going to the 6&6 that doesn't mean I'm in favor of the 2.9. I have some questions about that as well.

Senator Warner: I think the 2.9 is important. We need to make sure this was funded adequately and money is going to be there to flow through.

Representative Kreidt: With the dollar amount that the house appropriated the concern I have is with the amendment. I would prefer that we didn't use $1 an hour amount taking the dollar out and whatever appropriations we consider having the lump sum money going to the facility so we can appropriate those dollars in a way we see fit to the staff. It would be directed only to staff salaries and benefits. That way when you say $1 you are directing the facility to give each staff $1 an hour. If that dollar was gone, if they had a staff person that they felt needed more than $1 an hour they would have that prerogative to do that. If they felt they had a staff member that they felt only deserved 25 cents an hour then they could do that. If they had a particular department that change. Whatever amount we arrive at the facility would have the ability to use those dollars again for staff salaries and benefits.

Chairman Pollert: That is on another topic which we will try to go to next.

Senator Warner: Just for my own understanding the benefits package relative to this is calculated and shifts on its own relative to where we have set that. If we give them $1 raise the benefits package increases. The insurance portion would be fixed anyways.

Roxanne Woeste: The funding is strictly for $1 benefit. I don't' believe there is funding in there for the additional benefit. Perhaps the department could clarify. The funding is strictly for $1 an hour increase in compensation.

Chairman Pollert: We should go to the next question that she is probably going to ask with the DD as well.

Brenda Weisz: When we do the dollar increase there is FICA that will always increase. It has included the FICA increase. There are no other increases or benefits. FICA is incorporated in that number because those facilities will have to pay the increases. The number we provided to you gives you the number with the 7.65 on that dollar.

Senator Kilzer: I did have the privilege to have Brenda explain this to me previously. Suppose someone is making $10 an hour and they receive a 6&6 and 1. If they receive $10 at the present time the first thing they would get when this goes into effect would be the 6% increase. They would get a 60 cent increase. They would also get the $1 which would bring them up to $11.60. The next year of the biennium they would receive $11.60 plus a 6% increase of that amount. That is the way that these two figures are built together. I hope I got it right and I'm pretty sure I do.

Brenda Weisz: You said the inflation first and then the dollar for inflation? That is correct. For DD because they get paid on July 1. Their rates change in January the inflation comes in July.

Chairman Pollert: I think that would explain why the house version of the $4.9 million with the funds in it, why we aren't looking at the dollar for long term care because of the inflationary effects that it is going to have.

Representative Kreidt: In regards to nursing facility that 6%, the facility can do whatever option they want. They don't have to give a 6% salary increase with that amount of money. If they want to reflect that they can do it. They necessarily don't have to do that.

Brenda Weisz: That is right. It is set up differently because of the rate mechanism. They are budgeted because of rate setting. That is true with both sides of it.

Representative Kreidt: With the pass through if we remove the dollar there would be a formula put together where they would receive a lump sum money amount. If we said salaries or benefits and they wanted to do a $2 increase or they wanted to give them $1 towards retirement or health insurance they could do that.

Brenda Weisz: That is correct. It is the language.

Chairman Pollert: Coming up from the pass through for DD on the amendment for the $86,000 how is that different than the language for their proposal? Is the DD language for the dollar pass through different?

Brenda Weisz: My understanding for the amendment is that the dollar would then be added to the positions in DD. The rate setting is a bit different than DD so they budget based on FTE's and that is the amount of money that the facilities receive for their budget. As it stands right now for the Senate version with the dollar version the budgeted FTE's are allotted to the DD providers with the increase by that dollar.

Chairman Pollert: Could it be said that the benefit package to DD was attractive with the package offered by nursing homes? That is on another topic which we will try to go to next.

Representative Kreidt: Just catching up with the committee here, if I understand the amendment for the DD dollar increase, the 90% has been removed. They are just looking at a flat $1 and that would cover everyone?

Brenda Weisz: That is correct. The amendment was to provide $1 to the nursing facilities and $1 to DD and to QSP whether it was to the individual or the agency.

Chairman Pollert: Yes and that is a separate amendment. You are saying the 6&6 is going to inflationary increases are to go to their benefits package. Could they transfer the dollar to go to the benefit package instead or is this language pretty well stretching that it will be $1.

Roxanne Woeste: Sometimes we do not get paid by line item or the budgets of the DD. We set the budgets and the rate setting mechanism. We put the money in. They set the mechanism and manage the money. We do not ask for reports back.

Chairman Pollert: So its $1 based on the FTE's but it's up to that DD provider if they want to have a discretion if it's going to be wage or benefits or what they want to do.

Senator Warner: So we really have two issues here. I am less concerned about which individual employee gets which part of this. I don't want the agencies to be transferring money out of that. We have it dedicated towards increased compensation. Can they transfer it to any of the lines?

Brenda Weisz: We don't ask for information back and we don't manage by line item but I can tell you that those facilities know where the trouble lies. When it is legislative intent to do something to benefit their employees they look forward to doing that, they have in the past. Some intent language, they do try to follow through and extend those increases to the employees.

Senator Warner: The 7&7 was much more inclusive then the providers we have been talking about. The 7&7 affects the positions of everyone.

Brenda Weisz: Right. The 7&7 in the Governor's budget as well as the 6&6 was changed on the Senate floor amendment does provide inflation to all provider groups. For a couple of biennium's now we have treated them equally. Your Medicaid and CFS providers are at that.

Senator Warner: Dentists were rebased differently? The intent in the Governor's budget was whatever the inflator was. Any of them get rebased. The inflator is in the second year of the biennium, but the dentists are different?

Brenda Weisz: This is how the budget came forward from the Executive office. The dentists were part of the group we looked at for rebasing. There was no mechanism in which to develop that report. Since there was no rebasing report that came forward from that group, the other groups we have rebasing reports and those rebasing reports they brought the costs forward with the inflator to 2010. That is why there is 0 percent inflation for those rebased providers the first year. They come off of the rebasing report. That is included in the dentists for 75%.

Senator Warner: So that one provider needs to have an inflator for both years of the biennium?

Chairman Pollert: We will have a discussion on that one. The dentists are based off of bill charges. They aren't based off costs. That is a drastic difference.

Senator Kilzer: I think my question was partial answered by this last question. On the other providers though, as I recall, the rebasing is projected through June 30, 2010. That is the reason for the inflator only being applied in the second year of the biennium.

Brenda Weisz: Correct.

Representative Kreidt: This is probably in regards to some checks and balances. They do a cost report on an annual basis that is reviewed by the department. If that money wasn't going into the salary line item they would think that facilities are manipulating that money.

Brenda Weisz: That is very true. The cost report does reflect that. The only thing we don't have by authority or statute is to tell them where to spend the money. DD has a cost report that we see where their costs are.

Chairman Pollert: Any more questions?

Representative Kreidt: The Senate had proposed the 7&7

Just for my own understanding the benefits package relative to this is calculated and shifts on its own relative to where we have set that. If we give them $1 raise the benefits package increases. The insurance portion would be fixed anyways.

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Chairman Pollert: Any questions? Any motions?

Representative Kreidt: The Senate had proposed the 7&7% increase for the inflators and I would move we go back to the 6&6 that the House had proposed in their amendments.

Chairman Pollert: I will second that.

Senator Kilzer: On the motion that is before us on the 6&6 what about the 1 or the 2?

Chairman Pollert: That would be discussed down further because you have that as a separate amendment. The 7&7 in .0123 is a separate amendment than the dollar pass through that we are talking about on page 4 of the statement of purpose for the 2.96 million. That would be a separate discussion.

Senator Kilzer: Is the 6&6 for long term care, the DD providers?

Chairman Pollert: Department wide for everybody. We treat them all the same.

Representative Kreidt: That is the way that it automatically happens. The percentage increases.

Senator Kilzer: Hospitals would be at the 6&6 as well.

Chairman Pollert: It would be after 2010 because it is cost based. Hospitals, physicians, chiropractors, and ambulances would be at 0&6.

Senator Kilzer: I just wanted to make sure.

Chairman Pollert: Yes it would be department wide. I'm getting a lot of good signs.

Senator Warner: One part on the ambulance they were only rebased in the first year with Medicaid. If only they are rebased in the first year and they have to go back to the normal inflator.

Chairman Pollert: We will call the roll to go down to the 6&6. It passes 6-0-0. That motion passed. We are going to stay on long term care. That is going to take longer. I'm going to go to the amendment that was passed on the Senate floor .021. I'm coming back to that and it is going to take longer than 10-12 minutes to have that discussion. I don't want to short change that. Will you give us a history on .0211, since you know the long term care? It came from the executive budget at $60 and the house raised it to 75. Sen. Mathern had the amendment passed on the Senate floor that had it from 75-79. The fiscal note is around $200,000.

Representative Kreidt: For personal needs allowance this is for individuals. I see an FMR out of that. This is money that if someone wants to buy some personal items like better soap or hairspray. We felt that $75 a month is a fair amount of money. You have a lot of residents that weren't even spending the $60 but banking that. $75 a month for those special items that the resident would like to purchase we felt was a reasonable bond to be able to do that. We did go from the $60-75. The industry felt that it was a reasonable amount. That is where we arrived at that.

Senator Warner: Can Roxanne explain the language for basic care facilities and intermediate care for the mentally retarded. Those are the only two groups that were elevated to the $95? This does not include billed care?

Roxanne Woeste: That is correct. It does not include billed care.

Senator Warner: So it would not include anyone that is bedridden? That would be the distinction?

Chairman Pollert; We will get someone from DHS up here to get a better explanation.

Maggie Anderson: The amendment and provisions are for individuals in basic care not nursing homes and then the intermediate care facilities. The distinction there was during the last session there was an amendment brought forward to increase the ICFMR's. Those two items were coupled together. We worked with the long term care association and with CMS to decouple those. There was one desire to move the nursing home to a higher level. There was a desire to move the clients and an ICFMR to a higher level. There was no interest from the long term care association. There was for basic care and for the ICFMR's.

Senator Warner: I kind of understand that they normally pay the premiums out of this money. Is that correct?

Maggie Anderson: Individuals in the intermediate care facilities are Medicaid eligible so they will qualify for the long term subsidy for part D.

Senator Warner: Do you know what the average monthly charge would be?

Maggie Anderson: The average monthly charge could vary a lot. The cheapest premium is around 5-6 dollars and it goes up to several hundred, depending on which plan they use.

Senator Warner: It would be significant in our discussion.

Maggie Anderson: Well it depends on the prescription drugs you need and what plan it is to have them covered by your plan.

Senator Warner: So this would include all non prescription drugs?

Maggie Anderson: All of your over the counter drugs for your basic care.

Representative Ekstrom: I worked out the numbers and at the $95 a month rate you are at $1,140. I hope I don't find myself in a facility like that but that's not a lot of money. To be

serious, these people go to church and give to their church. They count this down to the last penny and by the time they got to the end of the month they have 28 cents left. This would be a good thing to do for the folks.

Chairman Pollert: Any other discussion? We have to have an acceptance or rejection of the amendment because there was a change. We can wait and have this discussion when we come back.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☒ Check here for Conference Committee

Hearing Date: 4/29/09

Recorder Job Number: 12387

Committee Clerk Signature

Minutes:

Chairman Pollert: Called the conference meeting together and let the record show that all committee members are present. With this I would like to bring up a couple of issues to see where we go. Case load utilization, does anyone want to bring that up?

Senator Fischer: I think we might as well talk about it. To get the ball rolling is what are we going to do about it? There are three categories. Long term care is one of them. For long term care the projected case load utilization rates the discussion has been when we talked about it has been if we leave this in or take it out, one thing I would like to see is some verbage that guarantees the department that if these estimates of utilization rates are wrong, it doesn't take them 10 minutes to get money. So they would get the authorization to spend the money if there was a deficit spending. I would like it recorded somehow that we are ok with that provided their matches go away or come to some point. Otherwise I can't support that. I'm not willing to take the chance. The bottom line of this is that what happens is you hurt people. I understand if you think there is going to be a fall off with economy or utilization but what we have seen happen in 5 months, what is going to happen in reality. I am very nervous about that.

Chairman Pollert: Who knows if the numbers are right or wrong? We did calculations last biennium on the case load utilizations and we were right. We were wrong on the costs. When I have these discussions with the leadership on my side, it's not my intention with the case load utilizations to increase. What we have done here creates a problem. It wouldn't be my intention that the provider rates are dropped services. I was quite frank with that by saying if they have to come forward for a deficiency appropriation that is what they have to do. If that happens and I am proven wrong they can put me in that section or into another policy committee. That is what I told them. We shouldn't reduce services or provider rates. To come forward with the deficiency appropriation, that is what they have to do. The discussion happened with the majority leader and the chairman of house appropriations. I didn't talk to anyone on your side because I wouldn't do that.

Representative Ekstrom: I have 2 amendments I would like to pass out. (Handout A) Amendment .0214. What this does is put specific language in there that says if the department of human services expenditures exceed fund levels due to cost and case load utilization programs exceeding the level anticipated by us that they can deficit spend. We may add more language that says they have to come to us for deficiency appropriation or they can borrow from the bank. That has been done in the past. I would like to move that amendment.

Senator Warner: I second that.

Chairman Pollert: When we did the calculations on our side of the aisle we did not change the costs that they gave us. When I read this amendment I can say that the department of human services is due to cost and case load utilization. That is like we are doing the cost. We never did play with that

Representative Ekstrom: We can change the wording to get it what I'm trying to do. I don't have trouble putting the language in there.

Chairman Pollert: What you are saying is what I stated on the record.

Senator Kilzer: Do they really need this authorization? Isn't this what they do anyway?

Representative Ekstrom: This was requested by the department. They asked me to put this forward.

Senator Fischer: I support this and the reason is because they have been put in the situation so many times in the past where they deficit spend and then they get all beat up because they are being accused of not controlling their budget. Whether that is true or not, every year this is controlled. The words can be changed as long as it's not completely changed. I have had a real fun experience with lobbyists. The thing is that it is the reason why I like it.

Representative Ekstrom: I think we would have more agreement on the first than of the next. Amendment B .0215. After the wording biennium we would take costs and "and" out. I think that takes care of your cost trouble.

Chairman Pollert: It would be different if we didn't play with the costs. We kept the numbers when we did it. We looked at the detail.

Representative Ekstrom: I will move the amendment to the amendment.

Senator Warner: I second that.

Chairman Pollert: Any further discussion?

Senator Fischer: I don't support this for the simple reasons with the dollars.

Chairman Pollert: We are on .0214. The only change is the language.

Senator Kilzer: Which one are we working off of?

Chairman Pollert: Amendment .0214. The substitute motion that was moved first for the whole amendment and the second and the substitute was to delete out the costs. When you look at the paragraph when it says section 10. We are working off the .0500 engrossment.

Roxanne Woeste: For the ease of discussion and going through the amendment, just think of this amendment as adding sections to that. At this time we aren't working with the engrossed bill but we are going to add the section to the bill and this is the section.

Chairman Pollert: So it might not be section 10 but section 18. We will call the roll. That passes 6-0-0.

Representative Ekstrom: I do know where this is going but I felt the need to bring it forward because we did have a disagreement with the Senate. What .0215 does is takes our cut and cuts it in half. We are the other way around. We add back half or delete half of what we put back in. I would move that amendment.

Chairman Pollert: There is not a second. That motion fails. That is the motion on the language. We would have to have the discussion on the $9.6, the $5.6 in long term care talking case load utilization and the $2.476. I would want someone to correct my math. Are those the three areas of utilization? I will ask Legislative Council to verify the number I have stated. I would entertain a motion if anyone wants to?

Representative Kreidt: I would so move the amendment.

Chairman Pollert: The case load utilization of 9.6 under the medical services, the 5.6 under long term are and the 2.476 million under the DD case load utilization. That number is $17,676,000. Is there any discussion?

Senator Kilzer: My question would be a little bit of a further explanation on how each one of the figures fits into the big picture, the overall appropriation for each of the 3 items. For example, the $5.6 million long term care I have on my notes that the $5.6 million that had been removed by the house in the executive budget the total amount is $194.8 million. That is a note that I had made. I was just wondering about the other two and the amounts that have been removed by the house fits into the whole executive appropriation.

Chairman Pollert: I can't address the $198 million. What you would be voting on is the three case load utilizations that is on page 4. That is 6 lines from the bottom of page 4. Right above at the same time that would reduce the amount of federal dollars coming in as well. If they aren't used the federal dollars aren't matched either. The total amount would be the 16.35978 of federal dollars. Also included in that would be the 9.5433 down at the bottom and also the 4.25911 would also be included in that motion. The total between general and federal would be roughly $26 million above the $15 million and the $6.7. It is $48 million. If our projections are right, those funds wouldn't be allocated. I don't know where the 198 is coming from but that would be a reduction on the Governor's budget. All of those are general fund/federal fund matches. Any other discussion?

Senator Kilzer: That is with the extra motion in place if and when they run short. That is the deficiency appropriation. That is one of the things that the Senate wasn't very high on was the utilization. The math that was done in the house we can wait and see what happens. There is just as likely to be an increase as there was a decrease in trends. I can go along with this and we should not be surprised if this figure goes the other way.

Chairman Pollert: Maybe I will have to have someone from the department step forward but they also have the authority to float amongst their agencies as well. I would suspect that if they would come forward for the deficiency appropriations that it would already be expended and they don't have the authority so the money switch can't happen anymore. They already have that authority. I would have to ask for a re-vote. They have the authority to go from one fund to another. Your motion was to?

Representative Ekstrom: They would do what they normally do but in the event that the other options fail, they do have the authority to still vote. My understanding from the department is that these items represent a certain amount of money. They really wanted that specific

language in there. When this happens, let the Legislature knows that this is very likely going to happen and that is why they wanted the authority.

Chairman Pollert: I would have to believe that what the turnback is going to be, that is just general funds. Some of the dollars are dealing with case load utilization. If they didn't use the general fund portion of that if they had a $10 million general fund whatever $10 million is as a percentage, if there is $20 million the federal dollars weren't used as well. That coincides with what Senator Kilzer is saying. I have one question that I'm going to bring Brenda up for. My question would be that in the 09-11 biennium, let's say you have to come forward. Let's say you have to access money. Let's say you are short on general funds of $10 million. It would be a $3.7 million general fund and $6.3 million of federal. With this motion and the amendment, would you be coming forward still being able to access the federal dollars to continue the program? What I'm getting at is instead of asking for the $3.7 million are you going to be able to get the other $6.7 so instead of coming for a deficiency appropriation of the $3.7 you don't come in for $10 million because you can't get the federal dollars. Do you see where I'm going? If that's the case you have to talk about a line of credit so you can get the money.

Brenda Weisz: We will need to have federal authority to access the federal funds if we have the general funds put back. If you make the adjustment to the budget and take out the general funds and the federal funds we will not have enough authority and we will have to go to the emergency commission to get the authority to accept and expend the federal funds and have a deficiency of the general fund side.

Chairman Pollert: I see that not being a problem but that is what you would have to do?

Brenda Weisz: Technically that is what we would have to do. We would still have the ability if there is money to move around. The only problem is that this amount of money that this underfunding is, is 1/3 of our human service centers. The amount of underfunding that we

proposed to be taken out is the equivalent to the funding for 1/3 of our human service centers. Even though we have flexibility there isn't a lot of money left after this change.

Chairman Pollert: But you have to make sure you have the authority because it would not be in my direction that if you have a deficiency appropriation that instead of asking for the $3.7 million that you have to ask for all $10 million because that is not a good scenario. You have to make sure that you have the authorization to get the federal dollars.

Brenda Weisz: The federal government will give us the money. The authorization wouldn't be a problem there. The problem with the authorization would be the amount of appropriation authority that you have in our bill so you would have to go ask for that in addition to the deficiency.

Chairman Pollert: In other words you are saying that in case you go in front of the emergency commission and that would be reminded by the chairman of the house appropriations of what happened in the DHS budget with the conference talks and the amendment. I would have to get up on the budget section to clear your case?

Brenda Weisz: Right.

Senator Kilzer: While you are there I have another question and that is if we get into this deficit situation and it most likely will occur during the end of the biennium which would be the last quarter when the FMAP has again fallen down to 60 something and there is a few additional dollars that would be favorably affected by the motion right?

Brenda Weisz: I will say this politically correct. The change in FMAP will compound the situation that we have before us with the utilization change. It will be the last 2 quarters of the next biennium. It will drop in January after the stimulus money.

Chairman Pollert: How was that different than this time when we are having to fund the $9.5 million because of the lower drop in FMAP. That isn't any different than having to come in and

say you have another $9.5 million plus the $17.67 general fund. You can say I told you so. Really there isn't any difference if you look at it that way. If there is I want to know that. It would be a similar situation kind of a thing because we would have to fund the FMAP. We have never not funded that when the FMAP percentage has dropped.

Brenda Weisz: You have funded the FMAP in the executive budget. Sometimes we have changes that occur during the legislative session. Often times an adjustment is made. It is currently been funded by that 9.5

Chairman Pollert: Could it not be in a bill or emergency measure that you have the authorization to go after special or federal funds? The next session could do that.

Brenda Weisz: An emergency clause is not for this budget. Because the FMAP is going to impact the budget you are deciding on today. The federal authority will change and the general funding will be for the biennium coming up. Then when we come before you for 11-13 we will also see an FMAP impact in that budget that we present to you from the executive side which will be outside of this change that we are seeing.

Chairman Pollert: But the assembly could authorize the ability for you to increase your special funds authority?

Brenda Weisz: Correct. The FMAP drop is going to affect the budget you are deciding on today. It will impact the budget. We are trying to finalize that this session.

Carol Olson: There is a difference. It isn't a difference that you can put down on a piece of paper as opposed to the approach you are talking about here. The difference comes in to the Legislative recall and memory. What will be happening here this legislative session and how it will be remembered next session. The department has been here before when it was gone in the deficiency spending. The problem is that we are very concerned about the utilization rates and our estimates as to where they are going to go and the depth of the reduction that is being

talked about here. We will do whatever is decided here. Again, I just want to go on record to let you know how demoralizing it is to a state agency to have to stand in front of a full committee for over an hour and be accused of mismanaging money when that wasn't the case at all. I personally as the director don't want to be having to go through that and I don't want anyone on our staff having to go through that either. When you talk about differences and what that means, that's what it means. We work hard to portray the direction of where we are going in the next biennium. It's not something that can be foreseen in the future. I'm up here because I want to protect the department from ever having to suffer those consequences again. It was unbearable. With that you will have to make the decision based on what you think is right. We have given you the information on what we believe to be accurate. You will have to take the direction that you feel is right. I will go on record to saying that I will not subject any of the staff of the department to an hour of what happened in 03.

Chairman Pollert: Do you think I would look forward from getting up in the budget section saying that I was wrong? I have had to say that a number of times too. I would have to say that before you even got up there. That would not be a pleasing duty. You said the same thing and then you chastised us in our house appropriations last session because of what we did and we were right. Now we were lucky. I understand that. I was chastised a lot publicly and privately.

Carol Olson: Your form is different than ours. We have to take it publicly. I don't think anyone wins under those circumstances and I mean anyone. I don't want to see that happen again. It's tough to get certain things through in an emergency meeting and in a budget section. We will do it and whatever it is that is decided. I wouldn't feel that I was doing my job if I didn't say something.

Senator Kilzer: I have sat on this long enough to go through both ways. Neither one of them are very pleasant when it comes to a turn back or a deficit. I think if this budget was realistic

and it is almost a horse a piece as to whether or not to go along with the house reductions. The more I think about it, I think about this reversion of going back to the larger FMAP. I think I'd rather leave the money in it and hope for a turnback at the end and not get penalized in the last two quarters of the biennium. I would not favor taking the money out. I would prefer to leave it in and let the Senate restore that.

Representative Kreidt: Did we have a motion and a second on the floor? With our subsection and this particular budget, we sit down. We spent 3-4 days going through this case load utilization numbers. Last session we could have taken more out and we wouldn't have to carry over the turnback that we did. This session we sat down and went through those things with a fine tooth comb. We felt we came up with realistic numbers to what would be utilized in the next two years. We felt very comfortable with those numbers. I think what came over from the house was a fair caseload utilization as we went forward. I think maybe we are overreacting. We did support the amendment here. I can remember last time where it was DD and we authorized loans up to $3.4 million. They needed funding that never happened. I feel comfortable with these numbers as did our section. I think they are sound.

Senator Fischer: If that's the case you must think we are nuts. We restored what you put in for good reasons. Maybe we ought to look at the budget over a biennium instead of over 3 months. Maybe we ought to take the nursing homes apart and see what makes them tick and see if at $9,000 a month is a little high. You could get on a ship and cruise for eternity for less money. The bottom line is that we are over here with this budget. What happens if we don't spend Medicaid, they pack their bag? The money doesn't go anywhere. It's not a premium that is being paid. It's very little part of service and yet you have people in your house that buck at repaying hospitals, doctors, ambulances at a lower rate than cost. I don't see anyone else doing that. I sure as hell don't. All this talk about who did what to whom, nobody did anything to

anybody. This could all be left at the Governor's budget and we could walk out the door. We just might feel as important.

Representative Kreidt: We didn't call you nuts. We wouldn't do that. You mentioned nursing homes. Last session we did look at nursing homes. We could have taken more out of nursing homes last time. I was willing to do that. We could have cut the utilization further we could have probably out another 90 beds. That is where the money came back. We would have been right on that. Say what you will we were pretty close.

Senator Fischer: What are we doing cutting children's health insurance? How does that make us look? Why don't we go beat up on kids while we are at it. The thing is that this whole discussion disgusts me. I don't have a dog in the fight but there are kids out there that would be a lot better citizens if they were healthy. Everyone wants to be the ultra conservative. You are saying that you can't do that because you will go home and not look conservative. Everyone wants to go home and get re-elected. If I don't do the right thing, either way I shouldn't be re-elected. So when we get into this Medicaid thing, why do they need an insurance policy? Fund them at an appropriate level that they have spent the better part of 2 years putting together. I don't think they are going to run out the door with cash under their arm. Spending all this time discussing this is ridiculous.

Chairman Pollert: I was hoping we would get to SCHIP today but I think we are too charged to make any kind of a vote right now. We will be in recess until tomorrow morning.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☒ Check here for Conference Committee

Hearing Date: 5/1/09 (AM)

Recorder Job Number: 12433

Committee Clerk Signature Marilyn Reinert

Minutes:

Chairman Pollert: Called the meeting to order and let the record show that every member is present. We didn't meet yesterday because I was getting amendments drafted which I will pass out now. Handout amendments (Attachment A). I know we looked through these a half hour ago or so. I'm going to start on page 2 of the statement of purpose. I will go back to the page to go through some sections. Where it says summary of conference committee actions, I will say this right off the bat so I don't have to discuss it through all the sections. The equity money was pulled out of 1012 and that will appear on Office of Management and Budget. The next item up is the salary under funding. You will see the amendment. If it's added up right it will be proposed at $1.4 million. There will be no federal funds on that like what happened in the house side. It is a general fund run through the department. The travel expense on the Senate side we had approved prior to the amendments. It should add up to what the Senate did. The FMAP of the $9.5 million that the Senate had to add in will be in here to lower the FMAP numbers or percentages for the $9.5 million. The travel and division information technology is part of the 1.4. The economic assistance is the same way. Child support is the same thing. Let's go to medical services and the first line item of salaries and wages. The one time funding and grants of medical assistance line item and supplemental payments is Rolla.

Everyone knows that that means. You will see the next line item of medically needy to reflect income levels of 83%. That is as the Senate had it. The house had the 75.

Representative Ekstrom: Just to freshen up my memory that is what was proposed in the Governor's budget correct.

Chairman Pollert: That is right. The next item on the bottom of page 3 is increased funding for the rebasing of the physician payment rates. The house had it at 20%. The Senate had risen it to 75%. The house agreed with that after much deliberation. What you will also see and it wasn't on the Senate amendment is that we agreed about the 100% of hospital rebasing that is also in there. We agreed with the Senate on the rebasing of the ambulance payment rates to the Medicare rates. They restored funding and grants the rebasing of dentist payment rates to the minimum of 75%. We agreed with the Senate on that.

Senator Warner: What is the discussion relative to that? This is rebased separately in a different way. This one was considered to be eligible for both years.

Chairman Pollert: This would be 75% of charges.

Senator Warner: What are the dollar amount if we were to do rebased and 6 plus 6 what would that dollar amount be?

Roxanne Woeste: I'm not sure you would have to ask the department.

Chairman Pollert: What you will see next is adjusting funding and language in the sections when you go through it. The funding for the state children's health insurance program to reflect utilization rates, if both sides remember the 200% has been defeated on the house side. What this amendment is going to reflect going to 160%. Then you will see the amendment down below you will see that currently if I'm correct the budget for ND cares there is $330,000. What we are seeing is adding funding for outreach for the SCHIP program of another $300,000. What we should see is language when we get back to the sections that says something to the

fact that it will be an outside third party. It won't be run through the ND cares. The department would be putting an FRP on that .My thoughts on this is that there is feelings on our side that they haven't been doing as good of a job as they should for outreach. It is my hope to bring more kids by doing this outreach program. It would be by doing this 200%. That is kind of my thought. That is where that is. You will see going to the next line item. You will also see that there is a backup to the backup. What I mean by that is there are 3 sections about the case load for $17 million. What we are saying is that we will see language that says to adds funding for a bank of ND line of credit if the department needs to access that for $8.5 million. If that has to be accessed they will have to come in front of the budget section. The language should be the same as last biennium on the $3.5 million that was done for the DD last biennium and session. That is why I said it is the backup to the backup because we accepted Representative Ekstrom's amendments on the deficiency payment. Going back to the long term care program we agreed with the Senate about the funding for third tier for the million dollars. That has not changed. That is what came in from the Governor's budget. That is in. The other funding we would have to have an explanation on.

Representative Kreidt: When the funding for the nursing home and basic care came out of the house we had taken the funding out of the health care trust fund. We reduced that by $200,000 and applied it to another bill in the house that was in regards to the situation in Steele for them to be able to go forward. There was a reduction of $200,000 off of the million that was originally in the house.

Chairman Pollert: If I have this correct the Senate had added $2.9 million of language in. This amendment pulls that off. The house side had a million out of the funds. That corrects it to $800,000. You will see that Representative Kreidt is going to bring forward an amendment dealing with that. Moving on down the line, $86,807 is the dollars for the DD providers. We did

not change that figure. The Senate added in QSP's for the dollar increase. That stays in. This is language for the medically fragile. It's the $1.1 million added in with the $400,000 that the house added in will get to $4.2 million total including federal and state funds. Going to aging services with salaries and wages that is about the travel and providing funding and grants. The no wrong doors was taken out for the $300,000. Prior to this we had done the $120,000 for the place at Arthur. Going on to children and family services it increases funding for the healthy families program. We had done that prior. We accepted that amendment from the Senate. We had done that amendment for adding funding for family group conferencing. We had taken $1 million off and it was $1.2. We put 100 in family counseling and the safety permanency fund. We have added funding for children's advocacy centers for $200,000. Going to mental health and what the first two items are about, the third item down is add funding and operating line to increase compulsive gambling. That was approved prior. We had also approved $100,000 for the Governor's prevention and advisory council. Going down to developmental disabilities is going to page 6. Those two items were all in one. Vocational Rehab is the same way. The travel is the same thing. The federal stimulus dollars, there will be language you will see in the sections when I go back to the front part of the amendments that deal with that. All the other $66,500,000 is dealing with the federal stimulus. All the remaining items are dealing with that. Going to the next page on the state hospital, the salaries and wages, travel the house had taken out $1 million out of the state hospital total. These amendments drop that figure to $500,000. The next page is the developmental center. In the wages and travel we restored the $150,000 for the onetime extraordinary repairs at Grafton. This would just be best if I say this all at once for the human services centers. The non global health initiative has been moved out of the amendments. Out of the amendments the young adult transition services is moved out. When I say the global behavioral health the FTE's are out of that. They have been taken out

for the DD case management. The peer support has been removed. That should be the human service centers. Before I go to the sections should we have a discussion? On page 2 section 2, this is dealing with the federal stimulus dollars. We have to have section 2 and 3 are related. The department has to be able to show that the federal stimulus dollars went for general fund expenditures. That is what sections 2 and 3 do so we don't have a problem.

Representative Ekstrom: What had been proposed originally when the federal stimulus dollars came in by the Governor is so we transition them in next biennium?

Chairman Pollert: What you may see happen in Section 3 is that the numbers in Section 3 may change a bit. That is what I'm being told.

Roxanne Woeste: That is correct. These were the numbers that were provided in the Senate appropriation by the department. Once the amendment is settled upon by the conference committee we may adjust these numbers to make sure they reflect appropriately what is.

Chairman Pollert: Whatever happens with the amendments DHS is going to have to get with Roxanne to get the accurate numbers before that. Section 4 is the bank of ND loan authorization. It's for $8.5 million. Is that the same wording we had last session for the DD grant part?

Roxanne Woeste: It is the same language however the language in the appropriation bill from last session. I have included that to make sure that this includes medical services, long term care, and DD. Those are the three areas where the case load utilization decreases were taken in. It's not verbatim but it is similar.

Chairman Pollert: Then section 5 is Representative Ekstrom's amendment. I am on the top of page 4. We can go through the line items there but there is the $400,000 with the numbers that I had discussed in the statement of purpose. The legislative intent is on the Senate side of section 13. We left that language there. Some of us had some heartburn over that but Senator

Kilzer was so persuasive to keep it in there. Critical access hospitals is language that needs to be in there for Rolla. Dementia care services is in section 15. Someone is going to have to remind me. That must have been language put in by the Senate.

Roxanne Woeste: It was drafted by the Senate.

Chairman Pollert: Section 16 is Legislative Council study on traumatic brain injury. That section also dealt with Veteran's. I think we added that so we could have more of an encompassing of other TBI plans or whatever you want to say.

Roxanne Woeste: That is correct. This language was originally included in the Senate version of the amendments. It would be more encompassing and emphasize more with traumatic brain injury individuals.

Chairman Pollert: Section 17 is the intent language for the outreach of the $300,000 to be a third party. Section 18 if I'm correct we have a roof leakage problem at the state hospital. That section was added by the Senate. That language would then stay in there. Section 20, I am going to need help on that.

Roxanne Woeste: Section 20 of the bill is the section relating to medical assistance. This is clean up language that the department brought into the Senate and the Senate did include that in your amendments and we have included that in the conference committee amendments. If the department members need more detail we will need to have them comment on that.

Maggie Anderson: It relates back to 2007 with HB 1453 when the bill authorized the department to increase the SCHIP income level to 150% of poverty when federal funds became available to do that. Those federal funds became available October 1, 2008 and the department increased that level. In the same bill the language was included to increase the Medicaid level for 6-19 year olds from 100% of poverty level to 133% of poverty should the federal law be changed to allow that. That federal law was not changed in the interim until the

SCHIP reauthorization was signed by the president in early February. At that time when we ran the information it was different because of the change of SCHIP and the declining enrollment and the increased enrollment in Medicaid. That was no longer the savings it was during the estimates provided in HB 1463. In addition to that it would remove about 2,400 from SCHIP and put them on Medicaid. While there are positives on the Medicaid side there may be some negative implications on the SCHIP side so that language removes that provision that was established.

Chairman Pollert: There was some discussion that there that we are at 140 at net but we are actually at 150 at net before these amendments, is that correct?

Maggie Anderson: Yes.

Chairman Pollert: Section 22 is Senator Fischer's amendment.

Senator Fischer: Yes it is. The only thing is that from the advice that I received from the doctor that runs an advocacy centers, I would like the department to comment on this. There has been some slight word changes. We should take a look at this to see. It is your amendment but there has been word changes.

Chairman Pollert: I know I was getting emails from social services saying they really didn't like the language and I don't know if that corrects that.

Senator Fischer: This is already corrected. This is from Dr. Norbert.

Chairman Pollert: Section 23 must be provided with part of the contracts with the insured.

Roxanne Woeste: Section 23 is a statutory change needed for SCHIP to go from 150-160. This would be to defeat HB 1478. That was the language for the SCHIP change. The funding is included in HB 1012 to go to 160.

Chairman Pollert: What is section 25 to repeal about?

Roxanne Woeste: That repeal was a section of century code relating to HB 1453. It goes along with section 20.

Chairman Pollert: And the emergency clause for section 2 and 18?

Roxanne Woeste: You are adding an emergency clause to the appropriation of the stimulus dollars and in section1 8 which allows the department to use that carry over until the Governor signs the bill.

Chairman Pollert: The only other thing I would say is on the next page is the dollar amount that shows how everything is affected. Could you give me those numbers?

Roxanne Woeste: On page 2 of the statement of purpose at the top of the page the numbers on the far right hand column is a comparison to the Senate version. The first number there should be $30,146,331. That is the Senate version of the estimated income. The bottom number is $30,799,102. You have to do the Senate version of that.

Chairman Pollert: I would rather get a total.

Senator Fischer: I have a couple of other things here. Dr. Norbert sent out to the department a final fiscal analysis. We had twice as much. You put $200,000 more in because of this. It is going to cost $100,000. The other thing is that this is a request for continuation of dental services we should include if the committee feels that way. It is a continuation of services provided by dentists at about a 5-1 match.

Chairman Pollert: So are you saying that at the bottom of the page when it says the ND dental association basically requests $50,000 to continue DD services in the 09-11 bienniums.

Senator Fischer: I don't know if a representative of the dental association is here how that works.

Chairman Pollert: We would let Roxanne figure that one out. Let me get this straight. You would like to have this language in and propose another $50,000 the way it looks?

Senator Fischer: That one is over funded.

Chairman Pollert: We will have that motion to reduce that to $100,000 but you need the language that is in yellow?

Senator Fischer: That is the language that would work best for the social services for the advocacy centers and the departments and kids.

Chairman Pollert: I really don't want to have a vote on that. We are going to have to come back to add some other stuff. Did you want Joe talk about this?

Joe Cichy: The dental services is a program that provides free dental care to the elderly and disabled that don't qualify for Medicaid insurance. They are the folks that fall through the cracks. This program started in 2003 and in 2001. It has provided over $1 million of care to these folks. It's a very good program. We have 160 dentists signed up for it. The money goes for administrative costs only. It doesn't go to the dentists. Many times it is 2-3 times. They may need general care or care from an oral surgeon and an orthodontist. The problem is that we haven't had enough money in the program. To provide as much care as we could and that is what this would allow.

Chairman Pollert: Has this been in the budget before?

Joe Cichy: It has been in the health department. They provided $36,000 a year and it came to a grant so this would be new.

Chairman Pollert: So you are saying that the grant got taken away? We felt that if we could do it this way. I have went through the amendments. Is there discussion about .0218 or any other addition? I don't like leaving something hanging. As much as I don't want to bring this up, if you take a look at the amendments from the Senate versions we did not have the language

in for the coverage of pregnant women at 165% of poverty. The reason that these aren't in the amendments is that it failed in the house. That is not it. We can accept motions. I will accept whatever amendments brought forward.

Representative Kreidt: This relates back to long term care on page 4 where we talked about the removal of the $200,000. I have a proposed amendment. (Attachment B). What this does is replaces the $200,000 out of the health care trust fund that was in the original house version that had a pass through of basic care and nursing homes of providing them a lump sum grant that would go from the facilities. This would be $200,000 with general fund plus $161,999. This would give them a little more of a cushion to bring it up to a figure that I would hope the industry would be very happy with. Again it still gives them the option to use the dollars for salaries or benefits. They can provide them in. If they want to give a dollar and a half raise to those individuals they can. I think this is a fair compromise. We did bring the DD within the $86,000 and 807 figure we did bring them to a figure that would make them whole. This would not quite do that but it is a realistic figure. Hopefully the committee can accept this amendment and allow a bit more money into going into a direct path. That is something they can start to do of putting them in the line items for the staff. The 6% is going to go into effect in January.

Chairman Pollert: Basically what you are trying to do is get from the $2.9 million and you are trying to restore $361,990. In the healthcare trust fund there is $800,000 and is all general funds?

Representative Kreidt: Yes.

Roxanne Woeste: I just want to make sure that is included in the health care trust fund.

Representative Kreidt: I would move the proposed amendment.

Representative Ekstrom: I will second that.

Chairman Pollert: Any discussion?

Senator Kilzer: Is this related to any other bill that is passed? It is compatible with other bills passed?

Representative Kreidt: Yes.

Chairman Pollert: Let's call the roll. This passes 6-0.

Senator Kilzer: I would move amendments .0218.

Representative Kreidt: I second that.

Chairman Pollert: Discussion?

Senator Warner: I would resist passing this. I was in understanding that other amendments were going to be forthcoming?

Chairman Pollert: I have the first and second and we can have discussion on further amendments. We have to look at these. What we have to do is come back in later in the day between 2-3 and that is what I would like to see us do anyway. What are your thoughts?

Senator Warner: Do we take voice amendments at that time or would you prefer them on paper?

Chairman Pollert: Rather on paper so we can get this pushed along. So if we vote on amendment .0218 or should we vote on it and have further amendments for discussions and we can vote.

Roxanne Woeste: We can vote on .0128 and then have motions to further amend.

Chairman Pollert: I'm open to that. I would like to get some part of that done. We will be back this afternoon so we can get these two drafted up. Is this included in the draft? We approved this but it wasn't put as a substitute motion to .0218.

Roxanne Woeste: I would include that in one draft. I would let you vote on that.

Chairman Pollert: Any other discussion? This motion passes 6-0-0.

Roxanne Woeste: This could be worked a couple different ways. We could rule that information in. If you would prefer to keep that separate until it's vote on that would be fine. I could to it either way.

Chairman Pollert: If there was a chance for us to finish up I would like to do that as long as we have that possibility. If Senator Fischer wants these two amendments put in we can do that or keep them separate.

Roxanne Woeste: How would you like to see it? We can draft them and it would just be those two sections. If they are approved we could mold them in.

Senator Fischer: I'm ok either way.

Chairman Pollert: We will be in recess until this afternoon.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1012

House Appropriations Committee
Human Resources Division

☒ Check here for Conference Committee

Hearing Date: 5/1/09 (PM)

Recorder Job Number: 12438

Committee Clerk Signature

Minutes:

Chairman Pollert: Called the meeting to order and noted that every member was present. I am going to handout a couple of items (Handout A).

Senator Fischer: This amendment is a result of the request that this piece be put in law in a different form. It has to do with who does interviews with the abused and neglected children. The original request had social workers or children protection advocates or anyone who talked to a child that may have been abused would have to audio or video record them. After visiting with Dr. Norberg from the advocacy center in Fargo this language was adopted in conjunction of the department. What the guidelines that she would like to see is some line drawn so that the advocacy centers because they have a background of doing these would set up guidelines for case referrals. They will draw the line of what a referral is. I would guess that an advocate for children of social services would see some indicators if they suspect a children has been abused a child will be brought into an advocacy center. There are centers in Fargo, Bismarck, Minot, and Dickinson. They will be interviewed at those centers. Part of the reason for that is not only is the interview being done by someone who is trained not to lead. They will do the medical and forensic interview. They keep the recordings. They may give copies to all parties especially if there is a court case. They keep one copy. The situation brought to the legislature

no one has the copy. It has caused quite a bit of trouble. When you stop and think about it maybe it should have been done when the advocacy centers were put together. It was always an intention of they could go there. In doing this, the advocacy centers are in the budget. The one in Fargo does 400 or more interviews a year. The one in Bismarck is about the same size. They are already in the budget. They would have to expand that by about $200,000 to cover the rest of the children. The advocacy centers out there already seek kids from all over. It's not just from Fargo. That is the reason and I move the amendment.

Senator Kilzer: I second that.

Chairman Pollert: A discussion really quick, the $200,000 was in amendments .0218.

Senator Fischer: Yes.

Senator Warner: I think this is a great idea. One small question, I always understood that the children's advocacy center had a level of dealing with lower level non criminal behavior. Are we elevating some non criminal behaviors where a simple intervention would be reprimanded?

Senator Fischer: That is the reason for the involvement of the local folks. They will make that decision when the guidelines are put together. We have child protection services and people that are qualified. They are the ones that have to make that call is this serious enough for those interview to be done? I think that is that we aren't elevating unless someone in a professional capacity feels that it is warranted.

Chairman Pollert: I will ask a roll. It passes 6-0-0. I have another amendment (Attachment B). This deals with the backup for the backup of the line of credit from the Bank of North Dakota. This would give the special fund authority in conjunction with the $8.5 million. We need to have this.

Representative Kreidt: I think we discussed that quite in depth. I would move the amendment.

Representative Ekstrom: I second that.

Chairman Pollert: Any discussion? It passes 6-0-0. This morning in drafting the amendments there was one thing left out and that was going from $75-90 in the personal care allowance. The house put it from $60-$75. The Senate put it from $75-$95.

Senator Warner: I think sometimes there has been a perception that because these people are so sedentary that they don't have need. We spoke of the issues of long term care. Those are the things we discussed earlier. It is specifically not for skilled nursing homes. It is for DD centers. Many of the DD people are out in the community and hold jobs. Some of them have special ends because of physical deformities. It's not uncommon for someone to have $150 shoes. These are people who have social lives and go out with friends. They would like to be able to go to a movie and pay their own way. Many of them have jobs where they make small amounts of money. Virtually all is clawed back. I really think the $95 is a fair reflection of a basic minimal standard of dignity and social presence in the community.

Chairman Pollert: If I can ask you, I was definitely in favor of the $15 increase. I don't know if I'm in favor of another $20. Would you be open to half of that amount that the Senate did at $85?

Senator Warner: I think we can sell that to the Senate. I am agreeing with your position.

Representative Kreidt: I guess I did feel that $75 was adequate. To show everyone I have a heart I will go with this.

Chairman Pollert: I will have to ask Roxanne. This would be half of that amount.

Roxanne Woeste: The change from $75-95 was 226. Before drafting my final set I will get the correct numbers.

Representative Kreidt: I will move that we use $85 for personal needs allowance in basic care and ICFMR's.

Representative Ekstrom: I second that.

Chairman Pollert: Any discussion? That motion is approved.

Senator Warner: I have 4 amendments. (Attachment C). I would like to move that increasing the health insurance children's program to 150 to 175% of poverty.

Representative Ekstrom: I second that.

Chairman Pollert: Any discussion?

Senator Kilzer: I would resist this motion because it is in direct conflict of the amendment we passed earlier today. If we are going to start picking away at the amendment we adopted this morning it's going to start to unravel unless it is a typo or a technical change. I'm not going to support that we start chipping away at the amendment.

Senator Warner: I did emphasize and state that I would be bringing in this amendment. One other thing is that Senator Kilzer has had concern in the past about adding people to programs. SCHIPS is a program of our large insurance company. It pays the same amount. It reimburses providers. I think this is a good program. It brings more people into a program that provides more satisfactory reimbursement rate for the providers.

Senator Fischer: I have a problem with it not because of it for reasons. Is there a change that can be made? I'm apprehensive about it. I will oppose the motion as well.

Senator Kilzer: I just want to point out and this may not pertain to the amendment as far as CHIPS is concerned I don't have a problem with reimbursement. This is just a disincentive for families to purchase private insurance. If a family goes without insurance for 6 months they have the ability to enroll their children. That is my only complaint. I don't have a problem with the reimbursement level for CHIPS.

Representative Kreidt: I would oppose this amendment too. I think we are headed down the right road with the proposed amendments that we have put into place. If we came back to the

house floor with 175% we would have difficulty including that. I wouldn't want to see that jeopardized.

Chairman Pollert: Senator Warner I applaud you for bringing this forward but we would be jeopardizing tier 3. We have had to do a sale on our side as far as some of the good programs it brought forward. Any other discussion? We will take a roll call. That motion fails.

Senator Warner: (Attachment D) I would like to move that the committee add a sum for a portion of the department of human services global health initiative. This would include funding only for the hospital contracts and the five full time equivalent positions of human service centers. This does not fund the FTE's at the state hospital.

Representative Ekstrom: I second that.

Chairman Pollert: Discussion?

Senator Warner: I've been pleased in the recent years to see a paradigm shift on how we treat those with mental illness. We need to keep funding that program.

Senator Kilzer: This is getting to be our own personal list. These are all excellent things but we do have to set our own priorities and be practical about it. This one in my mind is very worthy. Every nice thing that has been said about it is true. We have to have a line somewhere. We are higher than two years ago. This would be wonderful but we do have to draw a line somewhere.

Senator Warner: The bottom line is that this is a good way to save money. It will save money on the corrections side. By putting money up front we can do that. I honestly think it is a fiscally conservative approach.

Chairman Pollert: We will call the roll. This fails 2-4-0.

Representative Ekstrom: (Attachment E). This provides for folks who have had previously been mentally ill and have gotten somewhat better to provide mentoring and support for people

who aren't leaving their homes and have a tough time with their mental illness. The program has been incredibly supportive of this group of people. It has been very successful. It is less than what we had asked for originally. I would move this amendment.

Senator Warner: I second that.

Senator Kilzer: Specifically where does the money go? How is it channeled? Who makes out and receives the checks?

Representative Ekstrom: The way this money is used it goes through the service centers. They contract with these individuals to provide mentoring and support for other individuals who aren't doing as well as they are.

Senator Kilzer: So the money ends up in the hands of mentors?

Representative Ekstrom: Yes.

Chairman Pollert; The motion fails 2-4-0.

Senator Warner: (Attachment F). This is the major pro life initiative. This would increase the eligibility for Medicaid assistance benefits for pregnant women to $165% of poverty level.

Representative Ekstrom: I second that.

Senator Warner: At first I thought the results would be evident but they aren't. I do have to explain that the earlier we can get women into prenatal care the earlier we can get counseling and vitamins. We can start charting weight gain and advice on how to manage your diet. I think from the fiscally conservative standpoint we have seen the rewards of a normal healthy child being born. Two years ago I was in Denver for a conference. We had a public health official that says the cost of a 7 pound baby being born is around $1,000. A 3 pound baby would be $30,000. A 1.5 pound baby would be close to $1 million. The response that we get and the bang we get from our buck from doing early intervention would be an astonishing return. If we are going to do it from a fiscally conservative standpoint it is a wonderful investment.

Representative Ekstrom: One of the places that we have seen dramatic increases in costs it is to medical science. Once the child is not able to be in the home and we are sending them to Ann Carlsen. We know how much that costs. It is tremendously expensive. We are attempting to not have as many medically fragile children coming into the world.

Senator Kilzer: I don't want to take a lot of time because you have heard me talk about this before. That is about the increasing eligibility and putting more people in the wagon. That is what we are doing here. There are 387 additional cases per year. I don't think the answer is to do this. The answer is to encourage people to get in for early pre-natal care no matter what their third party payer happens to be. It's not just the Medicaid population that has difficulties. There are certain high risk groups whether it be a teenage mother or a lady in her 40's having her first child. These are ones that yield to low birth weight and premature children and the high risks of low birth weight. I don't think the best approach is to keep expanding the eligibility.

Chairman Pollert: Any other discussion? This had failed on the house by a vote of 40-49. That fails 2-4-0.

Senator Warner: (Attachment G). I have a self interest in this one. This would provide the dentists with a 6% inflationary increase. I am advocating on behalf of dentists everywhere.

Representative Ekstrom: I second that.

Senator Kilzer: I have a question and this may have to be answered by Brenda or Maggie. The rebasing that was done for the dentists was that projected to the end of the year 2010? Can you explain?

Brenda Weisz: No. We did a rebasing for the 4 provider groups that came forward with a report. The dentists didn't' have a rebasing report. That is why it included inflation in years 1 and 2.

Chairman Pollert: Any other discussion?

Senator Kilzer: I can yield some success to Senator Warner. I think we should pass this one. I believe Brenda.

Senator Fischer: I intend to support it.

Chairman Pollert: I don't want to rain on anyone's parade. When I look at our rebasing and I look at the hospitals not at 100% of the cost reports, the ambulances are at 75. The dentists are at 75% of bill charges. I know that is more than their costs. That is where I'm going to vote. Any other discussion? I think bill charges are more than cost. That motion fails.

Representative Ekstrom: One more thing is that I'd like to thank our chairman. It has been respectful. I do appreciate all the work that everyone has done on this.

Carol Olson: On behalf of the department. You have been an excellent chairman.

Representative Kreidt: I move that the Senate recede from the Senate amendments that 1012 be amended as follows.

Senator Fischer: I second that.

Chairman Pollert: We will take the roll call. It passes 6-0-0. I want to thank you for your time.

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number 1012 (, as (re)engrossed): Date: 4/25/09

Your Conference Committee _____

For the Senate:	YES	NO	For the House:	YES	NO
Sen. Kilzer	X		Rep. Pollert	X	
Sen. Fischer	X		Rep. Bellew	X	
Sen. Warner		X	Rep. Ekstrom		X

recommends that the (SENATE/HOUSE) (ACCEDE to) (RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) _____ -- _____

____, and place _____ on the Seventh order.

____, adopt (further) amendments as follows, and place _____ on the Seventh order:

____, having been unable to agree, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: _____
CARRIER: _____

LC NO. of amendment
LC NO. of engrossment
Emergency clause added or deleted
Statement of purpose of amendment

MOTION MADE BY: _____ pull equity

SECONDED BY: _____

VOTE COUNT ___ YES ___ NO ___ ABSENT

Revised 4/1/05

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number 1012 (, as (re)engrossed): Date: 4-28-09

Your Conference Committee _____

For the Senate:	YES	NO	For the House:	YES	NO
Sen. Kilzer	X		Rep. Pollert	X	
Sen. Fischer	X		Rep. Bellew	X	
Sen. Warner	X		Rep. Ekstrom	X	

recommends that the (SENATE/HOUSE) (ACCEDE to) (RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) _____ -- _____

____, and place _____ on the Seventh order.

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((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: _____
CARRIER: _____

LC NO. of amendment
LC NO. of engrossment
Emergency clause added or deleted
Statement of purpose of amendment

MOTION MADE BY: _____

SECONDED BY: _____

VOTE COUNT ___ YES ___ NO ___ ABSENT

Revised 4/1/05

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number 1012 (, as (re)engrossed): Date: _____

Your Conference Committee _____

For the Senate:	YES	NO	For the House:	YES	NO
Sen. Kilzer	Y		Rep. Pollert	X	
Sen. Fischer	X		Rep. Bellew	X	
Sen. Warner	X		Rep. Ekstrom	X	

eliminate funding for ADEC

recommends that the (SENATE/HOUSE) (ACCEDE to) (RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) _____ – _____

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DATE: _____
CARRIER: _____

LC NO. of amendment
LC NO. of engrossment
Emergency clause added or deleted
Statement of purpose of amendment

MOTION MADE BY: _____

SECONDED BY: _____

VOTE COUNT ___ YES ___ NO ___ ABSENT

Revised 4/1/05

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number 1012 (, as (re)engrossed): Date: 4/28/04

Your Conference Committee _____

For the Senate:	YES	NO	For the House:	YES	NO
Sen. Kilzer	X		Rep. Pollert	X	
Sen. Fischer	X		Rep. Bellew	X	
Sen. Warner	X		Rep. Ekstrom	X	

Have $100,000 in preparing recommends that the (SENATE/HOUSE) (ACCEDE to) (RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) _____ – _____

____, and place _____ on the Seventh order.

____, adopt (further) amendments as follows, and place _____ on the Seventh order:

____, having been unable to agree, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: _____
CARRIER: _____

LC NO. of amendment
LC NO. of engrossment
Emergency clause added or deleted
Statement of purpose of amendment

MOTION MADE BY: _____

SECONDED BY: _____

VOTE COUNT ___ YES ___ NO ___ ABSENT

Revised 4/1/05

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number 1012 (, as (re)engrossed): Date: 4/29/09

Your Conference Committee _____

For the Senate:	YES	NO	**For the House:**	YES	NO
Sen. Kilzer	X		Rep. Pollert	X	
Sen. Fischer	X		Rep. Kreidt	X	
Sen. Wanner	X		Rep. Ekstrom	X	

Go to 6e + 6e

recommends that the (SENATE/HOUSE) (ACCEDE to) (RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) _____ -- _____

____, and place _____ on the Seventh order.

____, adopt (further) amendments as follows, and place _____ on the Seventh order:

____, having been unable to agree, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: _____
CARRIER: _____

LC NO. of amendment
LC NO. of engrossment
Emergency clause added or deleted
Statement of purpose of amendment

MOTION MADE BY: _____

SECONDED BY: _____

VOTE COUNT ___ **YES** ___ **NO** ___ **ABSENT**

Revised 4/1/05

98013.0214
Title.

Prepared by the Legislative Council staff for
Representative Ekstrom
April 24, 2009

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

This amendment is for consideration for inclusion in a set of amendments under consideration regarding Engrossed House Bill No. 1012.

Page 5, after line 13, insert:

"**SECTION 10. 2009-11 SPENDING LEVEL - AUTHORIZATION.** If department of human services expenditures exceed funding levels approved by the sixty-first legislative assembly during the 2009-11 biennium due to cost and caseload/utilization of programs exceeding the level anticipated by the legislative assembly, the department may continue to spend at the increased level and may seek a deficiency appropriation from the sixty-second legislative assembly."

Renumber accordingly

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number 1012 (, as (re)engrossed): Date: _____

Your Conference Committee _____

For the Senate:	YES	NO	For the House:	YES	NO
Sen. Kilzer	X		Rep. Pollert	X	
Sen. Fischer	X		Rep. Kreidt	X	
Sen. Wardner	X		Rep. Ekstrum	X	

Move amendment .0214

recommends that the (SENATE/HOUSE) (ACCEDE to) (RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) _____ -- _____

____, and place _____ on the Seventh order.

____, adopt (further) amendments as follows, and place _____ on the Seventh order:

____, having been unable to agree, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: _____
CARRIER: _____

LC NO. of amendment
LC NO. of engrossment
Emergency clause added or deleted
Statement of purpose of amendment

MOTION MADE BY: _____

SECONDED BY: _____

VOTE COUNT ___ **YES** ___ **NO** ___ **ABSENT**

Revised 4/1/05

98013.0215
Title.

Prepared by the Legislative Council staff for
Representative Ekstrom
April 24, 2009

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

This amendment is for consideration for inclusion in a set of amendments under consideration regarding Engrossed House Bill No. 1012.

Page 2, line 7, replace "189,244,935" with "213,144,340" and replace "1,306,432,756" with "1,330,332,161"

Page 2, line 10, replace "310,797,543" with "334,696,948" and replace "1,877,716,114" with "1,901,615,519"

Page 2, line 11, replace "223,418,640" with "238,480,045" and replace "1,350,082,207" with "1,365,143,612"

Page 2, line 12, replace "87,378,903" with "96,216,903" and replace "527,633,907" with "536,471,907"

Page 3, line 3, replace "112,284,910" with "121,122,910" and replace "692,360,434" with "701,198,434"

Page 3, line 4, replace "218,890,181" with "233,951,586" and replace "1,508,974,811" with "1,524,036,216"

Page 3, line 5, replace "331,175,091" with "355,074,496" and replace "2,201,335,245" with "2,225,234,650"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment provides funding of $23,899,405, of which $8,838,000 is from the general fund, to restore one-half of the funding removed by the House for reductions in medical services, long-term care, and developmental disabilities grants projected caseload/utilization rates.

Prepared by the North Dakota Legislative Council
staff for Representative Kreidt
May 1, 2009

B

PROPOSED CONFERENCE COMMITTEE MOTION TO AMEND ENGROSSED HOUSE BILL NO. 1012

It was moved by _____ and seconded by _____ that the conference committee on House Bill No. 1012 add funding of $3,238,385, of which $361,990 is from the general fund, for additional funding for a supplemental salary and benefit supplemental payment for individuals employed by a nursing home or basic care facility.

Prepared by the North Dakota Legislative Council staff for Senator Fischer
May 1, 2009

A

PROPOSED CONFERENCE COMMITTEE MOTION TO AMEND ENGROSSED HOUSE BILL NO. 1012

It was moved by _____ and seconded by _____ that the conference committee replace the language in Section 22 of the bill with the following:

The department shall adopt guidelines for case referrals to a children's advocacy center. When cases are referred to a children's advocacy center, all interviews of the alleged abused or neglected child conducted at the children's advocacy center under this section shall be audio-recorded or video-recorded.

Prepared by the North Dakota Legislative Council
staff for Representative Pollert
May 1, 2009

B

PROPOSED CONFERENCE COMMITTEE MOTION TO AMEND ENGROSSED HOUSE BILL NO. 1012

It was move by _____ and seconded by _____ that the conference committee on House Bill No. 1012 add special funds of $14,485,398 for the federal share of the $8,500,000 of loan proceeds authorized in Section 4 of the bill.

Prepared by the North Dakota Legislative Council
staff for Senator Warner
May 1, 2009

C

PROPOSED CONFERENCE COMMITTEE MOTION TO AMEND ENGROSSED HOUSE BILL NO. 1012

It was moved by _____ and seconded by _____ that the conference committee on House Bill No. 1012 add funding of $1,372,944, of which $355,415 is from the general fund, for increasing the state children's health insurance program eligibility from 160 percent to 175 percent of the federal poverty level.

Prepared by the North Dakota Legislative Council
staff for Senator Warner
May 1, 2009

D

PROPOSED CONFERENCE COMMITTEE MOTION TO AMEND ENGROSSED HOUSE BILL NO. 1012

It was moved by _____ and seconded by _____ that the conference committee on House Bill No. 1012 add funding of $1,891,508, of which $1,786,602 is from the general fund, for a portion of the Department of Human Services' global health initiative, including funding for hospital contracts and five full-time equivalent positions at the human service centers.

Prepared by the North Dakota Legislative Council
staff for Representative Ekstrom
May 1, 2009

E

PROPOSED CONFERENCE COMMITTEE MOTION TO AMEND ENGROSSED HOUSE BILL NO. 1012

It was moved by _____ and seconded by _____ that the conference committee on House Bill No. 1012 add funding of $200,000 from the general fund for increasing funding for the peer support program.

Prepared by the North Dakota Legislative Council
staff for Senator Warner
May 1, 2009

F

PROPOSED CONFERENCE COMMITTEE MOTION TO AMEND ENGROSSED HOUSE BILL NO. 1012

It was moved by _____ and seconded by _____ that the conference committee on House Bill No. 1012 add funding of $2,546,511, of which $964,031 is from the general fund, for increasing the eligibility for medical assistance benefits for pregnant women to 165 percent of the federal poverty level.

Prepared by the North Dakota Legislative Council
staff for Senator Warner
May 1, 2009

6

PROPOSED CONFERENCE COMMITTEE MOTION TO AMEND ENGROSSED HOUSE BILL NO. 1012

It was moved by _____ and seconded by _____ that the conference committee on Engrossed House Bill No. 1012 add funding of $1,005,554, of which $371,208 is from the general fund, for providing dentists a 6 percent inflationary increase each year of the 2009-11 biennium.

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number 1012 (, as (re)engrossed): Date: 5/11/09

Your Conference Committee _____

For the Senate:	YES	NO	For the House:	YES	NO
Sen. Kilzer	X		Rep. Pollert	X	
Sen. Fischer 2	X		Rep. Kreidt 1	X	
Sen. Wardner	X		Rep. Ekstrum	X	

recommends that the (SENATE/HOUSE) (ACCEDE to) (RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) 1000 - 1000

____, and place _____ on the Seventh order.

____, adopt (further) amendments as follows, and place _____ on the Seventh order:

____, having been unable to agree, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: _____
CARRIER: _____

LC NO. of amendment
LC NO. of engrossment
Emergency clause added or deleted
Statement of purpose of amendment

MOTION MADE BY: Rep. Kreidt

SECONDED BY: Senator Fischer

VOTE COUNT 6 **YES** 0 **NO** 0 **ABSENT**

Revised 4/1/05

98013.0218
Title.
Fiscal No. 1

Prepared by the Legislative Council staff for
Representative Pollert
April 30, 2009

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1470-1477 of the House Journal and pages 1317-1323 and pages 1337 and 1338 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 1, line 2, after the first semicolon insert "to provide a contingent appropriation;"

Page 1, line 3, replace the first "and" with "to create and enact a new subsection to section 50-25.1-05 of the North Dakota Century Code, relating to the adoption of rules regarding the recording of interviews in child abuse or neglect cases;", after "25-04-05" insert ", 50-24.1-02.6", and after "50-24.5-04" insert ", 50-29-04"

Page 1, line 5, after "facilities" insert ", eligibility under the state children's health insurance program" and after "fund" insert "; and to repeal section 4 of chapter 422 of the 2007 Session Laws, relating to the effective date of the expansion of medical assistance benefits"

Page 1, line 17, replace "2,148,542" with "2,520,060" and replace "13,660,900" with "14,032,418"

Page 1, line 18, replace "(13,582,286)" with "(13,567,566)" and replace "46,528,070" with "46,542,790"

Page 1, line 20, replace "($11,434,02911)" with "($11,047,791)" and replace "60,188,970" with "60,575,208"

Page 1, line 21, replace "(16,622,573)" with "(16,290,983)" and replace "34,041,261" with "34,372,851"

Page 1, line 22, replace "5,188,544" with "5,243,192" and replace "26,147,709" with "26,202,357"

Page 2, line 3, replace "18,552,432" with "16,090,648" and replace "43,963,473" with "41,501,689"

Page 2, line 4, replace "4,364,279" with "4,966,224" and replace "72,176,081" with "72,778,026"

Page 2, line 6, replace "111,111,588" with "111,831,588" and replace "455,130,804" with "455,850,804"

Page 2, line 7, replace "189,244,935" with "154,082,672" and replace "1,306,432,756" with "1,271,270,493"

Page 2, line 10, replace "310,797,543" with "274,495,441" and replace "1,877,716,114" with "1,841,414,012"

Page 2, line 11, replace "223,418,640" with "233,105,383" and replace "1,350,082,207" with "1,359,768,950"

Page 2, line 12, replace "87,378,903" with "41,390,058" and replace "527,633,907" with "481,645,062"

Page 2, line 17, replace "715,235" with "958,104" and replace "8,209,132" with "8,452,001"

Page 2, line 18, replace "2,135,169" with "2,425,414" and replace "18,917,773" with "19,208,018"

Page 2, line 19, replace "823,712" with "1,080,022" and replace "10,641,067" with "10,897,377"

Page 2, line 20, replace "3,509,556" with "3,661,082" and replace "25,616,905" with "25,768,431"

Page 2, line 21, replace "3,699,225" with "4,086,258" and replace "29,760,855" with "30,147,888"

Page 2, line 22, replace "573,509" with "883,684" and replace "15,257,320" with "15,567,495"

Page 2, line 23, replace "3,675,196" with "4,003,786" and replace "24,362,468" with "24,691,058"

Page 2, line 24, replace "964,207" with "1,058,549" and replace "10,762,996" with "10,857,338"

Page 2, line 25, replace "9,519,982" with "11,226,902" and replace "66,911,926" with "68,618,846"

Page 2, line 26, replace "6,195,786" with "7,019,985" and replace "52,989,719" with "53,813,918"

Page 2, line 27, replace "31,811,577" with "36,403,786" and replace "263,430,161" with "268,022,370"

Page 2, line 28, replace "12,094,114" with "15,503,656" and replace "124,851,343" with "128,260,885"

Page 2, line 29, replace "19,717,463" with "20,900,130" and replace "138,578,818" with "139,761,485"

Page 3, line 3, replace "112,284,910" with "67,533,380" and replace "692,360,434" with "647,608,904"

Page 3, line 4, replace "218,890,181" with "325,207,261" and replace "1,508,974,811" with "1,615,291,891"

Page 3, line 5, replace "331,175,091" with "392,740,641" and replace "2,201,335,245" with "2,262,900,795"

Page 3, after line 6, insert:

"**SECTION 2. APPROPRIATION - FEDERAL FISCAL STIMULUS FUNDS - ADDITIONAL FUNDING APPROVAL.** The funds provided in this section, or so much of the funds as may be necessary, are appropriated from federal funds made available to the state under the federal American Recovery and Reinvestment Act of 2009, not otherwise appropriated, to the department of human services for the period beginning with the effective date of this Act and ending June 30, 2011, as follows:

Federal medical assistance percentage	$66,500,000
Elderly nutrition services	485,000

Child support incentive matching funds	3,200,000
Rehabilitation services and disability assistance and independent living	2,043,000
Individuals With Disabilities Education Act - Part C	2,140,000
Supplemental nutrition assistance program benefits and administration	9,874,747
Senior employment program	143,288
Older blind	3,170
Total federal funds	$84,389,205

The department of human services may seek emergency commission and budget section approval under chapter 54-16 for authority to spend any additional federal funds received under the federal American Recovery and Reinvestment Act of 2009 in excess of the amounts appropriated in this section for the period beginning with the effective date of this Act and ending June 30, 2011.

Any federal funds appropriated under this section, except for the funding of $66,500,000 relating to the federal medical assistance percentage and funding of $2,763,082 of child support incentive matching funds, are not a part of the agency's 2011-13 base budget. Any program expenditures made with these funds will not be replaced with state funds after the federal American Recovery and Reinvestment Act of 2009 funds are no longer available.

SECTION 3. GENERAL FUND TRANSFER TO BUDGET STABILIZATION FUND - EXCEPTION - USE OF GENERAL FUND AMOUNTS. Notwithstanding section 54-27.2-02, the state treasurer and the office of management and budget may not include in the amount used to determine general fund transfers to the budget stabilization fund at the end of the 2007-09 biennium under chapter 54-27.2 any general fund amounts resulting from the increased federal share of medical assistance payments resulting from federal medical assistance percentage changes under the federal American Recovery and Reinvestment Act of 2009. The state treasurer and the office of management and budget shall separately account for these amounts and 2009-11 biennium general fund amounts resulting from federal medical assistance percentage changes under the federal American Recovery and Reinvestment Act of 2009 and use these amounts to defray the expenses of continuing program costs of the department of human services from the general fund for the biennium beginning July 1, 2009, and ending June 30, 2011, as follows:

Inflationary increases for human service providers	$32,564,450
Rate increases for selected medicaid services due to rebasing	21,788,982
Rate increases for nursing homes due to property limit changes	3,000,000
Wage increases for employees of nursing homes, basic care, and developmental disabilities services providers and qualified service providers	15,867,327
Salary increases for department of human services employees	18,949,591
Total	$92,170,350

SECTION 4. BANK OF NORTH DAKOTA LOAN AUTHORIZATION - BUDGET SECTION APPROVAL - CONTINGENT APPROPRIATION. If the caseload/utilization of medical services, long-term care, and developmental disabilities services is more than anticipated by the sixty-first legislative assembly, the department of human services, subject to budget section approval, may borrow the sum of $8,500,000, or so much of the sum as may be necessary, from the Bank of North Dakota, which is appropriated for the purpose of providing the state matching share of additional medical assistance grants for medical services, long-term care, and developmental disabilities services, for the biennium beginning July 1, 2009, and ending June 30, 2011. The department of human services shall request funding from the sixty-second legislative assembly to repay any loan obtained pursuant to provisions of this section, including accrued interest.

SECTION 5. 2009-11 SPENDING LEVEL - AUTHORIZATION. If department of human services expenditures exceed funding levels, including loan proceeds appropriated in section 4 of this Act, approved by the sixty-first legislative assembly during the 2009-11 biennium due to caseload/utilization of programs exceeding the level anticipated by the legislative assembly, the department may continue to spend at the increased level and may seek a deficiency appropriation from the sixty-second legislative assembly."

Page 3, after line 18, insert:

"Supplemental payment - Critical access hospitals	0	400,000"

Page 3, line 19, replace "2,793,692" with "3,443,692"

Page 3, line 21, replace "3,146,298" with "4,196,298"

Page 4, line 5, replace "$4,324,506" with "$4,124,506"

Page 4, remove lines 22 through 29

Page 5, line 1, replace "$4,950,451" with "$5,150,451"

Page 5, line 2, replace "$1,000,000" with "$800,000"

Page 5, line 4, replace "each employee earning a salary that is less than the eightieth" with "employees beginning July 1, 2009. Basic care and skilled nursing care facilities may not use the money received under this section for providing salary and benefit enhancements to administrators or directors of nursing."

Page 5, remove lines 5 and 6

Page 5, line 9, replace "$18,929,151" with "$21,639,106" and replace "$7,000,000" with "$7,086,807"

Page 5, line 10, replace "$11,929,151" with "$14,552,299"

Page 5, line 11, replace "each employee earning a" with "employees beginning July 1, 2009. Developmental disabilities service providers may not use the money received under this section for providing salary and benefit enhancements to administrators."

Page 5, replace lines 12 and 13 with:

"SECTION 13. LEGISLATIVE INTENT - MEDICAID PROVIDER PAYMENTS. It is the intent of the legislative assembly that the department of human services establish a goal to set medicaid payments for hospitals, physicians, chiropractors, and ambulances at 100 percent of cost.

SECTION 14. SUPPLEMENTAL PAYMENT - CRITICAL ACCESS HOSPITALS. The grants - medical assistance line item in subdivision 2 of section 1 of this Act includes the sum of $400,000 of one-time funding from the general fund that the department of human services shall use for providing a supplemental payment to eligible critical access hospitals. A critical access hospital is eligible for a payment under this section only if its percentage of medical payments exceeds 25 percent of its total annual revenue in its most recent audited financial statements and is located in a city with a population that does not exceed 1,450. The department shall seek federal

medicaid funding to provide a portion of the $400,000 supplemental payment. If federal medicaid funding is not available for a portion of the payment, the department may spend the $400,000 from the general fund for making the supplemental payment only if the action will not result in a reduction in federal medicaid funding to the state.

SECTION 15. LEGISLATIVE INTENT - DEMENTIA CARE SERVICES. It is the intent of the sixty-first legislative assembly that the department of human services integrate the dementia care services program established in House Bill No. 1043, as approved by the sixty-first legislative assembly, with the home and community-based care services programs of the department.

SECTION 16. LEGISLATIVE COUNCIL STUDY - TRAUMATIC BRAIN INJURY. During the 2009-11 interim, the legislative council shall consider studying the impact of individuals with traumatic brain injury, including veterans who are returning from wars, on the state's human services system. The study must include an analysis of the estimated cost of providing human service-related services to the individuals with traumatic brain injury. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly.

SECTION 17. LEGISLATIVE INTENT - CHILDREN'S HEALTH INSURANCE PROGRAM OUTREACH. It is the intent of the sixty-first legislative assembly that the department of human services award a contract for outreach services for the state children's health insurance program to an entity other than an insurance company, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 18. UNSPENT 2007-09 BIENNIUM GENERAL FUND APPROPRIATIONS - EXCEPTION. The amount of $270,000 of the $3,100,000 for a sexual offender treatment addition at the state hospital appropriated in subdivision 3 of section 3 of 2007 Senate Bill No. 2012 is not subject to section 54-44.1-11 and may be spent during the 2009-11 biennium for completing roof repairs at the state hospital."

Page 7, after line 21, insert:

"**SECTION 20. AMENDMENT.** Section 50-24.1-02.6 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-02.6. ~~(Contingent effective date - See note) Medical assistance benefits - Eligibility criteria.~~

~~1. The department shall provide medical assistance benefits to otherwise eligible persons who are:~~

~~a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and~~

~~b. Minors who have countable income that does not exceed an amount determined under subsection 3.~~

~~2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.~~

~~3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law, that provide an income level for all minors born before~~

~~September 30, 1983, equal to one hundred percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined and that do not exceed legislative appropriations for that purpose.~~

~~4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.~~

~~(Contingent effective date - See note)~~ **Medical assistance benefits - Eligibility criteria.**

1. The department shall provide medical assistance benefits to otherwise eligible persons who are:

   a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and

   b. Minors who have countable income that does not exceed an amount determined under subsection 3.

2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.

3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law~~, that provide an income level for all individuals from birth through age eighteen equal to one hundred thirty-three percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined~~.

4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets."

Page 7, after line 29, insert:

"**SECTION 22.** A new subsection to section 50-25.1-05 of the North Dakota Century Code is created and enacted as follows:

The department shall adopt rules that require all interviews of the alleged abused or neglected child conducted under this section to be audio-recorded or video-recorded, when possible. The rules must provide that a recording may not be disclosed except in accordance with section 50-25.1-11.

SECTION 23. AMENDMENT. Section 50-29-04 of the North Dakota Century Code is amended and reenacted as follows:

50-29-04. Plan requirements. The plan:

1. Must be provided through private contracts with insurance carriers;

2. Must allow conversion to another health insurance policy;

3. Must be based on an actuarial equivalent of a benchmark plan;

4. Must incorporate every state-required waiver approved by the federal government;

5. Must include community-based eligibility outreach services; and

6. Must provide:

   a. A net income eligibility limit of one hundred ~~fifty~~ sixty percent of the poverty line;

   b. A copayment requirement for each pharmaceutical prescription and for each emergency room visit;

   c. A deductible for each inpatient hospital visit;

   d. Coverage for:

      (1) Inpatient hospital, medical, and surgical services;

      (2) Outpatient hospital and medical services;

      (3) Psychiatric and substance abuse services;

      (4) Prescription medications;

      (5) Preventive screening services;

      (6) Preventive dental and vision services; and

      (7) Prenatal services; and

   e. A coverage effective date that is the first day of the month, following the date of application and determination of eligibility."

Page 8, after line 21, insert:

"**SECTION 25. REPEAL.** Section 4 of chapter 422 of the 2007 Session Laws is repealed.

SECTION 26. EMERGENCY. Sections 2 and 18 of this Act are declared to be an emergency measure."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT - LC 98013.0218 FN 1

A copy of the statement of purpose of amendment is attached.

STATEMENT OF PURPOSE OF AMENDMENT:

House Bill No. 1012 - Summary of Conference Committee Action

	Executive Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
DHS - Management						
Total all funds	$65,842,656	$60,188,970	$386,238	$60,575,208	$66,479,591	($5,904,383)
Less estimated income	36,027,838	34,041,261	331,590	34,372,851	36,204,782	(1,831,931)
General fund	$29,814,818	$26,147,709	$54,648	$26,202,357	$30,274,809	($4,072,452)
DHS - Program/Policy						
Total all funds	$1,919,716,163	$1,877,716,114	$56,587,103	$1,934,303,217	$2,006,726,076	($72,422,859)
Less estimated income	1,375,189,679	1,350,082,207	102,575,948	1,452,658,155	1,494,337,033	(41,678,878)
General fund	$544,526,484	$527,633,907	($45,988,845)	$481,645,062	$512,389,043	($30,743,981)
DHS - State Hospital						
Total all funds	$70,001,527	$66,911,926	$1,706,920	$68,618,846	$69,900,728	($1,281,882)
Less estimated income	19,563,594	18,511,154	1,048,975	19,560,129	19,560,129	0
General fund	$50,437,933	$48,400,772	$657,945	$49,058,717	$50,340,599	($1,281,882)
DHS - Developmental Center						
Total all funds	$54,015,265	$52,989,719	$824,199	$53,813,918	$54,015,077	($201,159)
Less estimated income	37,160,672	36,572,644	587,914	37,160,558	37,160,558	0
General fund	$16,854,593	$16,417,075	$236,285	$16,653,360	$16,854,519	($201,159)
DHS - Northwest HSC						
Total all funds	$8,562,127	$8,209,132	$242,869	$8,452,001	$8,520,294	($68,293)
Less estimated income	3,680,172	3,471,996	203,790	3,675,786	3,675,786	0
General fund	$4,881,955	$4,737,136	$39,079	$4,776,215	$4,844,508	($68,293)
DHS - North Central HSC						
Total all funds	$20,923,799	$18,917,773	$290,245	$19,208,018	$20,863,550	($1,655,532)
Less estimated income	8,825,362	8,416,847	252,288	8,669,135	8,821,489	(152,354)
General fund	$12,098,437	$10,500,926	$37,957	$10,538,883	$12,042,061	($1,503,178)
DHS - Lake Region HSC						
Total all funds	$11,011,109	$10,641,067	$256,310	$10,897,377	$10,970,714	($73,337)
Less estimated income	4,747,559	4,524,710	218,572	4,743,282	4,743,282	0
General fund	$6,263,550	$6,116,357	$37,738	$6,154,095	$6,227,432	($73,337)
DHS - Northeast HSC						
Total all funds	$26,376,851	$25,616,905	$151,526	$25,768,431	$26,285,586	($517,155)
Less estimated income	14,320,535	14,029,163	131,280	14,160,443	14,293,997	(133,554)
General fund	$12,056,316	$11,587,742	$20,246	$11,607,988	$11,991,589	($383,601)
DHS - Southeast HSC						
Total all funds	$32,020,964	$29,760,855	$387,033	$30,147,888	$31,432,589	($1,284,701)
Less estimated income	15,966,058	15,188,388	336,874	15,525,262	15,682,522	(157,260)
General fund	$16,054,906	$14,572,467	$50,159	$14,622,626	$15,750,067	($1,127,441)
DHS - South Central HSC						
Total all funds	$15,913,332	$15,257,320	$310,175	$15,567,495	$15,785,227	($217,732)
Less estimated income	6,970,002	6,700,249	266,461	6,966,710	6,966,710	0
General fund	$8,943,330	$8,557,071	$43,714	$8,600,785	$8,818,517	($217,732)
DHS - West Central HSC						
Total all funds	$26,008,933	$24,362,468	$328,590	$24,691,058	$25,176,361	($485,303)
Less estimated income	12,693,292	12,254,021	281,204	12,535,225	12,587,579	(52,354)
General fund	$13,315,641	$12,108,447	$47,386	$12,155,833	$12,588,782	($432,949)
DHS - Badlands HSC						
Total all funds	$11,694,235	$10,762,996	$94,342	$10,857,338	$11,690,435	($833,097)
Less estimated income	5,429,653	5,182,171	82,184	5,264,355	5,404,355	(140,000)
General fund	$6,264,582	$5,580,825	$12,158	$5,592,983	$6,286,080	($693,097)
Bill total						
Total all funds	$2,262,086,961	$2,201,335,245	$61,565,550	$2,262,900,795	$2,347,846,228	($84,945,433)

Less estimated income	1,540,574,416	1,508,974,811	106,317,080	1,615,291,891	1,659,438,222	(44,146
General fund	$721,512,545	$692,360,434	($44,751,530)	$647,608,904	$688,408,006	($40,79

House Bill No. 1012 - DHS - Management - Conference Committee Action

	Executive Budget	House Version	Conference Committee Changes[1]	Conference Committee Version	Senate Version	Comparison to Senate
Salaries and wages	$19,303,132	$13,660,900	$371,518	$14,032,418	$19,176,867	($5,144,449)
Operating expenses	46,539,524	46,528,070	14,720	46,542,790	47,131,212	(588,422)
Contingent appropriation					171,512	(171,512)
Total all funds	$65,842,656	$60,188,970	$386,238	$60,575,208	$66,479,591	($5,904,383)
Less estimated income	36,027,838	34,041,261	331,590	34,372,851	36,204,782	(1,831,931)
General fund	$29,814,818	$26,147,709	$54,648	$26,202,357	$30,274,809	($4,072,452)
FTE	108.35	107.35	0.00	107.35	107.35	0.00

1

Management - Conference committee changes:	FTE	General Fund	Other Funds	Total
Administration Support Program				
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$39,323	$268,110	$307,433
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		7,128	7,592	14,72
Division of Information Technology Program				
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		8,197	55,888	64,085
Total conference committee changes - Management	0.00	$54,648	$331,590	$386,238

House Bill No. 1012 - DHS - Program/Policy - Conference Committee Action

	Executive Budget	House Version	Conference Committee Changes[1]	Conference Committee Version	Senate Version	Comparison to Senate
Salaries and wages	$44,664,959	$43,963,473	($2,461,784)	$41,501,689	$41,632,186	($130,497)
Operating expenses	73,251,082	72,176,081	601,945	72,778,026	74,434,398	(1,656,372)
Capital assets	13,000	13,000		13,000	13,000	
Grants	456,965,308	455,130,804	720,000	455,850,804	455,800,804	50,000
Grants - Medical assistance	1,344,821,814	1,306,432,756	(35,162,263)	1,271,270,493	1,348,081,484	(76,810,991)
Federal fiscal stimulus funds			84,389,205	84,389,205	84,389,205	
Contingent appropriation					2,374,999	(2,374,999)
Contingent borrowing			8,500,000	8,500,000		8,500,000
Total all funds	$1,919,716,163	$1,877,716,114	$56,587,103	$1,934,303,217	$2,006,726,076	($72,422,859)
Less estimated income	1,375,189,679	1,350,082,207	102,575,948	1,452,658,155	1,494,337,033	(41,678,878)
General fund	$544,526,484	$527,633,907	($45,988,845)	$481,645,062	$512,389,043	($30,743,981)
FTE	363.50	361.00	0.00	361.00	361.00	0.00

[1]

Program and Policy - Conference committee changes:	FTE	General Fund	Other Funds	Total
Economic Assistance Policy Program				
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$14,539	$99,126	$113,665
Child Support Program				
estore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		20,636	140,700	161,336
Medical Services Program				
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		13,203	90,020	103,223
Restore a portion of the House reduction for department travel (This amendment was also made by the Senate.)		10,915	8,653	19,568
Provide one-time funding in the grants - medical assistance line item for supplemental payments to small, rural critical access hospitals (This funding was also provided by the Senate.)		400,000	0	400,000
Restore funding for medically needy to reflect income levels of 83 percent of the federal poverty level as provided for in the executive budget (The House decreased funding to reflect income levels of 75 percent of the federal poverty level, and the Senate restored funding to reflect income levels of 83 percent.)		376,947	642,379	1,019,326
Increase funding for rebasing physician payment rates (This amendment was also made by the Senate.) (This amendment provides $47,700,000, of which $17,639,460 is from the general fund, for rebasing rates to 75 percent of the amount needed to rebase to 100 percent of cost. The House version provided $10,600,000, of which $3,919,880 is from the general fund, for rebasing rates to 20 percent of the amount needed to rebase to 100 percent of cost. The executive budget included funding of $13,250,000, of which $4,899,850 is from		10,779,670	18,370,330	29,150,000

the general fund, for rebasing rates to 25 percent of the amount needed to rebase to 100 percent of cost.)			
Restore funding in the grants - medical assistance line item for rebasing ambulance payment rates to Medicare rates as provided for in the executive budget (This amendment was also made by the Senate. The House version provided $1,508,336, of which $557,783 is from the general fund, to provide funding equal to 75 percent of the funding provided in the executive budget.)	185,927	316,851	502,778
Restore funding in the grants - medical assistance line item for rebasing dentist payment rates to a minimum of 75 percent of average billed charges as provided for in the executive budget (This amendment was also made by the Senate. The House version provided for rebasing dentist payment rates to a minimum of 70 percent of average billed charges.)	278,333	474,445	752,778
Adjust funding for the state children's health insurance program to reflect utilization reprojections and a revised premium amount (This amendment was also made by the Senate.) (This amendment maintains program eligibility at 160 percent of the federal poverty level.)	(2,832,256)	(8,110,063)	(10,942,319)
Add funding for outreach for the state children's health insurance program	300,000	0	300,000
Provide funding for an estimated decrease in the state's federal medical assistance percentage (FMAP) for the last seven months of the 2009-11 biennium	9,500,000	(9,500,000)	0
Add funding for a Bank of North Dakota line of credit if caseload/utilization rates are greater than anticipated	0	8,500,000	8,500,000
Long-Term Care Program			
Restore funding added in the executive budget and removed by the House for the addition of a third tier of personal care that would allow a maximum of 1,200 units of care per month (This amendment was also made by the Senate.)	1,021,922	1,741,524	2,763,446
Adjust funding for a salary and benefit supplemental payment for individuals employed by basic care and nursing care facilities from $4,950,451 from the general fund, $1,000,000 from the health care trust fund, and $8,788,677 from federal funds as provided by the House to $5,150,451 from the general fund, $800,000 from the health care trust fund, and $8,788,677 from federal funds	200,000	(200,000)	0
Add funding of $2,709,955, of which $86,807 is from the general fund, to the amounts provided by the House to provide total funding of $21,639,106, of which $7,086,807 is from the general fund and $14,552,299 is from federal funds, to provide a salary and benefit supplemental payment for individuals employed by developmental disabilities providers, except for administrators (This amendment was also made by the Senate.)	86,807	2,623,148	2,709,955
Add funding to provide a $1 per hour increase for qualified service providers (This amendment was also made by the Senate.)	853,268	963,026	1,816,294
Add funding in the grants - medical assistance line item for developmental disabilities providers who are serving severely medically fragile and behaviorally challenged individuals in addition to the funding of $1,186,857, of which $438,900 is from the general fund, added by the House (The Senate added funding of $5,131,059, of which $1,897,465 was from the general fund,	1,114,260	1,898,883	3,013,143

for providers who are serving severely medically fragile individuals.)			
Aging Services Program			
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)	1,005	6,852	7,857
Restore a portion of the House reduction for department travel (This amendment was also made by the Senate.)	1,753	5,232	6,985
Provide funding for a grant for the community of care program (This funding was also provided by the Senate.)	120,000	0	120,000
Children and Family Services Program			
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)	2,326	15,860	18,186
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)	527	1,326	1,853
Increase funding for the Healthy Families program by $200,000 from the general fund, from $300,000 from the general fund as provided for the 2007-09 biennium to $500,00 from the general fund for the 2009-11 biennium	200,000	0	200,000
Add funding for family group conferencing ($100,000) and for safety and permanency funds ($100,000) (The Senate added funding of $1,456,372, of which $1,200,000 was from the general fund, for family group conferencing.)	200,000	0	200,000
Add funding for children's advocacy centers	200,000	0	200,000
Mental Health and Substance Abuse Program			
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)	2,382	16,241	18,623
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)	7,921	22,858	30,779
Add funding in the operating expenses line item to increase compulsive gambling services to $650,000, of which $250,000 is from the general fund and $400,000 is from lottery proceeds. This is the same level as provided by the Senate. The House version provided funding of $550,000, of which $150,000 is from the general fund, and the executive budget recommended funding of $700,000, of which $300,000 is from the general fund and $400,000 is from lottery proceeds.	100,000	0	100,000
Restore funding in the grants line item for the Governor's Prevention and Advisory Council grants. The House version removed funding for the Governor's Prevention and Advisory Council grants. The executive budget and the Senate version provide funding of $200,000 from the general fund for the Governor's Prevention and Advisory Council grants.	100,000	0	100,000
Developmental Disabilities Council			
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)	0	2,223	2,223

Developmental Disabilities Division				
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		1,036	7,067	8,103
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		3,768	16,488	20,256
Vocational Rehabilitation				
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		800	5,453	6,253
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		8,548	28,121	36,669
Federal Stimulus Funding				
Provide for increased funding for supplemental nutrition assistance program benefits and related additional administrative expenses		0	9,874,747	9,874,747
Change the funding source and provide additional funding for child support enforcement activities		(2,763,082)	3,200,000	436,918
Change the funding source for Medicaid, foster care, and adoption payments due to the enhanced FMAP included in the American Recovery and Reinvestment Act of 2009		(66,500,000)	66,500,000	0
Provide funding for elderly nutrition services		0	485,000	485,000
Provide funding for the senior employment program		0	143,288	143,288
Provide funding for older blind services		0	3,170	3,170
Provide for increased funding for developmentally delayed infants aged 0 to 3 to reflect federal funds received for Individuals With Disabilities Education Act - Part C		0	2,140,000	2,140,000
Provide for increased funding for centers for independent living		0	243,000	243,000
Provide for increased funding for vocational rehabilitation services		0	1,800,000	1,800,000
Total conference committee changes - Program and Policy	0.00	($45,988,845)	$102,575,948	$56,587,103

Other changes affecting Program and Policy programs:

Adds a section of legislative intent providing that the department may exceed funding levels approved by the 2009 Legislative Assembly due to caseload/utilization of program exceeding the level anticipated by the 2009 Legislative Assembly and may seek a deficiency appropriation from the 2011 Legislative Assembly.

Adds a section of legislative intent regarding Medicaid reimbursement for hospitals, physicians, chiropractors, and ambulances (This section was also added by the Senate.)

Adds a section of legislative intent regarding dementia care services provided for in 2009 House Bill No. 1043 (This section was also added by the Senate.)

Adds a section to provide for a Legislative Council study of individuals with traumatic brain injury (The Senate had added a section to provide for a Legislative Council study of returning veterans and their families.)

Adds a section of legislative intent regarding state children's health insurance program outreach

Amends North Dakota Century Code (NDCC) Section 50-24.1-02.6 relating to medical assistance eligibility (This section was also added by the Senate.)

Creates a new subsection to NDCC Section 50-25.1-05 relating to the adoption of rules regarding the recording of interviews in child abuse or neglect cases (This section was also added by the Senate.)

Repeals Section 4 of Chapter 422 of the 2007 Session Laws relating to the effective date of the expansion of medical assistance benefits

Recognizes an additional estimated general fund tumback of $30.3 million from the 2007-09 biennium

House Bill No. 1012 - DHS - State Hospital - Conference Committee Action

	Executive Budget	House Version	Conference Committee Changes[1]	Conference Committee Version	Senate Version	Comparison to Senate
State Hospital	$70,001,527	$66,911,926	$1,706,920	$68,618,846	$69,900,728	($1,281,882)
Total all funds	$70,001,527	$66,911,926	$1,706,920	$68,618,846	$69,900,728	($1,281,882)
Less estimated income	19,563,594	18,511,154	1,048,975	19,560,129	19,560,129	0
General fund	$50,437,933	$48,400,772	$657,945	$49,058,717	$50,340,599	($1,281,882)
FTE	472.51	466.51	0.00	466.51	471.51	(5.00)

[1]

State Hospital - Conference committee changes:	FTE	General Fund	Other Funds	Total
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$153,342	$1,045,510	$1,198,852
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		4,603	3,465	8,068
Restore $500,000 of the $1 million reduction made by the House for one-time extraordinary repairs funding (The Senate restored all funding relating to this reduction.)		500,000	0	500,000
Total conference committee changes - State Hospital	0.00	$657,945	$1,048,975	$1,706,920

House Bill No. 1012 - DHS - Developmental Center - Conference Committee Action

	Executive Budget	House Version	Conference Committee Changes[1]	Conference Committee Version	Senate Version	Comparison to Senate
Developmental Center	$54,015,265	$52,989,719	$824,199	$53,813,918	$54,015,077	($201,159)
Total all funds	$54,015,265	$52,989,719	$824,199	$53,813,918	$54,015,077	($201,159)
Less estimated income	37,160,672	36,572,644	587,914	37,160,558	37,160,558	0
General fund	$16,854,593	$16,417,075	$236,285	$16,653,360	$16,854,519	($201,159)
FTE	445.54	445.54	0.00	445.54	445.54	0.00

[1]

Developmental Center - Conference committee changes:	FTE	General Fund	Other Funds	Total
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$86,211	$587,800	$674,011
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		$74	114	$188
Restore one-time funding for extraordinary repairs removed by the House (This adjustment was also made by the Senate.)		150,000	0	150,000
Total conference committee changes - Developmental Center	0.00	$236,285	$587,914	$824,199

House Bill No. 1012 - Human Service Centers - General Fund Summary

	Executive Budget	House Version	Conference Committee Changes[1]	Conference Committee Version	Senate Version	Comparison to Senate
DHS - Northwest HSC	4,881,955	4,737,136	39,079	4,776,215	4,844,508	(68,293)
DHS - North Central HSC	12,098,437	10,500,926	37,957	10,538,883	12,042,061	(1,503,178)
DHS - Lake Region HSC	6,263,550	6,116,357	37,738	6,154,095	6,227,432	(73,337)
DHS - Northeast HSC	12,056,316	11,587,742	20,246	11,607,988	11,991,589	(383,601)
DHS - Southeast HSC	16,054,906	14,572,467	50,159	14,622,626	15,750,067	(1,127,441)
DHS - South Central HSC	8,943,330	8,557,071	43,714	8,600,785	8,818,517	(217,732)
DHS - West Central HSC	13,315,641	12,108,447	47,386	12,155,833	12,588,782	(432,949)
DHS - Badlands HSC	6,264,582	5,580,825	12,158	5,592,983	6,286,080	(693,097)
Total general fund	$79,878,717	$73,760,971	$288,437	$74,049,408	$78,549,036	($4,499,628)

House Bill No. 1012 - Human Service Centers - Other Funds Summary

	Executive Budget	House Version	Conference Committee Changes[1]	Conference Committee Version	Senate Version	Comparison to Senate
DHS - Northwest HSC	3,680,172	3,471,996	203,790	3,675,786	3,675,786	
DHS - North Central HSC	8,825,362	8,416,847	252,288	8,669,135	8,821,489	(152,354)
DHS - Lake Region HSC	4,747,559	4,524,710	218,572	4,743,282	4,743,282	
DHS - Northeast HSC	14,320,535	14,029,163	131,280	14,160,443	14,293,997	(133,554)
DHS - Southeast HSC	15,966,058	15,188,388	336,874	15,525,262	15,682,522	(157,260)
DHS - South Central HSC	6,970,002	6,700,249	266,461	6,966,710	6,966,710	
DHS - West Central HSC	12,693,292	12,254,021	281,204	12,535,225	12,587,579	(52,354)
DHS - Badlands HSC	5,429,653	5,182,171	82,184	5,264,355	5,404,355	(140,000)
Total other funds	$72,632,633	$69,767,545	$1,772,653	$71,540,198	$72,175,720	($635,522)

House Bill No. 1012 - Human Service Centers - All Funds Summary

	Executive Budget	House Version	Conference Committee Changes[1]	Conference Committee Version	Senate Version	Comparison to Senate
DHS - Northwest HSC	8,562,127	8,209,132	242,869	8,452,001	8,520,294	(68,293)
DHS - North Central HSC	20,923,799	18,917,773	290,245	19,208,018	20,863,550	(1,655,532)
DHS - Lake Region HSC	11,011,109	10,641,067	256,310	10,897,377	10,970,714	(73,337)
DHS - Northeast HSC	26,376,851	25,616,905	151,526	25,768,431	26,285,586	(517,155)
DHS - Southeast HSC	32,020,964	29,760,855	387,033	30,147,888	31,432,589	(1,284,701)
DHS - South Central HSC	15,913,332	15,257,320	310,175	15,567,495	15,785,227	(217,732)
DHS - West Central HSC	26,008,933	24,362,468	328,590	24,691,058	25,176,361	(485,303)
DHS - Badlands HSC	11,694,235	10,762,996	94,342	10,857,338	11,690,435	(833,097)
Total all funds	$152,511,350	$143,528,516	$2,061,090	$145,589,606	$150,724,756	($5,135,150)
FTE	847.48	836.48	0.00	836.48	845.48	(9.00)

Northwest Human Service Center - Conference committee changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$29,268	$199,556	$228,824
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		9,811	4,234	14,045
Total conference committee changes - Northwest Human Service Center	0.00	$39,079	$203,790	$242,869

North Central Human Service Center - Conference committee changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$36,891	$251,527	$288,418
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		1,066	761	1,827
Total conference committee changes - North Central Human Service Center	0.00	$37,957	$252,288	$290,245

Lake Region Human Service Center - Conference committee changes:	FTE	General Fund	Other Funds	Total
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$31,430	$214,295	$245,725
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		6,308	4,277	10,585
Total conference committee changes - Lake Region Human Service Center	0.00	$37,738	$218,572	$256,310

Northeast Human Service Center - Conference committee changes:	FTE	General Fund	Other Funds	Total
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$18,919	$128,994	$147,913
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		1,327	2,286	3,613
Total conference committee changes - Northeast Human Service Center	0.00	$20,246	$131,280	$151,526

Southeast Human Service Center - Conference committee changes:	FTE	General Fund	Other Funds	Total
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$49,305	$336,167	$385,47[illegible]
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		854	707	1,561
Total conference committee changes - Southeast Human Service Center	0.00	$50,159	$336,874	$387,033

South Central Human Service Center - Conference committee changes:	FTE	General Fund	Other Funds	Total
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$38,598	$263,169	$301,767
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		5,116	3,292	8,408
Total conference committee changes - South Central Human Service Center	0.00	$43,714	$266,461	$310,175

West Central Human Service Center - Conference committee changes:	FTE	General Fund	Special Funds	Total
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$40,547	$276,456	$317,003

estore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		6,839	4,748	11,587
Total conference committee changes - West Central Human Service Center	0.00	$47,386	$281,204	$328,590

Badlands Human Service Center - Conference committee changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$12,042	$82,102	$94,144
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		116	82	198
Total conference committee changes - Badlands Human Service Center	0.00	$12,158	$82,184	$94,342

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number 1012 (, as (re)engrossed): Date: 5/1/09

Your Conference Committee _____

For the Senate:	YES	NO	For the House:	YES	NO
Sen. Kilzer	X		Rep. Porter	X	
Sen. Fischer	X		Rep. Kreidt 2	X	
Sen. Wagner	X		Rep. Ekstrom	X	

MOVE 0218

recommends that the (SENATE/HOUSE) (ACCEDE to) (RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) _____ -- _____

____, and place _____ on the Seventh order.

____, adopt (further) amendments as follows, and place _____ on the Seventh order:

____, having been unable to agree, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: _____
CARRIER: _____

LC NO. of amendment
LC NO. of engrossment
Emergency clause added or deleted
Statement of purpose of amendment

MOTION MADE BY: _____

SECONDED BY: _____

VOTE COUNT ___ **YES** ____ **NO** ____ **ABSENT**

Revised 4/1/05

98013.0219
Title.0600
Fiscal No. 2

Prepared by the Legislative Council staff for
Conference Committee
May 1, 2009

VR
5/2/09
1 of 18

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1470-1477 of the House Journal and pages 1317-1323 and pages 1337 and 1338 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 1, line 2, after the first semicolon insert "to provide a contingent appropriation;"

Page 1, line 3, replace the first "and" with "to create and enact a new subsection to section 50-25.1-05 of the North Dakota Century Code, relating to the adoption of rules regarding the recording of interviews in child abuse or neglect cases;", after "25-04-05" insert ", 50-24.1-02.6", and after "50-24.5-04" insert ", 50-29-04"

Page 1, line 5, after "facilities" insert ", eligibility under the state children's health insurance program" and after "fund" insert "; to repeal section 4 of chapter 422 of the 2007 Session Laws, relating to the effective date of the expansion of medical assistance benefits; and to declare an emergency"

Page 1, line 17, replace "2,148,542" with "2,520,060" and replace "13,660,900" with "14,032,418"

Page 1, line 18, replace "(13,582,286)" with "(13,567,566)" and replace "46,528,070" with "46,542,790"

Page 1, line 20, replace "($11,434,02911)" with "($11,047,791)" and replace "60,188,970" with "60,575,208"

Page 1, line 21, replace "(16,622,573)" with "(16,290,983)" and replace "34,041,261" with "34,372,851"

Page 1, line 22, replace "5,188,544" with "5,243,192" and replace "26,147,709" with "26,202,357"

Page 2, line 3, replace "18,552,432" with "16,090,648" and replace "43,963,473" with "41,501,689"

Page 2, line 4, replace "4,364,279" with "4,966,224" and replace "72,176,081" with "72,778,026"

Page 2, line 6, replace "111,111,588" with "111,831,588" and replace "455,130,804" with "455,850,804"

Page 2, line 7, replace "189,244,935" with "171,985,015" and replace "1,306,432,756" with "1,289,172,836"

Page 2, line 10, replace "310,797,543" with "292,397,784" and replace "1,877,716,114" with "1,859,316,355"

Page 2, line 11, replace "223,418,640" with "250,532,515" and replace "1,350,082,207" with "1,377,196,082"

Page 2, line 12, replace "87,378,903" with "41,865,269" and replace "527,633,907" with "482,120,273"

Page 2, line 17, replace "715,235" with "958,104" and replace "8,209,132" with "8,452,001"

Page 2, line 18, replace "2,135,169" with "2,425,414" and replace "18,917,773" with "19,208,018"

Page 2, line 19, replace "823,712" with "1,080,022" and replace "10,641,067" with "10,897,377"

Page 2, line 20, replace "3,509,556" with "3,661,082" and replace "25,616,905" with "25,768,431"

Page 2, line 21, replace "3,699,225" with "4,086,258" and replace "29,760,855" with "30,147,888"

Page 2, line 22, replace "573,509" with "883,684" and replace "15,257,320" with "15,567,495"

Page 2, line 23, replace "3,675,196" with "4,003,786" and replace "24,362,468" with "24,691,058"

Page 2, line 24, replace "964,207" with "1,058,549" and replace "10,762,996" with "10,857,338"

Page 2, line 25, replace "9,519,982" with "11,226,902" and replace "66,911,926" with "68,618,846"

Page 2, line 26, replace "6,195,786" with "7,019,985" and replace "52,989,719" with "53,813,918"

Page 2, line 27, replace "31,811,577" with "36,403,786" and replace "263,430,161" with "268,022,370"

Page 2, line 28, replace "12,094,114" with "15,503,656" and replace "124,851,343" with "128,260,885"

Page 2, line 29, replace "19,717,463" with "20,900,130" and replace "138,578,818" with "139,761,485"

Page 3, line 3, replace "112,284,910" with "68,008,591" and replace "692,360,434" with "648,084,115"

Page 3, line 4, replace "218,890,181" with "342,634,393" and replace "1,508,974,811" with "1,632,719,023"

Page 3, line 5, replace "331,175,091" with "410,642,984" and replace "2,201,335,245" with "2,280,803,138"

Page 3, after line 6, insert:

"**SECTION 2. APPROPRIATION - FEDERAL FISCAL STIMULUS FUNDS - ADDITIONAL FUNDING APPROVAL.** The funds provided in this section, or so much of the funds as may be necessary, are appropriated from federal funds made available to the state under the federal American Recovery and Reinvestment Act of 2009, not otherwise appropriated, to the department of human services, for the period beginning with the effective date of this Act and ending June 30, 2011, as follows:

Federal medical assistance percentage	$66,500,000
Elderly nutrition services	485,000

Child support incentive matching funds	3,200,000
Rehabilitation services and disability assistance and independent living	2,043,000
Individuals With Disabilities Education Act - Part C	2,140,000
Supplemental nutrition assistance program benefits and administration	9,874,747
Senior employment program	143,288
Older blind	3,170
Total federal funds	$84,389,205

The department of human services may seek emergency commission and budget section approval under chapter 54-16 for authority to spend any additional federal funds received under the federal American Recovery and Reinvestment Act of 2009 in excess of the amounts appropriated in this section, for the period beginning with the effective date of this Act and ending June 30, 2011.

Any federal funds appropriated under this section, except for the funding of $66,500,000 relating to the federal medical assistance percentage and funding of $2,763,082 of child support incentive matching funds, are not a part of the agency's 2011-13 base budget. Any program expenditures made with these funds will not be replaced with state funds after the federal American Recovery and Reinvestment Act of 2009 funds are no longer available.

SECTION 3. GENERAL FUND TRANSFER TO BUDGET STABILIZATION FUND - EXCEPTION - USE OF GENERAL FUND AMOUNTS. Notwithstanding section 54-27.2-02, the state treasurer and the office of management and budget may not include in the amount used to determine general fund transfers to the budget stabilization fund at the end of the 2007-09 biennium under chapter 54-27.2 any general fund amounts resulting from the increased federal share of medical assistance payments resulting from federal medical assistance percentage changes under the federal American Recovery and Reinvestment Act of 2009. The state treasurer and the office of management and budget shall separately account for these amounts and 2009-11 biennium general fund amounts resulting from federal medical assistance percentage changes under the federal American Recovery and Reinvestment Act of 2009 and use these amounts to defray the expenses of continuing program costs of the department of human services from the general fund, for the biennium beginning July 1, 2009, and ending June 30, 2011, as follows:

Inflationary increases for human service providers	$27,345,292
Rate increases for selected medicaid services due to rebasing	21,788,982
Rate increases for nursing homes due to property limit changes and other nursing home increases	7,788,572
Wage increases for employees of nursing homes, basic care, and developmental disabilities services providers and qualified service providers	16,229,317
Salary increases for department of human services employees	14,293,872
Total	$87,446,035

SECTION 4. BANK OF NORTH DAKOTA LOAN AUTHORIZATION - BUDGET SECTION APPROVAL - CONTINGENT APPROPRIATION. If the caseload/utilization of medical services, long-term care, and developmental disabilities services is more than anticipated by the sixty-first legislative assembly, the department of human services, subject to budget section approval, may borrow the sum of $8,500,000, or so much of the sum as may be necessary, from the Bank of North Dakota, which is appropriated for the purpose of providing the state matching share of additional medical assistance grants for medical services, long-term care, and developmental disabilities services, for the biennium beginning July 1, 2009, and ending June 30, 2011. The department of human services shall request funding from the sixty-second legislative assembly to repay any loan obtained pursuant to provisions of this section, including accrued interest.

SECTION 5. 2009-11 SPENDING LEVEL - AUTHORIZATION. If department of human services expenditures exceed funding levels, including loan proceeds appropriated in section 4 of this Act, approved by the sixty-first legislative assembly during the 2009-11 biennium due to caseload/utilization of programs exceeding the level anticipated by the legislative assembly, the department may continue to spend at the increased level and may seek a deficiency appropriation from the sixty-second legislative assembly."

Page 3, after line 18, insert:

"Supplemental payment - Critical access hospitals 0 400,000"

Page 3, line 19, replace "2,793,692" with "3,443,692"

Page 3, line 21, replace "3,146,298" with "4,196,298"

Page 4, line 5, replace "$4,324,506" with "$4,124,506"

Page 4, remove lines 22 through 29

Page 5, line 1, replace "$14,739,128" with "$17,977,513" and replace "$4,950,451" with "$5,512,441"

Page 5, line 2, replace "$1,000,000" with "$800,000" and replace "$8,788,677" with "$11,665,072"

Page 5, line 4, replace "each employee earning a salary that is less than the eightieth" with "employees beginning July 1, 2009. Basic care and skilled nursing care facilities may not use the money received under this section for providing salary and benefit enhancements to administrators or directors of nursing."

Page 5, remove lines 5 and 6

Page 5, line 9, replace "$18,929,151" with "$21,639,106" and replace "$7,000,000" with "$7,086,807"

Page 5, line 10, replace "$11,929,151" with "$14,552,299"

Page 5, line 11, replace "each employee earning a" with "employees beginning July 1, 2009. Developmental disabilities service providers may not use the money received under this section for providing salary and benefit enhancements to administrators."

Page 5, replace lines 12 and 13 with:

"**SECTION 13. LEGISLATIVE INTENT - MEDICAID PROVIDER PAYMENTS.** It is the intent of the legislative assembly that the department of human services establish a goal to set medicaid payments for hospitals, physicians, chiropractors, and ambulances at 100 percent of cost.

SECTION 14. SUPPLEMENTAL PAYMENT - CRITICAL ACCESS HOSPITALS. The grants - medical assistance line item in subdivision 2 of section 1 of this Act includes the sum of $400,000 of one-time funding from the general fund that the department of human services shall use for providing a supplemental payment to eligible critical access hospitals. A critical access hospital is eligible for a payment under this section only if its percentage of medical payments exceeds 25 percent of its total annual revenue in its most recent audited financial statements and is located in a

city with a population that does not exceed 1,450. The department shall seek federal medicaid funding to provide a portion of the $400,000 supplemental payment. If federal medicaid funding is not available for a portion of the payment, the department may spend the $400,000 from the general fund for making the supplemental payment only if the action will not result in a reduction in federal medicaid funding to the state.

SECTION 15. LEGISLATIVE INTENT - DEMENTIA CARE SERVICES. It is the intent of the sixty-first legislative assembly that the department of human services integrate the dementia care services program established in House Bill No. 1043, as approved by the sixty-first legislative assembly, with the home and community-based care services programs of the department.

SECTION 16. LEGISLATIVE COUNCIL STUDY - TRAUMATIC BRAIN INJURY. During the 2009-11 interim, the legislative council shall consider studying the impact of individuals with traumatic brain injury, including veterans who are returning from wars, on the state's human services system. The study must include an analysis of the estimated cost of providing human service-related services to the individuals with traumatic brain injury. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly.

SECTION 17. LEGISLATIVE INTENT - CHILDREN'S HEALTH INSURANCE PROGRAM OUTREACH. It is the intent of the sixty-first legislative assembly that the department of human services award a contract for outreach services for the state children's health insurance program to an entity other than an insurance company, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 18. UNSPENT 2007-09 BIENNIUM GENERAL FUND APPROPRIATIONS - EXCEPTION. The amount of $270,000 of the $3,100,000 for a sexual offender treatment addition at the state hospital appropriated in subdivision 3 of section 3 of 2007 Senate Bill No. 2012 is not subject to section 54-44.1-11 and may be spent during the 2009-11 biennium for completing roof repairs at the state hospital."

Page 7, after line 21, insert:

"**SECTION 20. AMENDMENT.** Section 50-24.1-02.6 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-02.6. ~~(Contingent effective date - See note) Medical assistance benefits - Eligibility criteria.~~

1. ~~The department shall provide medical assistance benefits to otherwise eligible persons who are:~~

   a. ~~Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and~~

   b. ~~Minors who have countable income that does not exceed an amount determined under subsection 3.~~

2. ~~The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.~~

3. ~~The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by~~

~~federal law, that provide an income level for all minors born before September 30, 1983, equal to one hundred percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined and that do not exceed legislative appropriations for that purpose.~~

~~4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.~~

~~(Contingent effective date - See note)~~ **Medical assistance benefits - Eligibility criteria.**

1. The department shall provide medical assistance benefits to otherwise eligible persons who are:

   a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and

   b. Minors who have countable income that does not exceed an amount determined under subsection 3.

2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.

3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law~~, that provide an income level for all individuals from birth through age eighteen equal to one hundred thirty-three percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined~~.

4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets."

Page 7, after line 29, insert:

"**SECTION 22.** A new subsection to section 50-25.1-05 of the North Dakota Century Code is created and enacted as follows:

The department shall adopt guidelines for case referrals to a children's advocacy center. When cases are referred to a children's advocacy center, all interviews of the alleged abused or neglected child conducted at the children's advocacy center under this section shall be audio-recorded or video-recorded.

SECTION 23. AMENDMENT. Section 50-29-04 of the North Dakota Century Code is amended and reenacted as follows:

50-29-04. Plan requirements. The plan:

1. Must be provided through private contracts with insurance carriers;

2. Must allow conversion to another health insurance policy;

3. Must be based on an actuarial equivalent of a benchmark plan;

4. Must incorporate every state-required waiver approved by the federal government;

5. Must include community-based eligibility outreach services; and

6. Must provide:

   a. A net income eligibility limit of one hundred ~~fifty~~ sixty percent of the poverty line;

   b. A copayment requirement for each pharmaceutical prescription and for each emergency room visit;

   c. A deductible for each inpatient hospital visit;

   d. Coverage for:

      (1) Inpatient hospital, medical, and surgical services;

      (2) Outpatient hospital and medical services;

      (3) Psychiatric and substance abuse services;

      (4) Prescription medications;

      (5) Preventive screening services;

      (6) Preventive dental and vision services; and

      (7) Prenatal services; and

   e. A coverage effective date that is the first day of the month, following the date of application and determination of eligibility."

Page 8, after line 21, insert:

"**SECTION 25. REPEAL.** Section 4 of chapter 422 of the 2007 Session Laws is repealed.

SECTION 26. EMERGENCY. Sections 2 and 18 of this Act are declared to be an emergency measure."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT - LC 98013.0219 FN 2

A copy of the statement of purpose of amendment is attached.

STATEMENT OF PURPOSE OF AMENDMENT:

House Bill No. 1012 - Summary of Conference Committee Action

	Executive Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
DHS - Management						
Total all funds	$65,842,656	$60,188,970	$386,238	$60,575,208	$66,479,591	($5,904,383)
Less estimated income	36,027,838	34,041,261	331,590	34,372,851	36,204,782	(1,831,931)
General fund	$29,814,818	$26,147,709	$54,648	$26,202,357	$30,274,809	($4,072,452)
DHS - Program/Policy						
Total all funds	$1,919,716,163	$1,877,716,114	$74,489,446	$1,952,205,560	$2,006,726,076	($54,520,516)
Less estimated income	1,375,189,679	1,350,082,207	120,003,080	1,470,085,287	1,494,337,033	(24,251,746)
General fund	$544,526,484	$527,633,907	($45,513,634)	$482,120,273	$512,389,043	($30,268,770)
DHS - State Hospital						
Total all funds	$70,001,527	$66,911,926	$1,706,920	$68,618,846	$69,900,728	($1,281,882)
Less estimated income	19,563,594	18,511,154	1,048,975	19,560,129	19,560,129	0
General fund	$50,437,933	$48,400,772	$657,945	$49,058,717	$50,340,599	($1,281,882)
DHS - Developmental Center						
Total all funds	$54,015,265	$52,989,719	$824,199	$53,813,918	$54,015,077	($201,159)
Less estimated income	37,160,672	36,572,644	587,914	37,160,558	37,160,558	0
General fund	$16,854,593	$16,417,075	$236,285	$16,653,360	$16,854,519	($201,159)
DHS - Northwest HSC						
Total all funds	$8,562,127	$8,209,132	$242,869	$8,452,001	$8,520,294	($68,293)
Less estimated income	3,680,172	3,471,996	203,790	3,675,786	3,675,786	0
General fund	$4,881,955	$4,737,136	$39,079	$4,776,215	$4,844,508	($68,293)
DHS - North Central HSC						
Total all funds	$20,923,799	$18,917,773	$290,245	$19,208,018	$20,863,550	($1,655,532)
Less estimated income	8,825,362	8,416,847	252,288	8,669,135	8,821,489	(152,354)
General fund	$12,098,437	$10,500,926	$37,957	$10,538,883	$12,042,061	($1,503,178)
DHS - Lake Region HSC						
Total all funds	$11,011,109	$10,641,067	$256,310	$10,897,377	$10,970,714	($73,337)
Less estimated income	4,747,559	4,524,710	218,572	4,743,282	4,743,282	0
General fund	$6,263,550	$6,116,357	$37,738	$6,154,095	$6,227,432	($73,337)
DHS - Northeast HSC						
Total all funds	$26,376,851	$25,616,905	$151,526	$25,768,431	$26,285,586	($517,155)
Less estimated income	14,320,535	14,029,163	131,280	14,160,443	14,293,997	(133,554)
General fund	$12,056,316	$11,587,742	$20,246	$11,607,988	$11,991,589	($383,601)
DHS - Southeast HSC						
Total all funds	$32,020,964	$29,760,855	$387,033	$30,147,888	$31,432,589	($1,284,701)
Less estimated income	15,966,058	15,188,388	336,874	15,525,262	15,682,522	(157,260)
General fund	$16,054,906	$14,572,467	$50,159	$14,622,626	$15,750,067	($1,127,441)
DHS - South Central HSC						
Total all funds	$15,913,332	$15,257,320	$310,175	$15,567,495	$15,785,227	($217,732)
Less estimated income	6,970,002	6,700,249	266,461	6,966,710	6,966,710	0
General fund	$8,943,330	$8,557,071	$43,714	$8,600,785	$8,818,517	($217,732)
DHS - West Central HSC						
Total all funds	$26,008,933	$24,362,468	$328,590	$24,691,058	$25,176,361	($485,303)
Less estimated income	12,693,292	12,254,021	281,204	12,535,225	12,587,579	(52,354)
General fund	$13,315,641	$12,108,447	$47,386	$12,155,833	$12,588,782	($432,949)
DHS - Badlands HSC						
Total all funds	$11,694,235	$10,762,996	$94,342	$10,857,338	$11,690,435	($833,097)
Less estimated income	5,429,653	5,182,171	82,184	5,264,355	5,404,355	(140,000)
General fund	$6,264,582	$5,580,825	$12,158	$5,592,983	$6,286,080	($693,097)
Bill total						
Total all funds	$2,262,086,961	$2,201,335,245	$79,467,893	$2,280,803,138	$2,347,846,228	($67,043,090)

Less estimated income	1,540,574,416	1,508,974,811	123,744,212	1,632,719,023	1,659,438,222	(26,719,199)
General fund	$721,512,545	$692,360,434	($44,276,319)	$648,084,115	$688,408,006	($40,323,891)

House Bill No. 1012 - DHS - Management - Conference Committee Action

	Executive Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
Salaries and wages	$19,303,132	$13,660,900	$371,518	$14,032,418	$19,176,867	($5,144,449)
Operating expenses	46,539,524	46,528,070	14,720	46,542,790	47,131,212	(588,422)
Contingent appropriation					171,512	(171,512)
Total all funds	$65,842,656	$60,188,970	$386,238	$60,575,208	$66,479,591	($5,904,383)
Less estimated income	36,027,838	34,041,261	331,590	34,372,851	36,204,782	(1,831,931)
General fund	$29,814,818	$26,147,709	$54,648	$26,202,357	$30,274,809	($4,072,452)
FTE	108.35	107.35	0.00	107.35	107.35	0.00

Department No. 326 - DHS - Management - Detail of Conference Committee Changes

	Conference committee changes[1]	Total Conference Committee Changes
Salaries and wages	$371,518	$371,518
Operating expenses	14,720	14,720
Contingent appropriation		
Total all funds	$386,238	$386,238
Less estimated income	331,590	331,590
General fund	$54,648	$54,648
FTE	0.00	0.00

[1]

Management - Conference committee changes:	FTE	General Fund	Other Funds	Total
Administration Support Program				
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$39,323	$268,110	$307,433
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		7,128	7,592	14,720
Division of Information Technology Program				
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		8,197	55,888	64,085
Total conference committee changes - Management	0.00	$54,648	$331,590	$386,238

House Bill No. 1012 - DHS - Program/Policy - Conference Committee Action

	Executive Budget	House Version	Conference Committee Changes[1]	Conference Committee Version	Senate Version	Comparison to Senate
Salaries and wages	$44,664,959	$43,963,473	($2,461,784)	$41,501,689	$41,632,186	($130,497)
Operating expenses	73,251,082	72,176,081	601,945	72,778,026	74,434,398	(1,656,372)
Capital assets	13,000	13,000		13,000	13,000	
Grants	456,965,308	455,130,804	720,000	455,850,804	455,800,804	50,000
Grants - Medical assistance	1,344,821,814	1,306,432,756	(17,259,920)	1,289,172,836	1,348,081,484	(58,908,648)
Federal fiscal stimulus funds			84,389,205	84,389,205	84,389,205	
Contingent appropriation					2,374,999	(2,374,999)
Contingent borrowing			8,500,000	8,500,000		8,500,000
Total all funds	$1,919,716,163	$1,877,716,114	$74,489,446	$1,952,205,560	$2,006,726,076	($54,520,516)
Less estimated income	1,375,189,679	1,350,082,207	120,003,080	1,470,085,287	1,494,337,033	(24,251,746)
General fund	$544,526,484	$527,633,907	($45,513,634)	$482,120,273	$512,389,043	($30,268,770)
FTE	363.50	361.00	0.00	361.00	361.00	0.00

[1]

Program and Policy - Conference committee changes:	FTE	General Fund	Other Funds	Total
Economic Assistance Policy Program				
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$14,539	$99,126	$113,665
Child Support Program				
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		20,636	140,700	161,336
Medical Services Program				
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		13,203	90,020	103,223
Restore a portion of the House reduction for department travel (This amendment was also made by the Senate.)		10,915	8,653	19,568
Provide one-time funding in the grants - medical assistance line item for supplemental payments to small, rural critical access hospitals (This funding was also provided by the Senate.)		400,000	0	400,000
Restore funding for medically needy to reflect income levels of 83 percent of the federal poverty level as provided for in the executive budget (The House decreased funding to reflect income levels of 75 percent of the federal poverty level, and the Senate restored funding to reflect income levels of 83 percent.)		376,947	642,379	1,019,326
Increase funding for rebasing physician payment rates (This amendment was also made by the Senate.) (This amendment provides $47,700,000, of which		10,779,670	18,370,330	29,150,000

$17,639,460 is from the general fund, for rebasing rates to 75 percent of the amount needed to rebase to 100 percent of cost. The House version provided $10,600,000, of which $3,919,880 is from the general fund, for rebasing rates to 20 percent of the amount needed to rebase to 100 percent of cost. The executive budget included funding of $13,250,000, of which $4,899,850 is from the general fund, for rebasing rates to 25 percent of the amount needed to rebase to 100 percent of cost.)			
Restore funding in the grants - medical assistance line item for rebasing ambulance payment rates to Medicare rates as provided for in the executive budget (This amendment was also made by the Senate. The House version provided $1,508,336, of which $557,783 is from the general fund, to provide funding equal to 75 percent of the funding provided in the executive budget.)	185,927	316,851	502,778
Restore funding in the grants - medical assistance line item for rebasing dentist payment rates to a minimum of 75 percent of average billed charges as provided for in the executive budget (This amendment was also made by the Senate. The House version provided for rebasing dentist payment rates to a minimum of 70 percent of average billed charges.)	278,333	474,445	752,778
Adjust funding for the state children's health insurance program to reflect utilization reprojections and a revised premium amount (This amendment was also made by the Senate.) (This amendment maintains program eligibility at 160 percent of the federal poverty level.)	(2,832,256)	(8,110,063)	(10,942,319)
Add funding for outreach for the state children's health insurance program	300,000	0	300,000
Provide funding for an estimated decrease in the state's federal medical assistance percentage (FMAP) for the last seven months of the 2009-11 biennium	9,500,000	(9,500,000)	0
Add funding for a Bank of North Dakota line of credit ($8,500,000) if caseload/utilization rates are greater than anticipated, including $14,485,398 of special funds for the related federal funding share	0	22,985,398	22,985,398
Long-Term Care Program			
Restore funding added in the executive budget and removed by the House for the addition of a third tier of personal care that would allow a maximum of 1,200 units of care per month (This amendment was also made by the Senate.)	1,021,922	1,741,524	2,763,446
Add funding of $3,238,385, of which $561,990 is from the general fund, to the amounts provided by the House to provide total funding of $17,977,513, of which $5,512,441 is from the general fund, $800,000 is from the health care trust fund, and $11,665,027 is from federal funds, to provide a salary and benefit supplemental payment for individuals employed by basic care and nursing care facilities except for administrators and contract nursing (The Senate added funding of $7,837,284, of which $2,976,801 was from the general fund, for a salary and benefit supplemental payment for individuals employed by basic care and nursing care facilities.)	561,990	2,676,395	3,238,385
Add funding of $2,709,955, of which $86,807 is from the general fund, to the amounts provided by the House to provide total funding of $21,639,106, of which $7,086,807 is from the general fund and $14,552,299 is from federal funds, to provide a salary and benefit supplemental payment for individuals employed by developmental disabilities providers, except for administrators (This amendment was also made by the Senate.)	86,807	2,623,148	2,709,955

Add funding to provide a $1 per hour increase for qualified service providers (This amendment was also made by the Senate.)	853,268	963,026	1,816,294
Add funding in the grants - medical assistance line item for developmental disabilities providers who are serving severely medically fragile and behaviorally challenged individuals in addition to the funding of $1,186,857, of which $438,900 is from the general fund, added by the House (The Senate added funding of $5,131,059, of which $1,897,465 was from the general fund, for providers who are serving severely medically fragile individuals.)	1,114,260	1,898,883	3,013,143
Add funding of $178,560, of which $113,221 is from the general fund, to increase the personal needs allowance for individuals in basic care facilities and ICR/MR facilities from $75 per month as provided by the House to $85 per month (The Senate added funding of $357,120, of which $226,442 was from the general fund, to increase the personal needs allowance from $75 to $95 per month.)	113,221	65,339	178,560
Aging Services Program			
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)	1,005	6,852	7,857
Restore a portion of the House reduction for department travel (This amendment was also made by the Senate.)	1,753	5,232	6,985
Provide funding for a grant for the community of care program (This funding was also provided by the Senate.)	120,000	0	120,000
Children and Family Services Program			
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)	2,326	15,860	18,186
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)	527	1,326	1,853
Increase funding for the Healthy Families program by $200,000 from the general fund, from $300,000 from the general fund as provided for the 2007-09 biennium to $500,00 from the general fund for the 2009-11 biennium	200,000	0	200,000
Add funding for family group conferencing ($100,000) and for safety and permanency funds ($100,000) (The Senate added funding of $1,456,372, of which $1,200,000 was from the general fund, for family group conferencing.)	200,000	0	200,000
Add funding for children's advocacy centers	200,000	0	200,000
Mental Health and Substance Abuse Program			
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)	2,382	16,241	18,623
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)	7,921	22,858	30,779
Add funding in the operating expenses line item to increase compulsive gambling	100,000	0	100,000

services to $650,000, of which $250,000 is from the general fund and $400,000 is from lottery proceeds. This is the same level as provided by the Senate. The House version provided funding of $550,000, of which $150,000 is from the general fund, and the executive budget recommended funding of $700,000, of which $300,000 is from the general fund and $400,000 is from lottery proceeds.			
Restore funding in the grants line item for the Governor's Prevention and Advisory Council grants. The House version removed funding for the Governor's Prevention and Advisory Council grants. The executive budget and the Senate version provide funding of $200,000 from the general fund for the Governor's Prevention and Advisory Council grants.	100,000	0	100,000
Developmental Disabilities Council			
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)	0	2,223	2,223
Developmental Disabilities Division			
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)	1,036	7,067	8,103
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)	3,768	16,488	20,256
Vocational Rehabilitation			
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)	800	5,453	6,253
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)	8,548	28,121	36,669
Federal Stimulus Funding			
Provide for increased funding for supplemental nutrition assistance program benefits and related additional administrative expenses	0	9,874,747	9,874,747
Change the funding source and provide additional funding for child support enforcement activities	(2,763,082)	3,200,000	436,918
Change the funding source for Medicaid, foster care, and adoption payments due to the enhanced FMAP included in the American Recovery and Reinvestment Act of 2009	(66,500,000)	66,500,000	0
Provide funding for elderly nutrition services	0	485,000	485,000
Provide funding for the senior employment program	0	143,288	143,288
Provide funding for older blind services	0	3,170	3,170
Provide for increased funding for developmentally delayed infants aged 0 to 3 to	0	2,140,000	2,140,000

reflect federal funds received for Individuals With Disabilities Education Act - Part C				
Provide for increased funding for centers for independent living		0	243,000	243,000
Provide for increased funding for vocational rehabilitation services		0	1,800,000	1,800,000
Total conference committee changes - Program and Policy	0.00	($45,531,634)	$102,003,080	$74,489,446

Other changes affecting Program and Policy programs:

Adds a section of legislative intent providing that the department may exceed funding levels approved by the 2009 Legislative Assembly due to caseload/utilization of programs exceeding the level anticipated by the 2009 Legislative Assembly and may seek a deficiency appropriation from the 2011 Legislative Assembly.

Adds a section of legislative intent regarding Medicaid reimbursement for hospitals, physicians, chiropractors, and ambulances (This section was also added by the Senate.)

Adds a section of legislative intent regarding dementia care services provided for in 2009 House Bill No. 1043 (This section was also added by the Senate.)

Adds a section to provide for a Legislative Council study of individuals with traumatic brain injury (The Senate had added a section to provide for a Legislative Council study of returning veterans and their families.)

Adds a section of legislative intent regarding state children's health insurance program outreach

Amends North Dakota Century Code (NDCC) Section 50-24.1-02.6 relating to medical assistance eligibility (This section was also added by the Senate.)

Creates a new subsection to NDCC Section 50-25.1-05 relating to the adoption of rules regarding the recording of interviews in child abuse or neglect cases (This section was also added by the Senate.)

Repeals Section 4 of Chapter 422 of the 2007 Session Laws relating to the effective date of the expansion of medical assistance benefits

Recognizes an additional estimated general fund turnback of $30.3 million from the 2007-09 biennium

House Bill No. 1012 - DHS - State Hospital - Conference Committee Action

	Executive Budget	House Version	Conference Committee Changes[1]	Conference Committee Version	Senate Version	Comparison to Senate
State Hospital	$70,001,527	$66,911,926	$1,706,920	$68,618,846	$69,900,728	($1,281,882)
Total all funds	$70,001,527	$66,911,926	$1,706,920	$68,618,846	$69,900,728	($1,281,882)
Less estimated income	19,563,594	18,511,154	1,048,975	19,560,129	19,560,129	0
General fund	$50,437,933	$48,400,772	$657,945	$49,058,717	$50,340,599	($1,281,882)
FTE	472.51	466.51	0.00	466.51	471.51	(5.00)

State Hospital - Conference committee changes:	FTE	General Fund	Other Funds	Total
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$153,342	$1,045,510	$1,198,852
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		4,603	3,465	8,068
Restore $500,000 of the $1 million reduction made by the House for one-time extraordinary repairs funding (The Senate restored all funding relating to this reduction.)		500,000	0	500,000
Total conference committee changes - State Hospital	0.00	$657,945	$1,048,975	$1,706,920

House Bill No. 1012 - DHS - Developmental Center - Conference Committee Action

	Executive Budget	House Version	Conference Committee Changes[1]	Conference Committee Version	Senate Version	Comparison to Senate
Developmental Center	$54,015,265	$52,989,719	$824,199	$53,813,918	$54,015,077	($201,159)
Total all funds	$54,015,265	$52,989,719	$824,199	$53,813,918	$54,015,077	($201,159)
Less estimated income	37,160,672	36,572,644	587,914	37,160,558	37,160,558	0
General fund	$16,854,593	$16,417,075	$236,285	$16,653,360	$16,854,519	($201,159)
FTE	445.54	445.54	0.00	445.54	445.54	0.00

[1]

Developmental Center - Conference committee changes:	FTE	General Fund	Other Funds	Total
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$86,211	$587,800	$674,011
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		$74	114	$188
Restore one-time funding for extraordinary repairs removed by the House (This adjustment was also made by the Senate.)		150,000	0	150,000
Total conference committee changes - Developmental Center	0.00	$236,285	$587,914	$824,199

House Bill No. 1012 - Human Service Centers - General Fund Summary

	Executive Budget	House Version	Conference Committee Changes[1]	Conference Committee Version	Senate Version	Comparison to Senate
DHS - Northwest HSC	4,881,955	4,737,136	39,079	4,776,215	4,844,508	(68,293)
DHS - North Central HSC	12,098,437	10,500,926	37,957	10,538,883	12,042,061	(1,503,178)
DHS - Lake Region HSC	6,263,550	6,116,357	37,738	6,154,095	6,227,432	(73,337)
DHS - Northeast HSC	12,056,316	11,587,742	20,246	11,607,988	11,991,589	(383,601)
DHS - Southeast HSC	16,054,906	14,572,467	50,159	14,622,626	15,750,067	(1,127,441)
DHS - South Central HSC	8,943,330	8,557,071	43,714	8,600,785	8,818,517	(217,732)
DHS - West Central HSC	13,315,641	12,108,447	47,386	12,155,833	12,588,782	(432,949)
DHS - Badlands HSC	6,264,582	5,580,825	12,158	5,592,983	6,286,080	(693,097)
Total general fund	$79,878,717	$73,760,971	$288,437	$74,049,408	$78,549,036	($4,499,628)

House Bill No. 1012 - Human Service Centers - Other Funds Summary

	Executive Budget	House Version	Conference Committee Changes[1]	Conference Committee Version	Senate Version	Comparison to Senate
DHS - Northwest HSC	3,680,172	3,471,996	203,790	3,675,786	3,675,786	
DHS - North Central HSC	8,825,362	8,416,847	252,288	8,669,135	8,821,489	(152,354)
DHS - Lake Region HSC	4,747,559	4,524,710	218,572	4,743,282	4,743,282	
DHS - Northeast HSC	14,320,535	14,029,163	131,280	14,160,443	14,293,997	(133,554)
DHS - Southeast HSC	15,966,058	15,188,388	336,874	15,525,262	15,682,522	(157,260)
DHS - South Central HSC	6,970,002	6,700,249	266,461	6,966,710	6,966,710	
DHS - West Central HSC	12,693,292	12,254,021	281,204	12,535,225	12,587,579	(52,354)
DHS - Badlands HSC	5,429,653	5,182,171	82,184	5,264,355	5,404,355	(140,000)
Total other funds	$72,632,633	$69,767,545	$1,772,653	$71,540,198	$72,175,720	($635,522)

House Bill No. 1012 - Human Service Centers - All Funds Summary

	Executive Budget	House Version	Conference Committee Changes[1]	Conference Committee Version	Senate Version	Comparison to Senate
DHS - Northwest HSC	8,562,127	8,209,132	242,869	8,452,001	8,520,294	(68,293)
DHS - North Central HSC	20,923,799	18,917,773	290,245	19,208,018	20,863,550	(1,655,532)
DHS - Lake Region HSC	11,011,109	10,641,067	256,310	10,897,377	10,970,714	(73,337)
DHS - Northeast HSC	26,376,851	25,616,905	151,526	25,768,431	26,285,586	(517,155)
DHS - Southeast HSC	32,020,964	29,760,855	387,033	30,147,888	31,432,589	(1,284,701)
DHS - South Central HSC	15,913,332	15,257,320	310,175	15,567,495	15,785,227	(217,732)
DHS - West Central HSC	26,008,933	24,362,468	328,590	24,691,058	25,176,361	(485,303)
DHS - Badlands HSC	11,694,235	10,762,996	94,342	10,857,338	11,690,435	(833,097)
Total all funds	$152,511,350	$143,528,516	$2,061,090	$145,589,606	$150,724,756	($5,135,150)
FTE	847.48	836.48	0.00	836.48	845.48	(9.00)

[1]

Northwest Human Service Center - Conference committee changes:	FTE	General Fund	Other Funds	Total
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$29,268	$199,556	$228,824
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		9,811	4,234	14,045
Total conference committee changes - Northwest Human Service Center	0.00	$39,079	$203,790	$242,869

North Central Human Service Center - Conference committee changes:	FTE	General Fund	Other Funds	Total
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$36,891	$251,527	$288,418
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		1,066	761	1,827
Total conference committee changes - North Central Human Service Center	0.00	$37,957	$252,288	$290,245

Lake Region Human Service Center - Conference committee changes:	FTE	General Fund	Other Funds	Total
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$31,430	$214,295	$245,725
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		6,308	4,277	10,585
Total conference committee changes - Lake Region Human Service Center	0.00	$37,738	$218,572	$256,310

Northeast Human Service Center - Conference committee changes:	FTE	General Fund	Other Funds	Total
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$18,919	$128,994	$147,913
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		1,327	2,286	3,613
Total conference committee changes - Northeast Human Service Center	0.00	$20,246	$131,280	$151,526

Southeast Human Service Center - Conference committee changes:	FTE	General Fund	Other Funds	Total
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$49,305	$336,167	$385,472
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		854	707	1,561
Total conference committee changes - Southeast Human Service Center	0.00	$50,159	$336,874	$387,033

South Central Human Service Center - Conference committee changes:	FTE	General Fund	Other Funds	Total
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating		$38,598	$263,169	$301,767

to this House reduction.)				
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		5,116	3,292	8,408
Total conference committee changes - South Central Human Service Center	0.00	$43,714	$266,461	$310,175

West Central Human Service Center - Conference committee changes:	**FTE**	**General Fund**	**Special Funds**	**Total**
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$40,547	$276,456	$317,003
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		6,839	4,748	11,587
Total conference committee changes - West Central Human Service Center	0.00	$47,386	$281,204	$328,590

Badlands Human Service Center - Conference committee changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Restore a portion of the House reduction for salaries and wages for anticipated savings from vacant positions and employee turnover (The Senate restored all funding relating to this House reduction.)		$12,042	$82,102	$94,144
Restore a portion of the House reduction for department travel (This adjustment was also made by the Senate.)		116	82	198
Total conference committee changes - Badlands Human Service Center	0.00	$12,158	$82,184	$94,342

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number 1012 (, as (re)engrossed): Date: 5/1/09

Your Conference Committee _____

For the Senate:	YES	NO	For the House:	YES	NO
Sen. Kilzer	X		Rep. Pollert	X	
Sen. Fischer	X		Rep. Kreidt	X	
Sen. Wanner	X		Rep. Ekstrom 2	X	

Move amendment

recommends that the (SENATE/HOUSE) (ACCEDE to) (RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) _____ -- _____

____, and place _____ on the Seventh order.

____, adopt (further) amendments as follows, and place _____ on the Seventh order:

____, having been unable to agree, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: _____
CARRIER: _____

LC NO. of amendment
LC NO. of engrossment
Emergency clause added or deleted
Statement of purpose of amendment

MOTION MADE BY: _____

SECONDED BY: _____

VOTE COUNT ___ **YES** ___ **NO** ___ **ABSENT**

Revised 4/1/05

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number 1012 (, as (re)engrossed): Date: 5/11/09

Your Conference Committee _____

For the Senate:	YES	NO	For the House:	YES	NO
Sen. Kilzer	X		Rep. Pollert	X	
Sen. Fischer 2	X		Rep. Kreidt 1	X	
Sen. Wardner	X		Rep. Ekstrom	X	

recommends that the (SENATE/HOUSE) (ACCEDE to/(RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) 1000 -- 1000

____, and place _____ on the Seventh order.

____, adopt (further) amendments as follows, and place _____ on the Seventh order:

____, having been unable to agree, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: _____
CARRIER: _____

LC NO.	of amendment
LC NO.	of engrossment
Emergency clause added or deleted	
Statement of purpose of amendment	

MOTION MADE BY: Rep. Kreidt

SECONDED BY: Senator Fischer

VOTE COUNT 6 **YES** 0 **NO** 0 **ABSENT**

Revised 4/1/05

REPORT OF CONFERENCE COMMITTEE

HB 1012, as engrossed: Your conference committee (Sens. Kilzer, Fischer, Warner and Reps. Pollert, Kreidt, Ekstrom) recommends that the **SENATE RECEDE** from the Senate amendments on HJ pages 1470-1477, adopt amendments as follows, and place HB 1012 on the Seventh order:

That the Senate recede from its amendments as printed on pages 1470-1477 of the House Journal and pages 1317-1323 and pages 1337 and 1338 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 1, line 2, after the first semicolon insert "to provide a contingent appropriation;"

Page 1, line 3, replace the first "and" with "to create and enact a new subsection to section 50-25.1-05 of the North Dakota Century Code, relating to the adoption of rules regarding the recording of interviews in child abuse or neglect cases;", after "25-04-05" insert ", 50-24.1-02.6", and after "50-24.5-04" insert ", 50-29-04"

Page 1, line 5, after "facilities" insert ", eligibility under the state children's health insurance program" and after "fund" insert "; to repeal section 4 of chapter 422 of the 2007 Session Laws, relating to the effective date of the expansion of medical assistance benefits; and to declare an emergency"

Page 1, line 17, replace "2,148,542" with "2,520,060" and replace "13,660,900" with "14,032,418"

Page 1, line 18, replace "(13,582,286)" with "(13,567,566)" and replace "46,528,070" with "46,542,790"

Page 1, line 20, replace "($11,434,02911)" with "($11,047,791)" and replace "60,188,970" with "60,575,208"

Page 1, line 21, replace "(16,622,573)" with "(16,290,983)" and replace "34,041,261" with "34,372,851"

Page 1, line 22, replace "5,188,544" with "5,243,192" and replace "26,147,709" with "26,202,357"

Page 2, line 3, replace "18,552,432" with "16,090,648" and replace "43,963,473" with "41,501,689"

Page 2, line 4, replace "4,364,279" with "4,966,224" and replace "72,176,081" with "72,778,026"

Page 2, line 6, replace "111,111,588" with "111,831,588" and replace "455,130,804" with "455,850,804"

Page 2, line 7, replace "189,244,935" with "171,985,015" and replace "1,306,432,756" with "1,289,172,836"

Page 2, line 10, replace "310,797,543" with "292,397,784" and replace "1,877,716,114" with "1,859,316,355"

Page 2, line 11, replace "223,418,640" with "250,532,515" and replace "1,350,082,207" with "1,377,196,082"

Page 2, line 12, replace "87,378,903" with "41,865,269" and replace "527,633,907" with "482,120,273"

Page 2, line 17, replace "715,235" with "958,104" and replace "8,209,132" with "8,452,001"

Page 2, line 18, replace "2,135,169" with "2,425,414" and replace "18,917,773" with "19,208,018"

Page 2, line 19, replace "823,712" with "1,080,022" and replace "10,641,067" with "10,897,377"

Page 2, line 20, replace "3,509,556" with "3,661,082" and replace "25,616,905" with "25,768,431"

Page 2, line 21, replace "3,699,225" with "4,086,258" and replace "29,760,855" with "30,147,888"

Page 2, line 22, replace "573,509" with "883,684" and replace "15,257,320" with "15,567,495"

Page 2, line 23, replace "3,675,196" with "4,003,786" and replace "24,362,468" with "24,691,058"

Page 2, line 24, replace "964,207" with "1,058,549" and replace "10,762,996" with "10,857,338"

Page 2, line 25, replace "9,519,982" with "11,226,902" and replace "66,911,926" with "68,618,846"

Page 2, line 26, replace "6,195,786" with "7,019,985" and replace "52,989,719" with "53,813,918"

Page 2, line 27, replace "31,811,577" with "36,403,786" and replace "263,430,161" with "268,022,370"

Page 2, line 28, replace "12,094,114" with "15,503,656" and replace "124,851,343" with "128,260,885"

Page 2, line 29, replace "19,717,463" with "20,900,130" and replace "138,578,818" with "139,761,485"

Page 3, line 3, replace "112,284,910" with "68,008,591" and replace "692,360,434" with "648,084,115"

Page 3, line 4, replace "218,890,181" with "342,634,393" and replace "1,508,974,811" with "1,632,719,023"

Page 3, line 5, replace "331,175,091" with "410,642,984" and replace "2,201,335,245" with "2,280,803,138"

Page 3, after line 6, insert:

"**SECTION 2. APPROPRIATION - FEDERAL FISCAL STIMULUS FUNDS - ADDITIONAL FUNDING APPROVAL.** The funds provided in this section, or so much of the funds as may be necessary, are appropriated from federal funds made available to the state under the federal American Recovery and Reinvestment Act of 2009, not otherwise appropriated, to the department of human services, for the period beginning with the effective date of this Act and ending June 30, 2011, as follows:

Federal medical assistance percentage	$66,500,000

Elderly nutrition services	485,000
Child support incentive matching funds	3,200,000
Rehabilitation services and disability assistance and independent living	2,043,000
Individuals With Disabilities Education Act - Part C	2,140,000
Supplemental nutrition assistance program benefits and administration	9,874,747
Senior employment program	143,288
Older blind	3,170
Total federal funds	$84,389,205

The department of human services may seek emergency commission and budget section approval under chapter 54-16 for authority to spend any additional federal funds received under the federal American Recovery and Reinvestment Act of 2009 in excess of the amounts appropriated in this section, for the period beginning with the effective date of this Act and ending June 30, 2011.

Any federal funds appropriated under this section, except for the funding of $66,500,000 relating to the federal medical assistance percentage and funding of $2,763,082 of child support incentive matching funds, are not a part of the agency's 2011-13 base budget. Any program expenditures made with these funds will not be replaced with state funds after the federal American Recovery and Reinvestment Act of 2009 funds are no longer available.

SECTION 3. GENERAL FUND TRANSFER TO BUDGET STABILIZATION FUND - EXCEPTION - USE OF GENERAL FUND AMOUNTS. Notwithstanding section 54-27.2-02, the state treasurer and the office of management and budget may not include in the amount used to determine general fund transfers to the budget stabilization fund at the end of the 2007-09 biennium under chapter 54-27.2 any general fund amounts resulting from the increased federal share of medical assistance payments resulting from federal medical assistance percentage changes under the federal American Recovery and Reinvestment Act of 2009. The state treasurer and the office of management and budget shall separately account for these amounts and 2009-11 biennium general fund amounts resulting from federal medical assistance percentage changes under the federal American Recovery and Reinvestment Act of 2009 and use these amounts to defray the expenses of continuing program costs of the department of human services from the general fund, for the biennium beginning July 1, 2009, and ending June 30, 2011, as follows:

Inflationary increases for human service providers	$27,345,292
Rate increases for selected medicaid services due to rebasing	21,788,982
Rate increases for nursing homes due to property limit changes and other nursing home increases	7,788,572
Wage increases for employees of nursing homes, basic care, and developmental disabilities services providers and qualified service providers	16,229,317
Salary increases for department of human services employees	14,293,872
Total	$87,446,035

SECTION 4. BANK OF NORTH DAKOTA LOAN AUTHORIZATION - BUDGET SECTION APPROVAL - CONTINGENT APPROPRIATION. If the caseload/utilization of medical services, long-term care, and developmental disabilities services is more than anticipated by the sixty-first legislative assembly, the department of human services, subject to budget section approval, may borrow the sum of $8,500,000, or so much of the sum as may be necessary, from the Bank of North Dakota, which is appropriated for the purpose of providing the state matching share of additional medical assistance grants for medical services, long-term care, and

developmental disabilities services, for the biennium beginning July 1, 2009, and ending June 30, 2011. The department of human services shall request funding from the sixty-second legislative assembly to repay any loan obtained pursuant to provisions of this section, including accrued interest.

SECTION 5. 2009-11 SPENDING LEVEL - AUTHORIZATION. If department of human services expenditures exceed funding levels, including loan proceeds appropriated in section 4 of this Act, approved by the sixty-first legislative assembly during the 2009-11 biennium due to caseload/utilization of programs exceeding the level anticipated by the legislative assembly, the department may continue to spend at the increased level and may seek a deficiency appropriation from the sixty-second legislative assembly."

Page 3, after line 18, insert:
"Supplemental payment - Critical access hospitals 0 400,000"

Page 3, line 19, replace "2,793,692" with "3,443,692"

Page 3, line 21, replace "3,146,298" with "4,196,298"

Page 4, line 5, replace "$4,324,506" with "$4,124,506"

Page 4, remove lines 22 through 29

Page 5, line 1, replace "$14,739,128" with "$17,977,513" and replace "$4,950,451" with "$5,512,441"

Page 5, line 2, replace "$1,000,000" with "$800,000" and replace "$8,788,677" with "$11,665,072"

Page 5, line 4, replace "each employee earning a salary that is less than the eightieth" with "employees beginning July 1, 2009. Basic care and skilled nursing care facilities may not use the money received under this section for providing salary and benefit enhancements to administrators or directors of nursing."

Page 5, remove lines 5 and 6

Page 5, line 9, replace "$18,929,151" with "$21,639,106" and replace "$7,000,000" with "$7,086,807"

Page 5, line 10, replace "$11,929,151" with "$14,552,299"

Page 5, line 11, replace "each employee earning a" with "employees beginning July 1, 2009. Developmental disabilities service providers may not use the money received under this section for providing salary and benefit enhancements to administrators."

Page 5, replace lines 12 and 13 with:

"**SECTION 13. LEGISLATIVE INTENT - MEDICAID PROVIDER PAYMENTS.** It is the intent of the legislative assembly that the department of human services establish a goal to set medicaid payments for hospitals, physicians, chiropractors, and ambulances at 100 percent of cost.

SECTION 14. SUPPLEMENTAL PAYMENT - CRITICAL ACCESS HOSPITALS. The grants - medical assistance line item in subdivision 2 of section 1 of this Act includes the sum of $400,000 of one-time funding from the general fund that the department of human services shall use for providing a supplemental payment to

eligible critical access hospitals. A critical access hospital is eligible for a payment under this section only if its percentage of medical payments exceeds 25 percent of its total annual revenue in its most recent audited financial statements and is located in a city with a population that does not exceed 1,450. The department shall seek federal medicaid funding to provide a portion of the $400,000 supplemental payment. If federal medicaid funding is not available for a portion of the payment, the department may spend the $400,000 from the general fund for making the supplemental payment only if the action will not result in a reduction in federal medicaid funding to the state.

SECTION 15. LEGISLATIVE INTENT - DEMENTIA CARE SERVICES. It is the intent of the sixty-first legislative assembly that the department of human services integrate the dementia care services program established in House Bill No. 1043, as approved by the sixty-first legislative assembly, with the home and community-based care services programs of the department.

SECTION 16. LEGISLATIVE COUNCIL STUDY - TRAUMATIC BRAIN INJURY. During the 2009-11 interim, the legislative council shall consider studying the impact of individuals with traumatic brain injury, including veterans who are returning from wars, on the state's human services system. The study must include an analysis of the estimated cost of providing human service-related services to the individuals with traumatic brain injury. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly.

SECTION 17. LEGISLATIVE INTENT - CHILDREN'S HEALTH INSURANCE PROGRAM OUTREACH. It is the intent of the sixty-first legislative assembly that the department of human services award a contract for outreach services for the state children's health insurance program to an entity other than an insurance company, for the biennium beginning July 1, 2009, and ending June 30, 2011.

SECTION 18. UNSPENT 2007-09 BIENNIUM GENERAL FUND APPROPRIATIONS - EXCEPTION. The amount of $270,000 of the $3,100,000 for a sexual offender treatment addition at the state hospital appropriated in subdivision 3 of section 3 of 2007 Senate Bill No. 2012 is not subject to section 54-44.1-11 and may be spent during the 2009-11 biennium for completing roof repairs at the state hospital."

Page 7, after line 21, insert:

"**SECTION 20. AMENDMENT.** Section 50-24.1-02.6 of the North Dakota Century Code is amended and reenacted as follows:

~~50-24.1-02.6. (Contingent effective date - See note) Medical assistance benefits - Eligibility criteria.~~

~~1. The department shall provide medical assistance benefits to otherwise eligible persons who are:~~

~~a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and~~

~~b. Minors who have countable income that does not exceed an amount determined under subsection 3.~~

~~2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest~~

~~income level achievable without exceeding legislative appropriations for that purpose.~~

~~3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law, that provide an income level for all minors born before September 30, 1983, equal to one hundred percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined and that do not exceed legislative appropriations for that purpose.~~

~~4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.~~

~~(Contingent effective date -- See note)~~ **Medical assistance benefits - Eligibility criteria.**

1. The department shall provide medical assistance benefits to otherwise eligible persons who are:

   a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and

   b. Minors who have countable income that does not exceed an amount determined under subsection 3.

2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.

3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law~~, that provide an income level for all individuals from birth through age eighteen equal to one hundred thirty-three percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined~~.

4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets."

Page 7, after line 29, insert:

"**SECTION 22.** A new subsection to section 50-25.1-05 of the North Dakota Century Code is created and enacted as follows:

The department shall adopt guidelines for case referrals to a children's advocacy center. When cases are referred to a children's advocacy center, all interviews of the alleged abused or neglected child conducted at the children's advocacy center under this section shall be audio-recorded or video-recorded.

SECTION 23. AMENDMENT. Section 50-29-04 of the North Dakota Century Code is amended and reenacted as follows:

50-29-04. Plan requirements. The plan:

1. Must be provided through private contracts with insurance carriers;
2. Must allow conversion to another health insurance policy;
3. Must be based on an actuarial equivalent of a benchmark plan;
4. Must incorporate every state-required waiver approved by the federal government;
5. Must include community-based eligibility outreach services; and
6. Must provide:
   a. A net income eligibility limit of one hundred ~~fifty~~ sixty percent of the poverty line;
   b. A copayment requirement for each pharmaceutical prescription and for each emergency room visit;
   c. A deductible for each inpatient hospital visit;
   d. Coverage for:
      (1) Inpatient hospital, medical, and surgical services;
      (2) Outpatient hospital and medical services;
      (3) Psychiatric and substance abuse services;
      (4) Prescription medications;
      (5) Preventive screening services;
      (6) Preventive dental and vision services; and
      (7) Prenatal services; and
   e. A coverage effective date that is the first day of the month, following the date of application and determination of eligibility."

Page 8, after line 21, insert:

"**SECTION 25. REPEAL.** Section 4 of chapter 422 of the 2007 Session Laws is repealed.

SECTION 26. EMERGENCY. Sections 2 and 18 of this Act are declared to be an emergency measure."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT - LC 98013.0219 FN 2

A copy of the statement of purpose of amendment is on file in the Legislative Council Office.

Engrossed HB 1012 was placed on the Seventh order of business on the calendar.

2009 TESTIMONY

HB 1012

4-7-09

Prepared by the North Dakota Legislative Council staff for Senate Appropriations
March 4, 2009

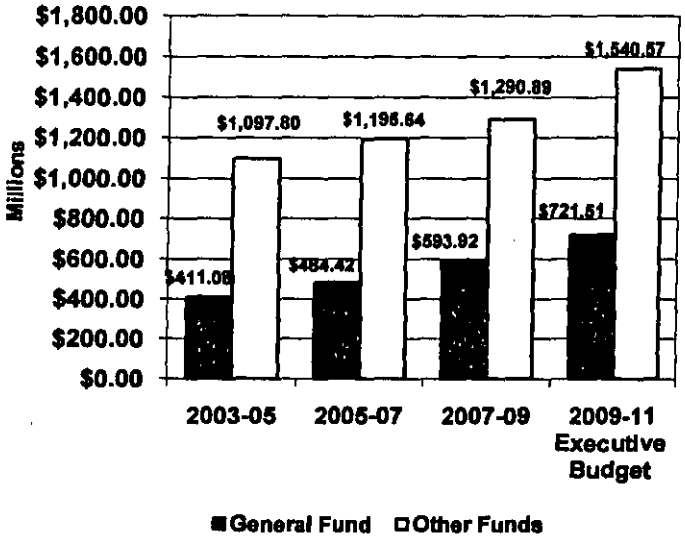
2

Department 325 - Department of Human Services
House Bill No. 1012

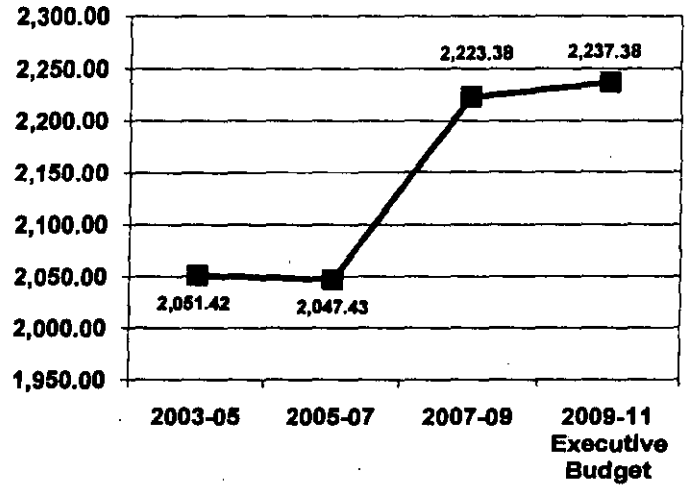
	FTE Positions	General Fund	Other Funds	Total
2009-11 Executive Budget	2,237.38	$721,512,545	$1,540,574,416	$2,262,086,961
2007-09 Legislative Appropriations	2,223.38	593,916,230	1,290,890,297	1,884,806,527[1]
Increase (Decrease)	14.00	$127,596,315	$249,684,119	$377,280,434

[1]The 2007-09 appropriation amounts include $2,759,109, $1,953,442 of which is from the general fund, for the agency's share of the $10 million funding pool appropriated to the Office of Management and Budget for special market equity adjustments for classified employees. The 2007-09 appropriation amounts do not include $1,820,303 of general fund and $22,670,431 of special funds carryover from the 2005-07 biennium.

Agency Funding



FTE Positions



Ongoing and One-Time General Fund Appropriations

	Ongoing General Fund Appropriation	One-Time General Fund Appropriation	Total General Fund Appropriation
2009-11 Executive Budget	$717,216,247	$4,296,298	$721,512,545
2007-09 Legislative Appropriations	582,028,966	11,887,264	593,916,230
Increase (Decrease)	$135,187,281	($7,590,966)	$127,596,315

First House Action

Attached is a summary of first house changes.

Executive Budget Highlights
(With First House Changes in Bold)

	General Fund	Other Funds	Total
Departmentwide			
1. Reflects the additional state matching funds required due to changes in the state's federal medical assistance percentage (FMAP). The FMAP determines the federal and state share of Medicaid, foster care, and other program expenditures. North Dakota's FMAP is decreasing from 63.15 percent in federal fiscal year 2009 to 63.01 percent in federal fiscal year 2010. The department anticipates North Dakota's FMAP to remain at 63.01 percent for federal fiscal year 2011. These changes are also reflected in selected program amounts below.	$10,177,538	($10,202,442)	($24,904)
Increases support from the health care trust fund from $525,597 in the 2007-09 biennium to $3,000,000 for the 2009-11 biennium. This change is also reflected in selected program amounts below.	$0	$2,474,403	$2,474,403

3. Provides a 7 percent **inflationary increase** in the second year of the biennium for rebased services (hospitals, physicians, chiropractors, and ambulances) and a 7 percent per year inflationary increase to providers of other services. The 2007 Legislative Assembly provided a 4 percent inflationary increase for the first year of the 2007-09 biennium and a 5 percent inflationary increase for the second year. These increases are also reflected in selected program amounts below. **The House decreased funding for inflationary increases for rebased services to 6 percent for the second year and to 6 percent per year for all other services.**	$37,156,758	$57,582,866	$94,739,624
4. Provides funding of $5,033,569 to address **salary equity** issues, including funding of $277,790 for the related second-year salary increase. **The House removed this funding.**	$3,458,505	$1,575,064	$5,033,569
5. Reduces funding for salaries and wages by $1 million from the general fund in anticipation of savings resulting from employee turnover and position vacancies. **The House reduced funding for salaries and wages by an additional $6,090,893, of which $2,000,000 was from the general fund, in anticipation of savings resulting from employee turnover and position vacancies.**	($1,000,000)	$0	($1,000,000)
6. Includes funding for paying accrued leave and sick leave of employees anticipated to retire during the 2009-11 biennium	$113,998	$277,948	$391,946
Management			
1. Adds 1 FTE position to perform additional duties required by Statement on Auditing Standards No. 112 regarding communicating internal control matters, including $126,265 for salaries and wages and $2,790 for related operating expenses. **The House removed the FTE position and the related funding.**	$56,724	$72,331	$129,055
2. Removes one-time funding provided for the 2007-09 biennium for the Medicaid management information system replacement project	($3,643,133)		($3,643,133)
Program and Policy			
1. Provides $3,374,210, of which $1,409,603 is from the general fund and $1,964,607 is from retained funds, for **Indian county payments**. The grants are provided at 100 percent of the excess costs calculated, pursuant to North Dakota Century Code (NDCC) Section 50-01.2-03.2(3).	$454,479	$0	$454,479
2. Reduces funding for temporary assistance for needy families (**TANF**) to $23,477,922, of which $5,531,958 is from the general fund and $6,174,667 is from retained funds. The funding level is anticipated to provide services for an average monthly caseload of 2,851 and to provide an average monthly payment of $343.12 per case.	$1,217,016	($3,124,633)	($1,907,617)
3. Provides $22,359,834, of which $350,197 is from the general fund and $6,263,361 is from retained funds and the remainder from federal funds, for **child care grants**. The change reflects an increase of $350,197 from the general fund, an increase of $1,037,542 in retained funds, and an increase of $1,241,647 in federal funds.	$350,197	$2,279,189	$2,629,386
4. Increases federal funding for **food stamps** to provide a total of $204,336,375 of federal funds	$0	$97,318,383	$97,318,383
5. Increases federal funding for the low-income home energy assistance program (**LIHEAP**) to provide a total of $52,562,722 of federal funds	$0	$12,022,292	$12,022,292
6. Provides $482,133,759, of which $138,162,168 is from the general fund, for **medical assistance grants** in the medical services program compared to $394,784,291 provided for the 2007-09 biennium, of which $112,382,988 was from the general fund. Major components of the additional funding are listed below:			

Adds funding for cost and caseload/utilization changes for medical assistance grants in the medical services program, including the cost of continuing the July 2008 inflationary increase for providers of 4 percent for the first year of the 2007-09 biennium and 5 percent for the second year. **The House decreased funding for medical assistance by $25,959,978, of which $9,600,000 is from the general fund, to reduce projected caseload/utilization rates.**	$10,123,581	$43,040,717	$53,164,298
Adds additional general fund support for medical assistance grants in the medical services program as a result of FMAP changes	$3,197,129	($3,197,129)	$0
Adds funding to rebase payment rates for the following services:			
Hospitals	$8,140,450	$13,872,664	$22,013,114
Physicians - **The House decreased funding to 20 percent of the amount needed to rebase to 100 percent of cost.**	4,899,850	8,350,150	13,250,000
Chiropractors - **The House decreased funding to 75 percent of the cost report.**	153,836	262,164	416,000
Ambulances - **The House decreased funding to provide funding equal to 75 percent of the funding provided in the executive budget.**	743,710	1,267,404	2,011,114
Total	$13,937,846	$23,752,382	$37,690,228
Provides for inflationary increases of 7 percent for the second year of the biennium for the rebased services and 7 percent per year for all other services. **The House decreased funding for inflationary increases for rebased services to 6 percent for the second year and to 6 percent per year for all other services.**	$6,734,524	$14,301,146	$21,035,670
Adds funding for increasing medical services dental payments to a minimum of an average of 75 percent of billed charges. **The House decreased funding by $1,955,935, of which $722,547 is from the general fund, to provide a minimum of 70 percent of average billed charges with inflation increases of 0 percent the first year and 7 percent the second year. The House also decreased funding for inflationary increases to 6 percent for the second year.**	$904,167	$1,540,971	$2,445,138
Adds funding to increase medically needy income levels to 83 percent of the federal poverty level. **The House decreased funding by $1,019,326, of which $376,947 is from the general fund, to increase medically needy levels to 75 percent of the federal poverty level.**	$2,041,614	$3,479,245	$5,520,859
7. Increases funding for **Healthy Steps** (children's health insurance program) to provide a total of $35,248,129, of which $9,122,897 is from the general fund, to provide health insurance coverage for an average of 6,021 children at a monthly premium of $243.93. The executive budget recommends raising eligibility requirements for the program to 200 percent of the federal poverty level. As of October 1, 2008, the Healthy Steps income level is 150 percent of the federal poverty level (includes the addition of 1.5 FTE positions). **The House removed the 1.5 new FTE positions and decreased funding to increase the program's eligibility from 150 percent to 160 percent of the federal poverty level.**	$4,473,765	$10,569,618	$15,043,383
8. Includes $19,416,262, of which $18,624,262 is from the general fund and $792,000 is from estate collections, for making Medicare Part D prescription drug **"clawback" payments** to the federal government for the estimated prescription drug costs paid by Medicare for individuals eligible for both Medicare and Medicaid. The amount provided is an increase of $266,647 from the 2007-09 biennium appropriation of $19,149,615 from the general fund.	($525,353)	$792,000	$266,647

9. Provides $422,244,637, of which $153,236,194 is from the general fund, for **nursing facility care** under the long-term care program compared to $370,080,827, of which $132,817,907 was from the general fund, provided for the 2007-09 biennium. Major components of the additional funding are listed below:			
Adds funding for cost and caseload/utilization changes for nursing homes, including the cost of continuing the July 2008 inflationary increase of 5 percent for both years of the 2009-11 biennium. **The House decreased funding for long-term care by $15,143,320, of which $5,000,000 is from the general fund, to reduce projected caseload/utilization rates.**	$9,061,002	$16,095,248	$25,156,250
Adds general fund support for nursing homes as a result of FMAP changes	$3,748,295	($3,748,295)	$0
Provides for an inflationary increase of 7 percent for each year of the 2009-11 biennium for nursing homes, including an increase in funding from the health care trust fund from $525,597 for 2007-09 to $3 million for 2009-11. **The House decreased funding for inflationary increases for nursing homes to 6 percent per year.**	$9,935,325	$16,924,167	$26,859,492
Adds funding to increase the personal needs allowance from $30 to $50 per month for individuals in an institutional setting who are "SSI only" and receive their personal needs allowance from Social Security (funding is based on a January 1, 2010, start date)	$148,068	$0	$148,068
10. Provides $17,070,865, of which $7,859,036 is from the general fund, for **basic care services** compared to $14,083,121, of which $6,097,305 was from the general fund, for the 2007-09 biennium. Major components of the additional funding are listed below:			
Adds funding for cost and caseload/utilization changes for basic care, including the cost of continuing the July 2008 inflationary increase of 5 percent for both years of the 2009-11 biennium. **The House decreased funding for long-term care by $15,143,320, of which $5,600,000 is from the general fund, to reduce projected caseload/utilization rates.**	$199,962	$617,468	$817,430
Adds additional general fund support for basic care as a result of FMAP changes	$92,129	($92,129)	$0
Provides for inflationary increases of 7 percent for each year of the 2009-11 biennium for basic care facilities. **The House decreased funding for inflationary increases for basic care facilities to 6 percent per year.**	$1,469,640	$700,674	$2,170,314
11. Adds funding to increase the funeral set-aside for Medicaid recipients from $5,000 to $7,000. **The House decreased funding by $283,000, of which $103,922 is from the general fund, to provide for an increase in the funeral set-aside from $5,000 to $6,000.**	$208,571	$357,429	$566,000
12. Increases funding for service payments for elderly and disabled **(SPED) and expanded SPED** to $18,057,693, of which $17,190,678 is from the general fund, compared to the 2007-09 biennium appropriation of $12,708,265, of which $12,111,009 was from the general fund. Major changes include:			
Increases funding for cost and caseload/utilization changes for SPED and expanded SPED and includes the cost of continuing the July 2008 inflationary increase of 5 percent for both years of the 2009-11 biennium	$2,846,777	$156,058	$3,002,835
Provides for inflationary increases of 7 percent for each year of the 2009-11 biennium for SPED and expanded SPED providers. **The House decreased funding for inflationary increases to 6 percent per year.**	$1,628,744	$82,017	$1,710,761

Adds funding for revising the SPED fee schedule based on the actual cost-of-living adjustment through January 2008 and an estimated cost-of-living adjustment for January 2009 to allow individuals with higher income levels to receive SPED services without paying a fee	$571,472	$30,077	$601,549
13. Increases funding for the **home and community-based care waiver** to $9,607,825, of which $3,552,959 is from the general fund, compared to the 2007-09 biennium appropriation of $4,943,345, of which $1,855,465 was from the general fund. Major changes include:			
Increases funding for cost and caseload/utilization changes for the home and community-based care waiver and includes the cost of continuing the July 2008 inflationary increase of 5 percent for both years of the 2009-11 biennium	$962,033	$1,913,938	$2,875,971
Adds additional general fund support for the home and community-based care waiver as a result of FMAP changes	$74,048	($74,048)	$0
Provides for inflationary increases of 7 percent for each year of the 2009-11 biennium for home and community-based care waiver providers. **The House decreased funding for inflationary increases to 6 percent per year.**	$314,701	$536,242	$850,943
Adds funding for implementing a waiver for children's hospice services (funding is for the second year of the 2009-11 biennium)	$316,700	$539,710	$856,410
14. Increases funding for **targeted case management** to $1,985,916, of which $734,368 is from the general fund, compared to the 2007-09 biennium appropriation of $923,325, of which $332,692 was from the general fund. Major changes include:			
Increases funding for cost and caseload/utilization changes for targeted case management and includes the cost of continuing the July 2008 inflationary increase of 5 percent for both years of the 2009-11 biennium	$313,440	$556,467	$869,907
Adds additional general fund support for targeted case management as a result of FMAP changes	$16,972	($16,972)	$0
Provides for inflationary increases of 7 percent for each year of the 2009-11 biennium for targeted case management providers. **The House decreased funding for inflationary increases to 6 percent per year.**	$71,264	$121,420	$192,684
15. Increases funding for the **personal care option** to $23,919,788, of which $8,845,373 is from the general fund, compared to the 2007-09 biennium appropriation of $19,086,421, of which $6,876,755 was from the general fund. Major changes include:			
Increases funding for cost and caseload/utilization changes for the personal care option and includes the cost of continuing the July 2008 inflationary increase of 5 percent for both years of the 2009-11 biennium	$247,518	$438,335	$685,853
Adds additional general fund support for the personal care option as a result of FMAP changes	$187,359	($187,359)	$0
Provides for inflationary increases of 7 percent for each year of the 2009-11 biennium for personal care option providers	$511,819	$872,249	$1,384,068
Adds funding for the addition of a third tier of personal care that would allow a maximum of 1,200 units of care per month (Funding is based on a January 1, 2010, start date. Currently, the maximum number of units of care available is 960 units per month.)	$1,021,922	$1,741,524	$2,763,446
16. Provides $323,056,043, of which $118,885,733 is from the general fund, for **developmental disabilities services** under the long-term care program compared to $274,423,470, of which $95,952,600 was from the general fund, provided for the 2007-09 biennium. Major components of the additional funding are:			

Adds funding for cost and caseload/utilization changes for developmental disabilities services, including the cost of continuing the July 2008 inflationary increase of 5 percent for both years of the 2009-11 biennium. **The House decreased funding for developmental disabilities grants by $6,695,511, of which $2,476,000 is from the general fund, to reduce projected caseload/utilization rates.**	$6,371,084	$11,099,000	$17,470,084
Adds general fund support for developmental disabilities services as a result of FMAP changes and the removal of funding from Bank of North Dakota loan proceeds	$5,073,875	($5,098,779)	($24,904)
Provides for inflationary increases of 7 percent for each year of the 2009-11 biennium for developmental disabilities services providers. **The House decreased funding for inflationary increases to 6 percent per year.**	$10,508,471	$18,028,646	$28,538,117
Adds general fund support to continue developmental disabilities grants funded with Bank of North Dakota loan proceeds in the 2007-09 biennium	$3,500,000	($3,500,000)	$0
Adds funding for developmental disabilities services to compensate families at the same level as ICF/MR providers serving children with similar intense medical needs	$238,274	$406,056	$644,330
Adds funding to compensate developmental disabilities services providers serving adults at the same level as ICF/MR providers serving adults with similar intense medical needs	$297,842	$507,570	$805,412
Adds funding to increase the personal needs allowance for individuals in an ICF/MR facility from $50 to $60 per month	$38,341	$65,339	$103,680
Adds funding to implement a home and community-based care waiver to provide intensive support for young children who have a diagnosis of autism spectrum disorder (funding is for the second year of the 2009-11 biennium) (includes the addition of 1 new FTE position). **The House removed the new FTE position.**	$450,724	$721,019	$1,171,743
17. Reduces funding for foster care to $58,900,156, of which $8,207,265 is from the general fund, for **foster care services** compared to the 2007-09 biennium appropriation of $60,897,869, of which $8,335,697 is from the general fund. Major components of the additional funding are:			
Adds funding for cost and caseload/utilization changes for foster care services, including the cost of continuing the July 2008 inflationary increase of 5 percent for both years of the 2009-11 biennium	($1,315,147)	($6,250,955)	($7,566,102)
Adds general fund support for foster care services as a result of FMAP changes	$146,163	($146,163)	$0
Provides for inflationary increases of 7 percent for each year of the 2009-11 biennium for foster care providers. **The House decreased funding for inflationary increases to 6 percent per year.**	$1,764,636	$5,573,792	$7,338,428
18. Provides $18,104,961, of which $7,407,980 is from the general fund, for **subsidized adoption** compared to the 2007-09 biennium appropriation of $13,894,075, of which $5,738,361 was from the general fund	$1,669,619	$2,541,267	$4,210,886
19. Adds funding to establish a pilot **aging and disability resource center. The House removed this funding.**	$600,000	$0	$600,000
20. Increases funding for **family preservation services** with Native American tribes (Currently, the department contracts with the Three Affiliated Tribes - Mandan, Hidatsa, and Arikara Nation and the Turtle Mountain Band of Chippewa Indians to deliver family preservation services. The additional funding would extend the contracts to the Standing Rock Sioux Tribe and the Spirit Lake Nation.)	$300,000	$0	$300,000

21. Increases funding for **centers of independent living** from $1,344,539, of which $530,958 is from the general fund, to $2,144,539, of which $1,330,958 is from the general fund. **The House decreased funding by $400,000.**	$800,000	$0	$800,000
22. Provides funding for **senior service providers** to supplement Older Americans Act funds	$900,000	$0	$900,000
23. Provides funding and 1 FTE position for **background checks** for child care providers	$323,921	$0	$323,921
24. Adds funding for **Governor's Prevention and Advisory Council** grants. (For the 2007-09 biennium, funding of $100,000 from the community health trust fund was appropriated to the Governor's office for the grants.) **The House removed this funding.**	$200,000	$0	$200,000
25. Provides funding of $700,000, of which $300,000 is from the general fund, for **compulsive gambling services** compared to $400,000 of special funds from lottery proceeds provided for the 2007-09 biennium. **The House decreased funding from the general fund from $300,000 to $150,000.**	$300,000	$0	$300,000
26. Deletes 7.5 FTE positions in the child support enforcement program	($264,174)	($357,796)	($621,970)
State Hospital			
1. Removes one-time funding provided for the 2007-09 biennium ($3,100,000 for a sexual offender treatment addition, $3,062,757 for capital improvements, and $1,153,500 for extraordinary repairs)	($7,316,257)		($7,316,257)
2. Reduces funding for salaries and wages in anticipation of savings resulting from employee turnover and position vacancies	($917,041)	($439,733)	($1,356,774)
3. Adds funding and 6 FTE positions for a **global behavioral health initiative** to address the capacity issues at the community level by providing a consistent rate among all regions for behavioral services. **The House removed this funding.**	$516,815		$516,815
4. Adds general fund support as the result of FMAP changes	$61,040	($61,040)	$0
5. Provides **one-time funding** for extraordinary repairs. **The House decreased this funding by $1 million.**	$3,231,017		$3,231,017
6. Provides **one-time funding** for equipment over $5,000	$246,220		$246,220
Developmental Center			
1. Removes one-time funding provided for the 2007-09 biennium ($300,000 for capital improvements, $547,092 for extraordinary repairs, and $80,782 for equipment)	($972,874)		($972,874)
2. Adds general fund support as the result of FMAP changes	$471,861	($471,861)	$0
3. Provides **one-time funding** for extraordinary repairs. **The House decreased this funding by $150,000.**	$712,675		$712,675
4. Provides **one-time funding** for equipment over $5,000	$75,000		$75,000
Human Service Centers			
1. Adds general fund support as the result of FMAP changes	$439,838	($439,838)	$0
2. Adds funding and 5 FTE positions at the following human service centers for a **global behavioral health initiative** to address the capacity issues at the community level by providing a consistent rate among all regions for behavioral services:			
North Central - Grants	$1,358,307	$100,000	$1,458,307
Northeast - Grants	280,663	81,200	361,863
Southeast - 4 FTE positions ($406,535), operating expenses ($7,840), and grants ($959,495)	1,190,124	183,746	1,373,870
South Central - 1 FTE position ($113,079) and operating expenses ($14,590)	127,669		127,669
West Central - Grants	279,546		279,546

Badlands - Grants	665,000	140,000	805,000
Total - **The House removed all funding and FTE positions except for funding of $315,360, of which $236,520 is from the general fund, for contract staffing at the Cooper House through the Southeast Human Service Center.**	$3,901,309	$504,946	$4,406,255
3. Adds funding and 4 FTE positions at the following human service centers for providing additional **oversight** and **monitoring** of developmental disabilities cases as required by the Centers for Medicare and Medicaid Services:			
North Central - 1 FTE case manager position	$58,793	$52,354	$111,147
Northeast - 1 FTE case manager position	58,793	52,354	111,147
Southeast - 1 FTE case manager position	58,793	52,354	111,147
West Central - 1 FTE case manager position	58,793	52,354	111,147
Total - **The House removed all funding and FTE positions.**	$235,172	$209,416	$444,588
4. Adds funding and 1 FTE program coordinator position for the **partnership program** at the Southeast Human Service Center ($99,970 for salaries and wages and $1,960 for related operating expenses). **The House removed this funding and FTE position.**	$61,490	$40,440	$101,930
5. Provides funding for **young adult transition residential services** at the Southeast Human Service Center ($426,844) and the West Central Human Service Center ($750,000). **The House removed this funding.**	$834,622	$342,222	$1,176,844
6. Provides funding and 1 FTE MI case manager position to complete vulnerable adult protection services at the South Central Human Service Center ($58,020 for salaries and wages and $15,108 for related operating expenses). **The House removed this funding and FTE position.**	$73,128		$73,128
7. Provides for inflationary increases of 7 percent for each year of the 2009-11 biennium for providers of the human service centers as follows:			
Northwest	$193,462	$1,064	$194,526
North Central	387,170	21,789	408,959
Lake Region	208,670		208,670
Northeast	443,799	169,774	613,573
Southeast	405,117	1,172	406,289
South Central	325,991		325,991
West Central	490,149	6,751	496,900
Badlands		25,217	25,217
Total - **The House decreased funding for inflationary increases to 6 percent per year.**	$2,454,358	$225,767	$2,680,125
8. Provides **one-time funding** for equipment over $5,000	$26,966	$28,534	$55,500

Other Sections in Bill

Transfers - Section 3 provides that the Department of Human Services may transfer appropriation authority between line items within each subdivision and between subdivisions for the 2009-11 biennium. The department is to report to the Budget Section after June 30, 2010, any transfers made in excess of $50,000 and to the Appropriations Committees of the 62nd Legislative Assembly any transfers made.

Legislative Council study - Child support enforcement - Section 5 provides for a Legislative Council study of the Department of Human Services' child support enforcement program.

Legislative Council study - Long-term care - Section 6 provides for a Legislative Council study of long-term care services in the state.

Additional federal funds - American Recovery and Reinvestment Act - Section 7 provides that if the Department of Human Services receives federal funds made available to the state from the American Recovery and Reinvestment Act or other federal ac[t] stimulate the national economy or to address state fiscal recovery in excess of the federal funding appropriated by the [L]islative Assembly, the Department of Human Services may accept the additional funding but may not spend the funding u[n]propriated by the Legislative Assembly.

Supplemental payments - Basic care and nursing home facility salary and benefit increase - Section 8 provides that funding of $14,739,128, of which $4,950,451 is from the general fund, $1,000,000 is from the health care trust fund, and $8,788,677 is from

federal funds, is appropriated in Section 1 of the bill for providing supplemental payments to basic care and skilled nursing care facilities to allow for a salary and benefit increase for each employee earning a salary that is less than the 80th percentile of the salary range at ·ch facility.

·pplemental payments - Developmental disabilities providers salary and benefit increase - Section 9 provides that funding of .8,929,151, of which $7,000,000 is from the general fund and $11,929,151 is from federal funds, is appropriated in Section 1 of the bill for providing supplemental payments to developmental disabilities providers to allow for a salary and benefit increase for each employee earning a salary that is less than the 90th percentile of the salary range of each developmental disabilities provider.

Developmental Center admissions - Section 10 amends NDCC Section 25-04-05 regarding screenings required prior to admission or readmission to the Developmental Center.

Nursing care facility - Personal needs allowance - Section 11 amends NDCC Section 50-24.5-04 to increase the personal needs allowance for individuals in basic care facilities from $60 to $75 per month.

Health care trust fund - Section 12 amends NDCC Section 50-30-02 to provide that money in the health care trust fund may not be included in draft appropriation acts under Section 54-44.1-06.

Continuing Appropriations

Child support collection and disbursement - NDCC Section 14-09-25 - Allows the department to receive child support payments and provide the funds to the custodial parent or appropriate governmental entity for those custodial parents receiving governmental assistance.

Child support improvement account - NDCC Section 50-09-15.1 - Allows the department to receive federal child support incentive funds and spend the funds in accordance with its business plan to improve the child support collection process.

Major Related Legislation

House Bill No. 1043 - This bill directs the Department of Human Services to contract for a dementia care services program in each area of the state served by a regional human service center to provide personalized care consultation services, training, and education relating to dementia; provides a $1.2 million general fund appropriation for the program; and provides for a report to the Legislative Council regarding the outcomes of the program.

House Bill No. 1044 - This bill provides that the Department of Human Services develop, within current appropriations, a program for services to transition-aged youth at risk.

·use Bill No. 1090 - This bill identifies the child care program currently administered by the Department of Human Services in statute.

·use Bill No. 1175 - This bill provides statutory changes regarding child support enforcement.

House Bill No. 1214 - This bill authorizes the Department of Human Services to sell land at the Developmental Center in Walsh County.

House Bill No. 1303 - This bill increases the amount of allowable bad debt expenses when determining nursing home rates.

House Bill No. 1307 - This bill provides for an increase of certain education expenses for determining nursing home rates.

House Bill No. 1327 - This bill allows a long-term care facility to reestablish 75 percent of its bed capacity under certain circumstances.

House Bill No. 1425 - This bill requires the state to pay the costs, in excess of the amount provided by the federal government, for the foster care and subsidized adoption programs.

House Bill No. 1433 - This bill provides a $337,114 special funds appropriation to the Department of Human Services for funding a special care rate for qualifying nursing homes.

House Bill No. 1472 - This bill creates an early childhood services advisory board.

House Bill No. 1477 - This bill amends NDCC Section 50-24.1-02.3 to increase the funeral set-aside for Medicaid recipients from $5,000 to $6,000.

House Bill No. 1478 - This bill amends NDCC Section 50-29-04 to increase the eligibility income limits for Healthy Steps to 160 percent of the federal poverty level.

House Bill No. 1540 - This bill relates to the funding of economic assistance programs in counties with federally recognized Indian reservation land. The bill provides a $337,423 general fund appropriation to the Department of Human Services for additional payments to counties that contain federally recognized Indian reservation land.

House Bill No. 1556 - This bill appropriates $100,000 from the general fund and $100,000 from special funds to the Department of Human Services for a study by the department of rates for private licensed developmental disabilities providers.

Senate Bill No. 2123 - This bill allows the Department of Human Services to require criminal history record checks in certain ·mstances.

·ate Bill No. 2162 - This bill relates to early childhood services.

Senate Bill No. 2174 - This bill establishes an autism spectrum disorder task force and provides a $3,000 general fund appropriation to the Department of Human Services for paying for expenses of the task force.

Senate Bill No. 2198 - This bill provides a $864,000 general fund appropriation to the Department of Human Services for providing services to individuals with traumatic brain injury.

Senate Bill No. 2231 - This bill provides a $350,000 general fund appropriation to the Department of Human Services to strengthen capacity of the North Dakota charitable emergency feeding network.

Senate Bill No. 2283 - This bill appropriates $964,031 from the general fund and $1,582,480 from federal funds to the Department of Human Services for expanding medical assistance benefits for pregnant women if approved by the federal government, but not earlier than January 2010.

Senate Bill No. 2286 - This bill provides a $20,000 general fund appropriation to the Department of Human Services for a grant to the Silver-Haired Education Association.

Senate Bill No. 2391 - This bill provides a $500,000 appropriation to the Department of Human Services from federal temporary assistance for needy families block grant funds for the alternatives-to-abortion program.

Senate Bill No. 2396 - This bill provides a $1,085,000 general fund appropriation to the Department of Human Services for implementing programs associated with the family impact initiative.

ATTACH:1

STATEMENT OF PURPOSE OF AMENDMENT:

House Bill No. 1012 - Funding Summary

	Executive Budget	House Changes	House Version
DHS - Management			
Salaries and wages	$19,303,132	($5,642,232)	$13,660,900
Operating expenses	46,539,524	(11,454)	46,528,070
Total all funds	$65,842,656	($5,653,686)	$60,188,970
Less estimated income	36,027,838	(1,986,577)	34,041,261
General fund	$29,814,818	($3,667,109)	$26,147,709
FTE	108.35	(1.00)	107.35
DHS - Program/Policy			
Salaries and wages	$44,664,959	($701,486)	$43,963,473
Operating expenses	73,251,082	(1,075,001)	72,176,081
Capital assets	13,000		13,000
Grants	456,965,308	(1,834,504)	455,130,804
Grants - Medical assistance	1,344,821,814	(38,389,058)	1,306,432,756
Total all funds	$1,919,716,163	($42,000,049)	$1,877,716,114
Less estimated income	1,375,189,679	(25,107,472)	1,350,082,207
General fund	$544,526,484	($16,892,577)	$527,633,907
FTE	363.50	(2.50)	361.00
DHS - State Hospital			
State Hospital	$70,001,527	($3,089,601)	$66,911,926
Total all funds	$70,001,527	($3,089,601)	$66,911,926
Less estimated income	19,563,594	(1,052,440)	18,511,154
General fund	$50,437,933	($2,037,161)	$48,400,772
FTE	472.51	(6.00)	466.51
DHS - Developmental Center			
Developmental Center	$54,015,265	($1,025,546)	$52,989,719
Total all funds	$54,015,265	($1,025,546)	$52,989,719
Less estimated income	37,160,672	(588,028)	36,572,644
General fund	$16,854,593	($437,518)	$16,417,075
FTE	445.54	0.00	445.54
DHS - Northwest HSC			
Northwest Human Service Center	$8,562,127	($352,995)	$8,209,132
Total all funds	$8,562,127	($352,995)	$8,209,132
Less estimated income	3,680,172	(208,176)	3,471,996
General fund	$4,881,955	($144,819)	$4,737,136
FTE	44.75	0.00	44.75
DHS - North Central HSC			
North Central Human Service Center	$20,923,799	($2,006,026)	$18,917,773
Total all funds	$20,923,799	($2,006,026)	$18,917,773
Less estimated income	8,825,362	(408,515)	8,416,847
General fund	$12,098,437	($1,597,511)	$10,500,926
FTE	117.78	(1.00)	116.78
DHS - Lake Region HSC			
Lake Region Human Service Center	$11,011,109	($370,042)	$10,641,067

Total all funds	$11,011,109	($370,042)	$10,641,067
Less estimated income	4,747,559	(222,849)	4,524,710
General fund	$6,263,550	($147,193)	$6,116,357
FTE	62.00	0.00	62.00
DHS - Northeast HSC			
Northeast Human Service Center	$26,376,851	($759,946)	$25,616,905
Total all funds	$26,376,851	($759,946)	$25,616,905
Less estimated income	14,320,535	(291,372)	14,029,163
General fund	$12,056,316	($468,574)	$11,587,742
FTE	138.10	(1.00)	137.10
DHS - Southeast HSC			
Southeast Human Service Center	$32,020,964	($2,260,109)	$29,760,855
Total all funds	$32,020,964	($2,260,109)	$29,760,855
Less estimated income	15,966,058	(777,670)	15,188,388
General fund	$16,054,906	($1,482,439)	$14,572,467
FTE	188.35	(6.00)	182.35
DHS - South Central HSC			
South Central Human Service Center	$15,913,332	($656,012)	$15,257,320
Total all funds	$15,913,332	($656,012)	$15,257,320
Less estimated income	6,970,002	(269,753)	6,700,249
General fund	$8,943,330	($386,259)	$8,557,071
FTE	87.50	(2.00)	85.50
DHS - West Central HSC			
West Central Human Service Center	$26,008,933	($1,646,465)	$24,362,468
Total all funds	$26,008,933	($1,646,465)	$24,362,468
Less estimated income	12,693,292	(439,271)	12,254,021
General fund	$13,315,641	($1,207,194)	$12,108,447
FTE	136.30	(1.00)	135.30
DHS - Badlands HSC			
Badlands Human Service Center	$11,694,235	($931,239)	$10,762,996
Total all funds	$11,694,235	($931,239)	$10,762,996
Less estimated income	5,429,653	(247,482)	5,182,171
General fund	$6,264,582	($683,757)	$5,580,825
FTE	72.70	0.00	72.70
Bill Total			
Total all funds	$2,262,086,961	($60,751,716)	$2,201,335,245
Less estimated income	1,540,574,416	(31,599,605)	1,508,974,811
General fund	$721,512,545	($29,152,111)	$692,360,434
FTE	2237.38	(20.50)	2216.88

›use Bill No. 1012 - DHS - Management - House Action

	Executive Budget	House Changes[1]	House Version
Salaries and wages	$19,303,132	($5,642,232)	$13,660,900
Operating expenses	46,539,524	(11,454)	46,528,070
Total all funds	$65,842,656	($5,653,686)	$60,188,970
Less estimated income	36,027,838	(1,986,577)	34,041,261
General fund	$29,814,818	($3,667,109)	$26,147,709
FTE	108.35	(1.00)	107.35

[1]Management - House changes:	FTE	General Fund	Other Funds	Total
Administration Support Program				
Remove 1 new FTE position added in the executive budget to perform additional duties required by Statement on Auditing Standards No. 112 regarding communicating internal control matters, including $126,265 for salaries and wages and $2,790 for operating expenses	(1.00)	($56,724)	($72,331)	($129,055)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(131,076)	(268,110)	(399,186)
Decrease funding for department travel		(14,256)	(15,184)	(29,440)
Remove funding for state employee salary equity adjustments		(3,458,506)	(1,575,064)	(5,033,570)
rovide funding for expenses relating to the early childhood services advisory board created in House Bill No. 1472		20,776	0	20,776
Division of Information Technology Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(27,323)	(55,888)	(83,211)
Total House changes - Management	(1.00)	($3,667,109)	($1,986,577)	($5,653,686)

Other changes affecting Management programs or multiple programs of the department:

Add a section to provide for a Legislative Council study of the Department of Human Services child support enforcement program including the review of arrearages in terms of total owned and interest accrued and the review of child support enforcement in other states.

Add a section to provide that if the Department of Human Services receives federal funding to stimulate the national economy or to address state fiscal recovery in excess of the federal funding appropriated by the 2009 Legislative Assembly, the department may accept the additional federal funds, but may not spend the funding until appropriated by the Legislative Assembly.

House Bill No. 1012 - DHS - Program/Policy - House Action

	Executive Budget	House Changes[1]	House Version
Salaries and wages	$44,664,959	($701,486)	$43,963,473
Operating expenses	73,251,082	(1,075,001)	72,176,081
Capital assets	13,000		13,000
Grants	456,965,308	(1,834,504)	455,130,804
Grants - Medical assistance	1,344,821,814	(38,389,058)	1,306,432,756
Total all funds	$1,919,716,163	($42,000,049)	$1,877,716,114
Less estimated income	1,375,189,679	(25,107,472)	1,350,082,207
General fund	$544,526,484	($16,892,577)	$527,633,907
FTE	363.50	(2.50)	361.00

[1]Program and Policy - House changes:	FTE	General Fund	Other Funds	Total
Economic Assistance Policy Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($48,462)	($99,126)	($147,588)
Child Support Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(68,787)	(140,700)	(209,487)
Medical Services Program				
Decrease funding for department travel		(21,830)	(17,306)	(39,13
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(44,010)	(90,020)	(134,030
Decrease funding added in the executive budget for medically needy to reflect income levels of 75 percent of the federal poverty level (The executive budget included funding of $5,520,859, of which $2,041,614 is from the general fund, to increase medically needy income levels to 83 percent of the federal poverty level.)		(376,947)	(642,379)	(1,019,326)
Decrease funding added in the executive budget for inflation increases for rebased services from 7 percent to 6 percent for the second year of the biennium		(793,420)	(1,389,355)	(2,182,775)
Decrease funding added in the executive budget for rebasing physician payment rates. The House version provides $10,600,000, of which $3,919,880 is from the general fund, for rebasing rates to 20 percent of the amount needed to rebase to 100 percent of cost. The executive budget included funding of $13,250,000, of which $4,899,850 is from the general fund, for rebasing physician payment rates to 25 percent of the amount needed to rebase to 100 percent of cost.		(979,970)	(1,670,030)	(2,650,000)
Decrease funding added in the executive budget for rebasing chiropractor payment rates. The House version provides $312,000, of which $115,377 is from the general fund, for rebasing rates to 75 percent of the cost report. The executive budget included funding of $416,000, of which $153,836 is from the general fund, for rebasing rates to 100 percent of cost.		(38,459)	(65,541)	(104,000)
Decrease funding added in the executive budget for rebasing ambulance payment		(185,927)	(316,851)	(502,77

rates. The House version provides $1,508,336, of which $557,783 is from the general fund, to provide funding equal to 75 percent of the funding provided in the executive budget. The executive budget included funding of $2,011,114, of which $743,710 is from the general fund, to rebase ambulance payment rates to Medicare rates.				
Decrease funding added in the executive budget for rebasing dentist payment rates from a minimum of 75 percent of average billed charges with inflation increases of 7 percent each year to a minimum of 70 percent of average billed charges with inflation increases of 0 percent the first year and 7 percent the second year		(722,547)	(1,233,388)	(1,955,935)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(111,048)	(561,337)	(672,385)
Decrease funding for medical services to reduce projected caseload/utilization rates		(9,600,000)	(16,359,978)	(25,959,978)
Decrease funding for the funeral set-aside for Medicaid recipients by $283,000, of which $103,922 is from the general fund, to provide for an increase in the set-aside from $5,000 to $6,000 as provided for in House Bill No. 1477. The executive budget included funding of $566,000, of which $208,571 is from the general fund, to increase the funeral set-aside for Medicaid recipients from $5,000 to $7,000.		(103,922)	(179,078)	(283,000)
Decrease funding for the state children's health insurance program by $2,809,222, of which $727,025 is from the general fund, including the removal of 1.5 FTE positions. The House version provides funding to increase the state children's health insurance program from 150 percent to 160 percent of the federal poverty level in accordance with provisions of House Bill No. 1478. The executive budget included funding of $4,429,649, of which $1,146,392 is from the general fund, for increasing the eligibility for the state children's health insurance program from 150 percent to 200 percent of the federal poverty level and to add 1.5 new FTE positions.	(1.50)	(727,025)	(2,082,197)	(2,809,222)
Long-Term Care Program				
Add funding to increase the personal needs allowance for individuals in basic care facilities from $60 to $75 per month (funding provided is for a January 1, 2010, effective date)		112,320	0	112,320
Add funding to increase the personal needs allowance for individuals in an ICF/MR facility from $60 per month as recommended in the executive budget to $75 per month (funding provided is for a January 1, 2010, effective date)		57,511	98,009	155,520
Add funding to increase nursing facility bed limits in the formula for nursing home payments from $138,907 to $169,098 for single rooms and $92,604 to $112,732 for double rooms (Of the $877,518, $324,506 is from the health care trust fund and $553,012 is from federal funds.)		0	877,518	877,518
Add funding of $14,739,128, of which $4,950,451 is from the general fund, $1 million is from the health care trust fund, and $8,788,677 is from federal funds, to provide a salary and benefit supplemental payment for individuals employed by basic care and nursing care facilities earning a salary that is less than the 80th percentile of the salary range at each facility		4,950,451	9,788,677	14,739,128
Add funding to provide for a salary and benefit supplemental payment for		7,000,000	11,929,151	18,929,151

developmental disabilities providers currently earning a salary that is less than the 90th percentile of the salary range of each provider				
Remove the new FTE position added in the 2009-11 executive budget relating to the implementation of a home and community-based care waiver to provide support for children who have a diagnosis of autism spectrum disorder	(1.00)	(66,872)	(66,871)	(133,743)
Provide funding for increasing the payment rates for children and adults who are severely medically fragile and behaviorally challenged residing at the Anne Carlsen Center and other developmental disabilities providers experiencing losses		438,900	747,957	1,186,857
Remove funding included in the executive budget for the addition of a third tier of personal care that would allow a maximum of 1,200 units of care per month		(1,021,922)	(1,741,524)	(2,763,446)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(4,544,584)	(7,103,292)	(11,647,876)
Decrease funding for long-term care to reduce projected caseload/utilization rates		(5,600,000)	(9,543,320)	(15,143,320)
Decrease funding for developmental disabilities grants to reduce projected caseload/utilization rates		(2,476,000)	(4,219,511)	(6,695,511)
Aging Services Program				
Remove funding for a pilot aging and disability resource center		(600,000)	0	(600,000)
Decrease funding for department travel		(3,506)	(10,464)	(13,970)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(3,350)	(6,852)	(10,20.
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(15,200)	0	(15,200)
Children and Family Services Program				
Decrease funding for department travel		(1,054)	(2,652)	(3,706)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(7,754)	(15,860)	(23,614)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(436,192)	(823,013)	(1,259,205)
Mental Health and Substance Abuse Program				
Decrease funding for department travel		(15,842)	(45,715)	(61,557)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(7,940)	(16,241)	(24,181)
Decrease funding for compulsive gambling services by $150,000 from the general fund, from $700,000, of which $300,000 is from the general fund and $400,000 is from special funds from lottery proceeds, as provided for in the executive budget to $550,000, of which $150,000 is from the general fund and $400,000 is from special funds from lottery proceeds. The 2007-09 legislative appropriation for compulsive gambling services is $400,000 of special funds from lottery proceeds.		(150,000)	0	(150,000)

Remove funding for Governor's Prevention and Advisory Council grants		(200,000)	0	(200,000)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(21,237)	0	(21,237)
Developmental Disabilities Council				
Decrease funding for department travel		0	(4,446)	(4,446)
Developmental Disabilities Division				
Decrease funding for department travel		(7,536)	(32,975)	(40,511)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(3,455)	(7,067)	(10,522)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(27,199)	0	(27,199)
Vocational Rehabilitation				
Decrease funding for department travel		(17,096)	(56,242)	(73,338)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(2,666)	(5,453)	(8,119)
Decrease funding for centers for independent living by $400,000 from the general fund, from $2,144,539, of which $1,330,958 is from the general fund, as included in the executive budget to $1,744,539, of which $930,958 is from the general fund		(400,000)	0	(400,000)
Total House changes - Program and Policy	(2.50)	($16,892,577)	($25,107,472)	($42,000,049)

Other changes affecting Program and Policy programs:

Add a section of legislative intent regarding the funding for basic care and nursing home facility salary and benefit supplemental payments

Add a section of legislative intent regarding the funding for developmental disabilities providers salary and benefit supplemental payments

Amend North Dakota Century Code (NDCC) Section 50-30-02 relating to the health care trust fund to provide that money in the fund may not be included in drafts of appropriation bills introduced as part of the executive budget

Amend NDCC Section 50-24.5-04 to increase the personal needs allowance for individuals in basic care facilities from $60 to $75 per month

Add a section to provide for a Legislative Council study of long-term care services

House Bill No. 1012 - DHS - State Hospital - House Action

	Executive Budget	House Changes[1]	House Version
State Hospital	$70,001,527	($3,089,601)	$66,911,926
Total all funds	$70,001,527	($3,089,601)	$66,911,926
Less estimated income	19,563,594	(1,052,440)	18,511,154
General fund	$50,437,933	($2,037,161)	$48,400,772
FTE	472.51	(6.00)	466.51

[1]State Hospital - House changes:	FTE	General Fund	Other Funds	Total
Decrease one-time funding for extraordinary repairs from $3,231,017 to $2,231,017		($1,000,000)	$0	($1,000,000)
Remove funding included in the executive budget for the global health initiative, including 6 new FTE positions	(6.00)	(516,815)	0	(516,815)
Decrease funding for department travel		(9,206)	(6,930)	(16,136)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(511,140)	(1,045,510)	(1,556,650)
Total House changes - State Hospital	(6.00)	($2,037,161)	($1,052,440)	($3,089,601)

House Bill No. 1012 - DHS - Developmental Center - House Action

	Executive Budget	House Changes[1]	House Version
Developmental Center	$54,015,265	($1,025,546)	$52,989,719
Total all funds	$54,015,265	($1,025,546)	$52,989,719
Less estimated income	37,160,672	(588,028)	36,572,644
General fund	$16,854,593	($437,518)	$16,417,075
FTE	445.54	0.00	445.54

[1]Developmental Center - House changes:	FTE	General Fund	Other Funds	Total
Decrease one-time funding for extraordinary repairs from $712,675 to $562,675		($150,000)	$0	($150,000)
Decrease funding for department travel		(148)	(228)	(376)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(287,370)	(587,800)	(875,170)
Total House changes - Developmental Center	0.00	($437,518)	($588,028)	($1,025,546)

ıse Bill No. 1012 - Human Service Centers - General Fund Summary of House Action

	Executive Budget	House Changes[1]	House Version
DHS - Northwest HSC	$4,881,955	($144,819)	$4,737,136
DHS - North Central HSC	12,098,437	(1,597,511)	10,500,926
DHS - Lake Region HSC	6,263,550	(147,193)	6,116,357
DHS - Northeast HSC	12,056,316	(468,574)	11,587,742
DHS - Southeast HSC	16,054,906	(1,482,439)	14,572,467
DHS - South Central HSC	8,943,330	(386,259)	8,557,071
DHS - West Central HSC	13,315,641	(1,207,194)	12,108,447
DHS - Badlands HSC	6,264,582	(683,757)	5,580,825
Total general fund	$79,878,717	($6,117,746)	$73,760,971

House Bill No. 1012 - Human Service Centers - Other Funds Summary of House Action

	Executive Budget	House Changes[1]	House Version
DHS - Northwest HSC	$3,680,172	($208,176)	$3,471,996
DHS - North Central HSC	8,825,362	(408,515)	8,416,847
DHS - Lake Region HSC	4,747,559	(222,849)	4,524,710
DHS - Northeast HSC	14,320,535	(291,372)	14,029,163
DHS - Southeast HSC	15,966,058	(777,670)	15,188,388
DHS - South Central HSC	6,970,002	(269,753)	6,700,249
DHS - West Central HSC	12,693,292	(439,271)	12,254,021
DHS - Badlands HSC	5,429,653	(247,482)	5,182,171
Total other funds	$72,632,633	($2,865,088)	$69,767,545

⁻louse Bill No. 1012 - Human Service Centers - All Funds Summary of House Action

	Executive Budget	House Changes[1]	House Version
DHS - Northwest HSC	$8,562,127	($352,995)	$8,209,132
DHS - North Central HSC	20,923,799	(2,006,026)	18,917,773
DHS - Lake Region HSC	11,011,109	(370,042)	10,641,067
DHS - Northeast HSC	26,376,851	(759,946)	25,616,905
DHS - Southeast HSC	32,020,964	(2,260,109)	29,760,855
DHS - South Central HSC	15,913,332	(656,012)	15,257,320
DHS - West Central HSC	26,008,933	(1,646,465)	24,362,468
DHS - Badlands HSC	11,694,235	(931,239)	10,762,996
Total all funds	$152,511,350	($8,982,834)	$143,528,516
FTE	847.48	(11.00)	836.48

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Northwest Human Service Center - House changes:	FTE	General Fund	Other Funds	Total
Decrease funding for department travel		($19,621)	($8,468)	($28,089)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(97,561)	(199,556)	(297,117)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(27,637)	(152)	(27,789)
tal House changes - Northwest Human Service Center	0.00	($144,819)	($208,176)	($352,995)

North Central Human Service Center - House changes:	FTE	General Fund	Other Funds	Total
Remove funding added in the executive budget for the global health initiative		($1,358,307)	($100,000)	($1,458,307)
Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Decrease funding for department travel		(2,132)	(1,521)	(3,653)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(122,969)	(251,527)	(374,496)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(55,310)	(3,113)	(58,423)
Total House changes - North Central Human Service Center	(1.00)	($1,597,511)	($408,515)	($2,006,026)

Lake Region Human Service Center - House changes:	FTE	General Fund	Other Funds	Total
Decrease funding for department travel		($12,616)	($8,554)	($21,170)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(104,767)	(214,295)	(319,062)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(29,810)	0	(29,81
Total House changes - Lake Region Human Service Center	0.00	($147,193)	($222,849)	($370,042)

Northeast Human Service Center - House changes:	FTE	General Fund	Other Funds	Total
Remove funding added in the executive budget for the global health initiative		($280,663)	($81,200)	($361,863)
Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Decrease funding for department travel		(2,654)	(4,571)	(7,225)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(63,064)	(128,994)	(192,058)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(63,400)	(24,253)	(87,653)
Total House changes - Northeast Human Service Center	(1.00)	($468,574)	($291,372)	($759,946)

Southeast Human Service Center - House changes:	FTE	General Fund	Other Funds	Total
Remove funding added in the executive budget for the global health initiative	(4.00)	($1,190,124)	($183,746)	($1,373,870)
Provide funding for contract staffing at the Cooper House	0.00	236,520	78,840	315,360

Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Remove funding added in the executive budget for young adult transition residential services		(184,622)	(242,222)	(426,844)
Remove funding and FTE position added in the executive budget for the partnership program	(1.00)	(61,490)	(40,440)	(101,930)
Decrease funding for department travel		(1,707)	(1,414)	(3,121)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(164,349)	(336,167)	(500,516)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(57,874)	(167)	(58,041)
Total House changes - Southeast Human Service Center	(6.00)	($1,482,439)	($777,670)	($2,260,109)

South Central Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative	(1.00)	($127,669)	$0	($127,669)
Remove funding and FTE position added in the executive budget to complete ulnerable adult protection services	(1.00)	(73,128)	0	(73,128)
Decrease funding for department travel		(10,231)	(6,584)	(16,815)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(128,661)	(263,169)	(391,830)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		(46,570)	0	(46,570)
Total House changes - South Central Human Service Center	(2.00)	($386,259)	($269,753)	($656,012)

West Central Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative		($279,546)	$0	($279,546)
Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Remove funding added in the executive budget for young adult transition residential services		(650,000)	(100,000)	(750,000)
Decrease funding for department travel		(13,677)	(9,496)	(23,173)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(135,157)	(276,456)	(411,613)
crease funding added in the executive budget for inflationary increases for		(70,021)	(965)	(70,986)

all services except the rebased services to provide 6 percent per year increases

Total House changes - West Central Human Service Center	(1.00)	($1,207,194)	($439,271)	($1,646,465)

Badlands Human Service Center - House changes:	**FTE**	**General Fund**	**Other Funds**	**Total**
Remove funding added in the executive budget for the global health initiative		($665,000)	($140,000)	($805,000)
Decrease funding for department travel		(232)	(163)	(395)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(40,139)	(82,102)	(122,241)
Decrease funding added in the executive budget for inflationary increases for all services except the rebased services to provide 6 percent per year increases		21,614	(25,217)	(3,603)
Total House changes - Badlands Human Service Center	0.00	($683,757)	($247,482)	($931,239)

north dakota department of human services

Glossary of Terms and Acronyms

January 2009

960 - Refers to the State Form Number 960 (SFN 960) for the reporting of suspected child abuse or neglect.

AASK - Adults Adopting Special Kids is a collaboration involving the department's Children and Family Services Division, Catholic Charities North Dakota, and PATH ND. They work together to promote and facilitate the adoption of children with special needs from the foster care system.

Abuse - Any willful act or omission by a caregiver or other person, which results in physical injury, mental anguish, unreasonable confinement, sexual abuse or exploitation, or financial exploitation of a vulnerable adult.

Abused Child - An individual under the age of 18 years who is suffering from abuse as defined in Subdivision A of Subsection 1 of Section 14-09-22 caused by a person responsible for the child's welfare, and "sexually abused child" means an individual under the age of 18 years who is subjected by a person responsible for the child's welfare to any act in violation of sections 12.1-20-01 through 12.1-20-07, sections 12.1-20-11 through 12.1-20-12.2, or Chapter 12.1-27.2 (sex offenses listed in the criminal code). (14-09-22 "Inflicts, or allows to be inflicted, upon the child, bodily injury, substantial bodily injury, or serious bodily injury as defined by section 12.1-01-04 or mental injury") (12.1-01-04 "Bodily injury" means any impairment of physical condition, including physical pain. "Serious bodily injury" means bodily injury that creates a substantial risk of death or which causes serious permanent disfigurement, unconsciousness, extreme pain, permanent loss or impairment of the function of any bodily member or organ, a bone fracture, or impediment of air flow or blood flow to the brain or lungs. "Substantial bodily injury" means a substantial temporary disfigurement, loss, or impairment of the function of any bodily member or organ.)

Access Services - Services such as transportation, escort/shopping assistance, outreach, and information and assistance, which help people to identify, obtain, and use existing services.

ACJ - Alliance for Children's Justice is a statewide multi-disciplinary coalition of professionals and parents dedicated to quality child protection services in North Dakota.

ACS - Affiliated Computer Services Inc. is the company North Dakota has contracted with for its Medicaid Management Information System replacement project and its Pharmacy Point of Sale system project.

Acute Care Unit - A service unit in the department's Human Service Centers that provides general outpatient mental health services.

ADA - Americans with Disabilities Act of 1990 [Pub. L. 101-336; 104 Stat. 327; 42 U.S.C. § 12101 et seq.]

ADL - Activities of Daily Living refers to daily self-care personal activities that include bathing, dressing and undressing, eating or feeding, toileting, continence, transferring in and out of a bed, or chair, or on and off the toilet; and mobility inside the home.

Administrative Assessment - Process of documenting reports of suspected child abuse or neglect that do not meet the criteria for a Child Protection Services Assessment.

Administrative Referral - Process of documenting the referral of reports of suspected child abuse or neglect that fall outside the jurisdiction of the county where the report is received.

Adoption Assistance - A form of monetary assistance to families adopting children from foster care who have special needs. This assistance can take the form of a monthly payment, Medicaid as a backup to a family's private health insurance, or reimbursement of nonrecurring expenses related to adoption.

Adoption Search/Disclosure - The process whereby an adopted individual, a birth parent, or birth sibling of an adopted individual, or an adult child of a deceased adopted individual can request and receive identifying information related to the adoption.

Adoption Subsidy - See Adoption Assistance.

Adult Day Care - A program of non-residential activities provided at least three (3) hours per day on a regularly scheduled basis one or more days per week and encompassing both health and social services needed to ensure the optimal functioning of the individual.

Adult Education Transition Services (AETS) - Refers to services provided to students 18-21 years of age who are eligible for Developmental Disabilities Case Management Services and can benefit from residential and/or day services provided in the developmental disabilities system while they are still in school. This is a joint initiative between the Department of Public Instruction and the Department of Human Services. Individuals must meet eligibility requirements. Education agencies and Medicaid provide funding.

Adult Family (Foster) Care - Provision of 24-hour room, board, supervision, and extra care to adults who are unable to function independently or who may benefit from a family home environment. Care is provided in a licensed home.

ADRC - Aging and Disability Resource Center is a visible and trusted place at the community-level where people can turn for information and counseling on all available long term support and service options. It functions as a single point of entry to public long term support programs and services. North Dakota does not have an ADRC.

Aging Services - Refers to the Aging Services Division of the N.D. Department of Human Services, which administers programs and services for older persons and vulnerable adults as the designated State and Area Agency on Aging under the Older Americans Act.

Approved Relative - An unlicensed child care provider who is eligible to participate in the Child Care Assistance Program. By federal law, an approved relative must be related to the child by marriage, blood relationship, or court order such as a grandparent, great-grandparent, aunt, uncle, or a sibling age 18 or older who does not live with the child. These providers can care for up to 5 children including their own children under the age of 12. All adults living in the home are checked against the ND Office of Attorney General's sex offender list.

Arrearages - Past-due, unpaid child support owed by the noncustodial parent. Also may be referred to as "arrears."

ASAM - American Society of Addiction Medicine, Patient Placement Criteria, Second Edition-Revised. These are the clinical guidelines used for matching clients to the appropriate level of care for the treatment of substance-related disorders.

ASFA - The Adoption and Safe Families Act of 1997 [Pub. L. 105-89; 111 Stat. 2115; 42 U.S.C. § 1305 et seq.] is federal legislation to shorten the length of time in foster care and to ensure safety and permanency for children.

Assisted Living - An environment that helps people maintain as much independence as possible by providing apartment-like units and individualized support services, which accommodate individual needs and abilities. Assisted living facilities are required to be licensed in the North Dakota.

Assistive Technology (AT) Device - Any item or piece of equipment used to maintain or improve the functional capabilities of individuals with disabilities.

Assistive Technology (AT) Service - Any service that directly assists an individual with a disability in selecting, acquiring or using an assistive technology device. AT services may include: evaluation, purchasing, designing, leasing, training for individuals, family members, and professionals; and coordinating therapies. It also includes services that expand access to electronic and information technology for people with disabilities.

Attendant Care Service (ACS) - Hands-on care, of both a supportive and medical nature, specific to a client who is ventilator-dependent for a minimum of 20 hours per day and includes nursing activities that have been delegated by the Nurse Manager to the ACS provider. ACS is an all-inclusive service that provides direct care to ventilator-dependent individuals to meet their care needs.

Attendant Care Service Provider - Is a Qualified Service Provider (QSP) who is an unlicensed assistive person enrolled and in good standing with the North Dakota Board of Nursing. The attendant care service is provided under the direction of a licensed nurse who is enrolled with the Department of Human Services as a QSP to provide Nurse Management.

Background Check - (See also *Criminal Background Check*) Refers to the check that is currently done on child care provider applicants (licensed and self-certified) to see if a person's name appears on the ND Child Abuse and Neglect Index showing a finding of "services required" for child abuse or neglect and to see if the person is on the ND Office of Attorney General's List of Convicted Sex Offenders and Offenders Against Children.

Basic Care Assistance Program - Supplements room and board payments made by individuals of limited means living in basic care facilities. The Basic Care Assistance Program is funded with state general funds.

Basic Care Facility - A licensed residential facility that provides room and board and services to individuals who need health, social, or personal care services, but do not require extensive medical services.

Benchmark – A specific measurement as it relates to progress toward meeting a standard or goal.

BEST - Basic Employment and Skills Training program provides motivation and job seeking skills to Supplemental Nutrition Assistance Program recipients who are required to register for work. The department contracts with Job Service North Dakota to provide the service in Burleigh County and Cass County.

Best Practice - Practices that incorporate the best objective information currently available from recognized experts regarding effectiveness and acceptability.

BLHSC - Badlands Human Service Center is located in Dickinson. (*See HSC definition.*)

Business Services - Part of Vocational Rehabilitation, *Business Services* is also known as *Rehabilitation Consulting and Services* and provides consultation, technical assistance, and information to businesses so they can resolve disability-related issues and have an available source of qualified employees.

CA/N - Child Abuse and Neglect

Care Coordinator - Describes the comprehensive case manager in a child and family case involving severe emotional disturbance.

CARF - Commission for Accreditation for Rehabilitation Facilities

Case Management - A process in which a professional case manager assesses the needs of the client and arranges, coordinates, monitors and evaluates services, and advocates to meet the specific client's needs in the least restrictive environment.

CCAP - Child Care Assistance Program provides partial payment for child care services provided to children from qualifying low-income families.

CCDBG - Child Care Development Block Grant

CCWIPS - The Comprehensive Child Welfare, Information, and Payment System is a computerized case management and payment system for foster care and adoption services.

CFS - Refers to the Children and Family Services Division of the Department of Human Services. CFS has administrative responsibility for the policies and procedures relating to children and families. The division is responsible for program supervision and technical assistance for the delivery of public child welfare services.

CFSR - Child and Family Services Review is a federal child welfare review conducted in all states. North Dakota uses this same process to conduct child welfare reviews in each region of the state annually.

Child and Family Team - Related to children's mental health services and child welfare services, the Child and Family Team consists of the child, family and persons most pertinent in the life of the child and family, as determined by the family (in most instances). The team meets to identify family strengths, needs, risks, and resources to reduce and/or eliminate the risk of removal from the home, reunification, emotional and educational needs, child abuse and neglect and ensure the safety, permanency and well-being of children and families.

Child Care Provider - A person, group of persons, or agency that is responsible for the education and supervision of the child/children in their care in exchange for money, goods, or services.

Child Care Provider Licensing - County social service offices conduct child care licensing studies, investigate complaints, and issue correction orders. The Department of Human Services' regional child welfare administrators review applications and studies, and issue licenses, denials, revocations, and suspensions. The Department's "State Office," which includes the Children and Family Services Division and the Legal Unit, develops and reviews regulations, policies, and procedures; conducts licensing training; reviews notices before issuance; and provides technical assistance.

Child Care Resource and Referral (CCR&R) – In North Dakota, two CCR&R agencies assist families searching for licensed child care and educate families about what to look for in providers. They also collect and maintain a database of providers, compile supply and demand information, provide and coordinate provider training, provide technical assistance to help providers become licensed and to improve quality, support child care programs in other ways, and work with communities to address child care issues. Established in 1992 by the North Dakota Legislature, the CCR&R programs in the state are supported by public funding (mainly from the ND Department of Human Services) and private funding.

Child Fatality Review Panel - A multi-professional group that meets to review the deaths of all minors in the state and identifies trends or patterns in the deaths of minors.

CHIP - Children's Health Insurance Program. See Healthy Steps and State Children's Health Insurance entries.

Chore Service - These tasks enable a client to remain in the home. Tasks include heavy housework and periodic cleaning, professional extermination, snow removal, and the task must be the responsibility of the client and not the responsibility of the landlord. Emergency Response Systems (ERS), such as electronic devices enabling the client to secure help in an emergency by activating the "help" button, are also available under this service.

CIL - Center for Independent Living. The four CILs in North Dakota provide services to individuals with disabilities so they can live and work more independently in their homes and communities.

Client Assistance Program (CAP) - Designed to inform and advise all Vocational Rehabilitation clients and applicants about the benefits available under the Federal Rehabilitation Act of 1973, and to assist clients in securing those services.

CMHS Block Grant - Community Mental Health Service Block Grant

Congregate Care - Refers to a specialized group residential facility that provides programming for elderly individuals with mental retardation to help them maintain their current level of functioning. The health and medical conditions of the individuals served are stable and do not require continued nursing or medical care.

Continuum of Care - A functional philosophy that seeks to ensure clients receive the right service in the right place at the right time.

Co-occurring Disorders (COD) - Individual has one or more substance-related disorders along with one or more mental disorders.

Corporate Guardianship - A service purchased on behalf of individuals eligible for developmental disabilities case management services when a district court has determined the individual requires a guardian and no one else is available to serve as guardian.

The Council for Quality and Leadership - Often referred to as "The Council" or "CQL," this entity accredits providers of services for mentally retarded/developmentally disabled people.

CP - For child support purposes, the Custodial Parent is the person (generally a parent) who has primary care, custody, and control of a child or, if a court has made a custody determination, the person who has legal custody of a child.

CPS - Child Protection Services protect the health and welfare of children by encouraging the reporting of children known to be or suspected of being abused or neglected; provide services for the protection and treatment of abused and neglected children to protect them from further harm.

CPS Assessment - A fact finding process designed to provide information that enables a determination to be made whether services are required for the protection and treatment of a child. These assessments are completed by County Social Service Board social workers.

CPS Assessment Decision - The result of a CPS assessment, which reflects whether services are required for the protection and treatment of an abused or neglected child.

Criminal Background Check - Fingerprints are taken and sent to the North Dakota Bureau of Criminal Investigation (BCI) and the Federal Bureau of Investigation (FBI) to determine if there is any criminal history record information regarding the person. This type of background check is being proposed for child care providers and is currently in place in North Dakota for foster care and non-relative adoptions, as well as North Dakota's CareCheck Registry – the existing voluntary criminal background check process for child care providers. (See *Background Check entry.*)

CRU - Crisis Residential Units provide generally short-term stabilization and support to individuals diagnosed with mental illness and/or chemical dependence who are experiencing crisis as a result of exacerbation of symptoms.

CSAP - Center for Substance Abuse Prevention is the sole federal organization with responsibility for improving accessibility and quality of substance abuse prevention services.

CSAT - Center for Substance Abuse Treatment is a component of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS), that works to expand the availability of effective treatment and recovery services for alcohol and drug problems.

CSCC - Children Services Coordinating Committee

CSHCN - Children with Special Health Care Needs. As defined at the federal level, this population of children has or is at increased risk for chronic physical, developmental, behavioral, or emotional conditions requiring health and related services of a type or amount beyond that required by children generally.

CSHS - Children's Special Health Services (formerly Crippled Children's Services) is part of the Department of Health; it provides services directly or through contracts to children with special health care needs and their families.

Day Supports - This is a single day program, which encompasses services previously known as Developmental Day Activity, Developmental Work Activity, Prevocational Work Activity and Adult Day Care. Day supports may include assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills; provision of social, recreational, and therapeutic activities to maintain physical, recreational, personal care, and community integration skills; development of non-job task oriented prevocational skills such as compliance, attendance, task completion, problem solving and safety; and supervision for health and safety. Services are provided in settings appropriate to an individual's needs.

DC - Refers to the Developmental Center. Located in Grafton, N.D., it provides residential and other services to individuals with developmental disabilities.

DD - Refers to the Developmental Disabilities service system, which provides case management, day supports, residential services, and family support services to individuals with mental retardation or developmental disabilities of all ages, and early intervention services to infants and toddlers who are at risk for, or experiencing developmental delays.

DDS - Disability Determination Services makes eligibility decisions for Social Security Disability Insurance and Supplemental Security Income so that eligible individuals can receive disability benefits. This is part of the ND Department of Human Services.

Debit Card - A card that may be used to electronically withdraw account deposits at an Automated Teller Machine (ATM) or a bank teller window, or to use at a point-of-sale (POS) machine to purchase goods, or services, or to obtain cash. Debit cards are used by the Department of Human Services to pay cash assistance under TANF programs and to distribute child support payments to custodial parents. Custodial parents receiving child support payments may also choose "direct deposit" as an alternative.

Determination - The result of an assessment of suspected institutional child abuse or neglect.

Developmental Disability - Refers to a severe chronic condition that constitutes a lifelong mental or physical impairment, which became apparent during childhood and has hampered an individual's ability to participate in mainstream society, either socially or vocationally.

Direct Deposit - For child support purposes, it is a process involving the electronic funds transfer of support payments from the State Disbursement Unit (SDU) into a custodial parent's bank account. This is done only upon the request of the custodial parent. Custodial parents may also choose to receive payments via a debit card.

Disease Management - A system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant (for example, Medicaid recipients). Disease management: (1) supports the physician or practitioner/patient relationship and plan of care, (2) emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and empowerment strategies, and (3) evaluates clinical, quality of life and economic outcomes on an on-going basis with a goal of improving participants overall health.

Diversion Assistance - An alternative to Temporary Assistance for Needy Families (TANF) assistance, Diversion Assistance is available for no more than four months in a year, and is intended to allow individuals to avoid some of the complications of TANF in an effort to quickly achieve self-sufficiency.

DJS - Division of Juvenile Services is a division of the North Dakota Department of Corrections and Rehabilitation. DJS is responsible for the custody of delinquent and unruly children placed in its care by the courts.

DRA - Deficit Reduction Act of 2005 [Pub. L. 109-171; 120 Stat. 4; 42 U.S.C. § 1108, et seq.]

Dual Diagnosed - Diagnosed with two disorders such as those individuals diagnosed with mental illness and chemical dependence or individuals diagnosed with mental illness and developmental disabilities.

Dual Eligibles - Individuals who qualify for both Medicaid (state and federally-funded health coverage for low-income persons) and Medicare (federal health coverage program for persons age 65 and older and other qualifying individuals with disabilities).

DUR Board - Drug Utilization Review Board is a volunteer board whose makeup and duties appear in Code of Federal Regulations and subsequently in state statute. Comprised of pharmacists and physicians, the Board was established to advise the Medicaid program on prior authorization and other pharmacy cost control and utilization matters.

EAP - Economic Assistance Policy is a division of the department that administers policy for and includes the following programs: Child Care Assistance Program, Basic Care Assistance Program, Energy Assistance (also referred to as Low Income Home Energy Assistance, or LIHEAP), Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF), including Diversion Assistance and Job Opportunities and Basic Skills (JOBS). EAP is also responsible for Medicaid Estate Recovery, Quality Control, and System Support and Development.

Early Head Start - A federally funded program that serves income eligible infants, toddlers and expectant parents. Early Head Start provides services that include prenatal development/healthy pregnancy, child development, health, nutrition, parent education/family development and parent leadership opportunities. Early Head Start reserves 10 percent of its enrollment for children with special needs.

Early Intervention Services - Refers to a statewide program for infants and toddlers who range from newborn to three years of age who have a developmental delay, disability, or a condition that could result in substantial limitations if intervention is not provided. Intervention services are designed to help address the physical and developmental needs of children, and to augment the capacity of their families to meet their special needs.

Early Learning Guidelines - These voluntary guidelines are intended as a resource for parents, child care providers, pre-kindergarten and Head Start teachers, and others. They outline the skills, knowledge, and dispositions young children need prior to entering first grade.

EFT - Electronic Funds Transfer is a process by which money is transmitted electronically from one bank to another.

English Language Learners (ELL) - People who are learning the English. Another related term commonly used is English as a Second Language (ESL).

Environmental Modification - Physical adaptions to the home necessary to ensure the health, welfare, and safety of a client or that enable a client to function with greater independence in his/her home.

Expanded SPED Program - Expanded Service Payments to the Elderly and Disabled Program is a companion program to the Basic Care Assistance Program. It pays for services that can be provided in the home and community so that people can avoid having to move to a basic care facility. The Expanded SPED Program is funded with state general funds.

Extended Personal Care - Includes hands-on care of a medical nature that is specific to the needs of an eligible individual and will enable an individual to live at home. This service is provided by a Qualified Service Provider (QSP), and to the extent permitted by State law, is care that would otherwise be provided by a nurse. A nurse licensed to practice in the state will provide training to a QSP approved by the Department to provide the required care and will provide at a minimum, a review of the client's needs every six months to determine if additional training is required. Activities of daily living (ADL) and instrumental activities of daily living (IADL) are not a part of this service.

Extended Services - This refers to long term supports provided by a job coach for individuals with disabilities employed in the community.

FACSES - The Fully Automated Child Support Enforcement System is the statewide automated system that supports the processing of child support cases in North Dakota and supports the State Disbursement Unit (SDU) in processing child support payments.

Family Caregiver Support Program - Federally funded under the Older Americans Act, this Aging Services program offers help to caregivers who are caring for an adult age 60 or older, or who are themselves age 55 or older and are caring for grandchildren or relatives who are age 18 or younger or for an adult child with a disability who is between 19 and 59 years of age. Services include information and referral, assistance from a trained caregiver coordinator to help caregivers assess needs and access support services, individual and family counseling, support groups, training, and respite care for caregivers.

Family Group Decision Making - Relating to the provision of child welfare services, this is defined as a strengths-based collaborative, coordinated decision making process using family, agency and support service resources to ensure the safety, permanency and well-being of children and families.

Family Home Care - The provision of room, board, supervisory care, and personal care service to an eligible elderly or disabled individual by the spouse or by one the following relatives, or the current or former spouse of one of the following relatives of the elderly or disabled person: parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew. The family home care provider does not need to be present in the home on a 24-hour basis if the welfare and safety of the client is maintained.

Family Personal Care -This helps individuals remain with their family members and provides extraordinary care payments to the legal spouse of a recipient for the provision of personal care or similar services.

Family Subsidy - A program that may reimburse a family for excess expenses related to their child's disability. This offers support to enable families to keep their children in their homes when lack of financial support would make it very difficult for families to care for their children at home. A child may be eligible for this program through age 21.

Family Support Services - Refers to services, which are provided for eligible individuals with developmental disabilities to enable them to remain in appropriate home environments. Services are based on the primary caregiver's need for support in meeting the health, safety, developmental and personal care needs of their family member. Personal care needs include activities of daily living such as eating, bathing, dressing, and personal hygiene. When the eligible client is a minor, out-of-home support may also be provided in a licensed family home. This Family Care Option may be appropriate for children who cannot remain in their family home on a full-time basis. It is available only if the child is not considered deprived within the definition of NDCC 27-20-02 (5), and is not considered boarding care according to the definition of the North Dakota Department of Public Instruction.

FFY - Federal Fiscal Year runs from October 1 to September 30.

Fidelity - This is the degree of adherence to essential elements in the implementation of evidence-based clinical practice. Program with high fidelity are expected to have greater effectiveness in achieving desired client outcomes.

FIDM - The Financial Institution Data Match process is operated by the Child Support Enforcement program in coordination with financial institutions and pursuant to federal and state laws. The process provides for a data match system in which account records are matched with child support cases.

FLEP - Family Life Education Program. The department of human services is required by law (NDCC 50-06-06.10) to enter into an agreement with the North Dakota State University extension service for the design of a program to educate and support individuals at all points within the family life cycle. The program must provide support for families and youth with research-based information relating to personal, family, and community concerns and must contain a research component aimed at evaluation of planned methods or programs for prevention of family and social problems. The program must address: 1) child and youth development; 2) parent education with an emphasis on parents as educators; 3) human development; 4) interpersonal relationships; 5) family interaction and family systems; 6) family economics; 7) intergenerational issues; 8) impact of societal changes on the family; 9) coping skills; and 10) community networks and supports for families.

FMAP - Federal Medical Assistance Percentage is the federal matching rate for the Medicaid program. FMAP changes annually on October 1.

Food Stamps - See Supplemental Nutrition Assistance Program or SNAP.

Front End System/FRAME - An added component to the Department's current child welfare computer system that makes intake and data entry more efficient and user-friendly and supports enhanced case management services.

GA - General Assistance is a county program designed to cover emergency needs of low-income individuals or families. The covered needs may include rent, fuel and utilities, medical, and burial expenses.

Good Start, Grow Smart - The federal initiative that encouraged states to develop early learning guidelines, professional development systems, and quality rating systems and required Head Start programs to demonstrate progress in children's learning.

Governor's Prevention Advisory Council (GPAC) on Drugs and Alcohol - Formed by an executive order from the Governor's office, the council is charged with oversight and monitoring of substance abuse prevention activities across state agencies in North Dakota. The Department holds two of the eight council membership positions.

Guardian Ad Litem - A court-appointed child advocate mandated by North Dakota law for all abused and neglected children involved in a Juvenile Court proceeding.

HCBS - Home and Community Based Services refers to the array of services that are essential and appropriate to sustain individuals in their homes and communities, and to delay or prevent institutional care.

Head Start - This is a federally funded program for families with pre-school aged children who meet income eligibility guidelines. Head Start is family-focused and provides early literacy and education, child development, child health services (dental, physical, social-emotional, nutrition) and parent education and support services.

Head Start-State Collaboration Office (HS-SCO) - This office is designed to create a visible presence at the state level to assist in the development of significant, multi-agency and public-private partnerships between Head Start and the state. The following are the federally-identified purposes of the HS-SCO: Build early childhood systems and access to comprehensive services and support for all children of families with low-incomes; Create partnership agreements and initiatives between Head Start and appropriate state programs/agencies and encourage Head Start's capacity to be a partner in State initiatives on behalf of children and their families; and Facilitate the involvement of Head Start in State policies, plans, processes and decisions affecting the Head Start target population and other families with low-incomes.

Health Care Trust Fund - This trust fund was established by the 1999 North Dakota Legislature as a source of funding for grants and loans to pay for legislatively approved projects.

Health Tracks - See North Dakota Health Tracks.

Healthy Steps - Is North Dakota's Children's Health Insurance Program that offers comprehensive health coverage for children 18 years of age and younger. To qualify, a child's family must have a net income that is greater than the Medicaid eligibility level, but not exceeding 150% of the federal poverty level. (Deductions for child care, child support, and taxes are allowed when determining eligible income.) Healthy Steps is a "State Children's Health Insurance Program" (SCHIP).

HIPAA - Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 42 U.S.C. § 1301 et seq.] that among other things standardizes the format of certain health care information that is transmitted electronically and regulates the release of health care information. HIPAA impacts entities (and their computer systems) that handle individual health care information.

Home Delivered Meal - Provides a well-balanced meal to any qualifying individual who lives alone and is unable to prepare an adequate meal, or who lives with another person who is unable or not available to prepare an adequate meal for the recipient.

Homemaker Service - Includes tasks such as housekeeping, laundry, and shopping, this service allows an individual to maintain or develop the independence needed to remain in the home.

HSC – Human Service Centers are part of the Department and provide help to individuals and families with concerns including family and relationship issues, mental illness, addiction, disabilities, and other needs. Centers are located in Bismarck (WCHSC), Devils Lake (LRHSC), Dickinson (Badlands HSC or BLHSC), Fargo (SEHSC), Grand Forks (NEHSC), Jamestown (SCHSC), Minot (NCHSC), and Williston (NWHSC).

IADL - Instrumental Activities of Daily Living means activities requiring cognitive ability or physical ability, or both. Instrumental activities of daily living include meal preparation, shopping, managing money, doing housework, laundry, taking medicine, transportation, using the telephone, and mobility outside the home.

ICAMA - Interstate Compact on Adoption and Medical Assistance

ICFMR - Intermediate Care Facility for the Mentally Retarded is a residential facility operated pursuant to federal regulations and serving people with developmental disabilities and related conditions. The programming provided is for individuals with extensive needs. Each client must receive a continuous active treatment program, which includes an aggressive and consistent program of training, health services, and related services so that the client acquires the ability to function with as much self-determination and independence as possible.

ICPC - Interstate Compact on the Placement of Children relates to the placement of foster children across state lines.

ICWA - **Indian Child Welfare Act** of 1978 [Pub. L. 95-608; 92 Stat. 3069; 25 USCA § 1901 et seq.] recognizes the importance of allowing tribal courts to assume full responsibility for the placement of Indian children in foster care and adoptive homes. Under ICWA, Indian tribes may intervene in such State court proceedings concerning Indian children, and Indian Tribal courts have exclusive jurisdiction over some such proceedings.

IDDT - Integrated Dual Disorder Treatment is an evidence-based practice that improves the quality of life of people with co-occurring mental and substance use disorders by promoting consumer and family involvement in service delivery, stable housing as a necessary condition of recovery, and employment as an expectation for many. The IDDT model integrates mental health and substance abuse services utilizing treatment that combines pharmacological, psychological, educational, and social interventions to address the needs of consumers and their families and other support system members. The implementation of IDDT promotes system change, organizational change, and clinical change.

Individualized Supported Living Arrangement (ISLA) - This residential service is provided to people with developmental disabilities and/or mental retardation in their own homes or apartments. The level of support provided is individualized to the person's need for training and assistance with personal care, laundry, money management, etc. Individuals who receive ISLA typically need a higher level of support than people in a Supported Living Arrangement (SLA).

Infant Development - Home-based, family focused services that provide supports to families of eligible infants and toddlers at high risk for, or with developmental delays or disabilities. An Individual Family Service Plan is developed that identifies services and learning opportunities that support the family in meeting the needs of their child, enhance their child's development, and increase the child's and family's participation in everyday routines and activities within the home and community. An eligible child may receive Infant Development services until he or she is three years of age.

Institutional Child Abuse or Neglect - Situations of known or suspected child abuse or neglect where the institution responsible for the child's welfare is a residential child care facility, a treatment or care center for the mentally retarded, a public or private residential educational facility, a maternity home, or any residential facility owned or managed by the state or a political subdivision of the state.

Integrated Treatment - The skills and techniques used by treatment providers to comprehensively address both mental health and substance abuse issues in people with co-occurring disorders.

Intensive In-Home Services - Services provided under contract with a private agency to families who have at least one child about to be placed in foster care. The program's purpose is to preserve the family, prevent foster care, and assist with family re-unification of children who are placed in foster care.

Intergovernmental Transfer (IGT) – This is a complex funding process that was used by North Dakota and about 20 other states to access extra federal Medicaid dollars. The Health Care Financing Administration approved the IGT as part of North Dakota's Medicaid State Plan Amendment. Funds generated by the IGT were deposited into the Health Care Trust Fund. In a compromise worked out in Congress, this source of extra federal Medicaid funding has been phased out. The final North Dakota payment was in July 2004.

IPAT - Refers to the Interagency Program for Assistive Technology. IPAT's mission is to increase access to assistive technology devices and services for individuals with disabilities regardless of their type of disability, age, or income level in order to positively impact work, independent living, learning, community involvement and recreation.

IV-D - Refers to Title IV-D of the Social Security Act [Pub. L. 93-647; 42 U.S.C. title IV-D]. A Child Support Enforcement program that provides services to locate parents, to establish paternity, to establish child support and medical support obligations, to enforce child support and medical support obligations, and to review and adjust obligations. Services are provided to families receiving public assistance [through Temporary Assistance for Needy Families (TANF) or Medicaid], in cases in which a child has been placed in foster care or upon application for services from either parent.

IPE - Is an Individualized Plan for Employment. It describes the nature and scope of rehabilitation, employment and training services provided to an individual with a disability to help that individual reach his or her employment goal. A Vocational Rehabilitation counselor and the client write the client's IPE.

JCAHO - Joint Commission on Accreditation of Healthcare Organizations

JOBS - Job Opportunities and Basic Skills program provides vocational training and employment for eligible individuals through TANF for the purpose of entering or reentering the job market. The Department of Human Services Program contracts with Job Service North Dakota, Career Options, Spirit Lake Employment and Training, and Turtle Mountain Tribal Employment and Training to provide JOBS program services.

Kinship Care - A Temporary Assistance for Needy Families (TANF) program that allows relatives, with supportive services, to provide care and protection to children who are under the care, custody, and control of County Social Services and who would otherwise be in foster care.

Licensed Child Care Providers – Are required to maintain at least minimum standards related to physical size of the facility, safety features, cleanliness, staff qualifications, and staff-to-child ratios. See the definitions of the licensed child care provider categories: licensed family child care, licensed group child care, licensed child center, licensed preschools, licensed school-age programs, and multiple license facility. (Unlicensed child care provider categories include: self-declared providers, formerly called "self-certified," approved relative providers, and registered providers.)

Licensed Family Child Care - Care for 7 or fewer children in the provider's own home.

Licensed Group Child Care - Care for 8 to 18 children in the home or other type of facility.

Licensed Child Care Center - Care for 19 or more children in public or private buildings, churches or schools; children are often grouped by age.

Licensed Preschools - Part-time educational and socialization experiences for children age 2 years to kindergarten

Licensed School-Age Programs - The care of 19 or more school-age children before and/or after school; some programs provide care during school holidays and summer vacations.

LIHEAP - Low Income Home Energy Assistance Program that is also referred to as the energy assistance program. It provides heating assistance grants and services for qualifying low-income households. Benefits equal each household's estimated cost of heat minus a percentage of the household's income and are usually paid directly to heating fuel suppliers.

Local Child Protection Team - A multidisciplinary team of staff members from public and private community agencies who assist child protection service agencies to make decisions and recommendations for families involved in Child Protection System (CPS) assessments.

Long Term Care Facility - (As defined by North Dakota law) A skilled nursing facility/nursing home, basic care facility, assisted living facility, or swing bed hospital unit. Common usage generally equates it to a nursing facility.

Long Term Care Ombudsman - A person who identifies, investigates, and resolves complaints made by or on behalf of residents of long term care facilities and tenants of assisted living facilities. The ombudsman also works in other ways to protect the health, safety, welfare, and rights of residents.

LRHSC - Lake Region Human Service Center is located in Devils Lake. (*See HSC entry.*)

MA - Medical Assistance, commonly referred to as "Medicaid," provides medical assistance to certain specified groups of needy low-income individuals as defined by federal law.

Managed Care - A system of health care that combines delivery and payment and influences utilization of services by employing management techniques (i.e., case management, referral for specialty services, etc.) designed to promote the delivery of cost-effective health care.

MDS - Minimum Data Set is an assessment used to determine a nursing facility resident's classification for rate setting purposes.

Medicaid - See MA above.

Medicaid Systems Project - Also referred to as "The Project," it is the technology project dealing with the replacement of North Dakota's Medicaid Management Information System (MMIS), Pharmacy Point of Sale (POS) system, and the Medicaid Decision Support System.

Medicaid Waiver for Home and Community Based Services - A program authorized by federal law that funds in-home and community based services to individuals who meet Medicaid eligibility standards and require the level of care provided in a nursing facility. This waiver combines the previously separate waivers for aged and disabled and traumatic brain injury populations. The waiver's goal is to adequately and appropriately sustain individuals in their own homes and communities and to delay or divert institutional care. The waiver provides service options for a continuum of home and community based services in the least restrictive environment.

Medicaid Waiver for Mentally Retarded and Developmentally Disabled - A program authorized by federal law that funds in-home and community based services for individuals with mental retardation and/or developmental disabilities who meet Medicaid eligibility standards and require the level of care provided in an Intermediate Care Facility for Mentally Retarded (ICFMR).

Medicare Part D - The federal Medicare Prescription Drug Program that provides Medicare beneficiaries with access to prescription drug coverage from a host of private plans.

Medicare Savings Programs - Medicaid coverage that pays all or part of the Medicare premiums, deductibles, and co-insurance for Qualified Medicare Beneficiaries, Specified Low income Medicare Beneficiaries and Qualifying Individuals.

Mental Retardation - Is a condition diagnosed by age 18 and characterized both by a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life such as communication, self-care, and getting along in social situations and school activities. Mental retardation is sometimes referred to as a cognitive or intellectual disability.

MFP – Money Follows the Person is a federal Real Choice Systems Change Rebalancing grant that supports the transition of qualifying Medicaid-eligible individuals from institutional settings to home and community-based long term services.

MHSAS - Mental Health & Substance Abuse Services is a division of the Department of Human Services.

MHSIP - Mental Health Statistical Improvement Project is the statistical and outcome measurement system for the Department's community based mental health system of care at the regional human service centers.

MMIS - Medicaid Management Information System is the computer system that processes all Medicaid claims. Developed in 1978, it is also used to monitor utilization and to provide information needed to manage the Medicaid program. (*See Medicaid Systems Project.*)

MSLA - Minimally Supervised Living Arrangement is a community waiver group home or community complex setting, which provides training in community integration, social, leisure, and daily living skills.

Multiple License Facility – Entity that has more than one type of child care license such as a Center and Preschool license.

NCHSC - North Central Human Service Center is located in Minot. (See HSC entry.)

NDSH - North Dakota State Hospital

Neglect - The failure of a caregiver to provide essential services necessary to maintain the physical and mental health of another person in the caregiver's care.

Neglected Child - Uses the definition in juvenile law for a "deprived child." A child who is without proper parental care, control, subsistence or education necessary for the child's physical, mental or emotional health or morals. A child who has been placed for care or adoption in violation of law. A child who has been abandoned. A child who is without proper care (as described above) because of the physical, mental, emotional, or other illness, or disability of the parent. A child who is in need of treatment and whose caregiver has refused to participate in treatment, which is court-ordered. A child who was subject to prenatal exposure to chronic or severe use of alcohol or any controlled substance. A child who is present in an environment subjecting the child to exposure to a controlled substance, chemical substance or drug paraphernalia.

NEHSC - Northeast Human Service Center is located in Grand Forks. (*See HSC definition.*)

New Hire Reporting - Under this reporting process mandated by federal and state law, employers must submit new hire information within 20 days of hiring to the State Directory of New Hires, a component of the Child Support Enforcement Division.

NF LOC Determination - Nursing Facility Level of Care Determination is an assessment based on established criteria of an individual's medical needs. A determination must be completed before an individual can receive Medicaid funded nursing facility services or home and community-based services through the Medicaid Waiver for Home and Community Based Services.

Non-Custodial Parent (NCP) - For child support purposes, this is the parent who does not have primary care, custody, and control of the child(ren) or, if a court has made a custody determination, the parent who does not have legal custody of the child(ren).

Non-Medical Transportation - Transportation the enables individuals to access essential community services such as grocery stores, pharmacies, banking, post office, laundromat, utility company, social services, and the social security office, in order to maintain themselves in their home. *Non-Medical Transportation Driver with Vehicle* refers to situations when the driver with the vehicle is considered as solely transporting the client to and from his/her home and points of destination. *Non-Medical Transportation Escort* is solely accompanying the client for the purpose of assisting in boarding and exiting, as well as during transport, in order that the client may complete the activity for which (non-medical) transportation is authorized.

North Dakota Health Tracks - Also known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT), this program provides preventive health care to Medicaid eligible individuals up to age 21. Services include physical exams and screenings, immunizations, and referrals.

No Services Required - A Child Protection Services (CPS) assessment decision, which reflects the belief that a child has not been abused or neglected.

No Services Required, Services Recommended - A CPS assessment decision that reflects the belief that a child has not been abused or neglected, but the family may be in need of preventative services.

NSDUH - National Survey on Drug Use and Health is a survey of the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's Office of Applied Studies.

Nurse Management - This is an aspect of Attendant Care Services. Nurse Management is the provision of nursing assessment, care planning, training of skilled nursing tasks to an Attendant Care Services (ACS) provider, and monitoring of delegated tasks, for clients who are ventilator-dependent and receiving Attendant Care Services.

Nursing Facility Level of Care Determination - See NF LOC Determination.

NWHSC - Northwest Human Service Center is located in Williston. (*See HSC definition.*)

Obligee - The person to whom a child support obligation is owed, generally the custodial parent (CP). It may also be an entity to which a child support obligation is owed.

Obligor - The person who is obliged to pay child support. See also noncustodial parent (NCP).

Older Americans Act (OAA) - The Older Americans Act of 1965 [Pub. L. 89-73; 79 Stat. 219; 42 U.S.C. § 3001 et seq.] provides federal funding for services to older persons, especially those who are low income, socially needy, frail, or minority persons. Among the services offered are nutrition services, support services, Long Term Care Ombudsman program, and information and referral.

Olmstead Commission - Established by an executive order of the Governor, the commission monitors services and conducts planning in order to comply with the United States Supreme Court's Olmstead decision related to providing appropriate community-based services for individuals with disabilities, consistent with needs and available resources of the state.

Olmstead Decision - A 1999 U.S. Supreme Court decision, *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 119 S.Ct. 2176 (1999), in which the Court held that it is a form of discrimination under the Americans With Disabilities Act of 1990 (ADA) if a state fails to find community placements for institutionalized individuals if: 1) the state's treatment professionals have determined that community placement is appropriate, 2) the individual does not oppose the transfer to a community setting, and 3) the placement can be reasonably accommodated taking into account the resources available to the state and the needs of others with disabilities.

Outreach - Actions and communication initiated by an agency or organization for the purpose of identifying potential clients and encouraging their use of existing services and benefits.

PACE - Program of All-inclusive Care for the Elderly involves Northland Healthcare Alliance and Medicaid and began operation in August 2008. It is a managed care program providing patient-centered, coordinated care to frail elderly individuals who are eligible for Medicare and Medicaid and live in the community. The goal is to meet individual health needs through a care team so participants can remain living independently in the community.

PAR - Progress Assessment Review is a written instrument used as the basis of the eligibility process within Developmental Disabilities. The instrument includes an assessment of needs, which helps determine level of care and authorization of services.

Parent Aides - Individuals who, through training and support, work with parents who are at risk of abusing or neglecting their children. County social service boards employ the aides.

Part C - Is a section within the federal law of the Individuals with Disabilities Education Act (IDEA) [Pub. L. 94-142; 84 Stat. 175; 20 U.S.C. § 1400 et seq.] that entitles a child under the age of three years and their family to certain supports, services, and rights, which in North Dakota are known as Early Intervention Services for Infants and Toddlers. Part C provides federal financial assistance to states to develop and implement a collaborative statewide system of services for these children and their families.

Participant Directed Service - Sometimes called Self-Directed Supports, this option gives the individual the most control over his or her services and supports and also the most responsibility.

Partnerships Program - Integrated comprehensive services for children with serious emotional disorders.

PASRR - Pre-Admission Screening and Resident Review is a federal requirement that every person who seeks admission to a nursing facility be screened by the state for evidence of mental retardation or mental illness. If either exists, the screening is intended to determine if nursing facility care is necessary, and if so, to determine if specialized services are needed.

Peer Support Services - These consumer centered services have a rehabilitation and recovery focus and are designed to promote skills for coping with and managing symptoms while facilitating the use of natural resources and the enhancement of community living skills. Support services are provided by a person who has progressed in his or her own mental health or substance abuse recovery and is working to assist other people with those issues. Because of their life experience, peers have expertise that professional training cannot replicate.

Peer Support Specialist - An occupational title for a person who has progressed in his or her own recovery from a mental disorder and is working to assist other people with a mental disorder. Their life experiences give these individuals expertise that cannot be replicated by professional training.

PEPP - Parental Employment Pilot Project. Renamed "PRIDE" (Parental Responsibility Initiative for the Development of Employment) in late 2006. (See PRIDE definition below.)

PERM - Payment Error Rate Measurement is an examination of selected Medicaid and Healthy Steps (SCHIP) provider claims to determine if a service is required and the beneficiary is eligible.

Personal Care Service - A service that provides assistance with bathing, dressing, toileting, continence, transferring, mobility in the home, eating, and personal hygiene, passive range of motion exercises and simple bandage changes. When specified within the plan of care, this service may also include cueing or prompting, housekeeping tasks such as bed making, dusting and vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the individual, rather than the individual's family.

Pharmacy Point of Sale - This is a computerized point of sale (POS) system that allows pharmacists to enter claims on a real time basis into the payment system. Within seconds, providers receive confirmation that a claim has been processed for payment or denied. If a claim is denied, providers receive immediate information about the reason. The system also prevents payment of duplicate claims, audits claims to ensure the health of Medicaid recipients is maintained by preventing inappropriate drug dispensing, reduces administrative costs and streamlines identification of recipient liability for pharmacy providers.

Portability - An individual can move from one area of the state to another or from one service to another and his/ her individual budget and waiver eligibility can remain the same.

Preschool - Programs that typically serve children age three through entrance into kindergarten.

Prevention Activities - Activities with goals of eliminating or reducing the factors that cause or predispose individuals to increased risk, disease, problems, or disabilities.

PRIDE - Parental Responsibility Initiative for the Development of Employment provides employment-related services to noncustodial parents who are behind in their child support obligations. It is administered through the Child Support Enforcement Division with TANF funding assistance. The goal is to help the parents obtain work in order to increase their incomes so that they can support their children. This may result in better family relationships and improved visitation. The Department has implemented it in Dickinson and Grand Forks. It was formerly referred to as PEPP (Parental Employment Pilot Project).

Prime Time Care - A prevention program designed to provide temporary child care to families at risk of neglecting or abusing their children.

Psychiatric Residential Treatment Facility (PRTF) - (*Formerly called Residential Treatment Center or RTC*) A facility or a distinct part of a facility that provides children and adolescents with a 24-hour, therapeutic environment integrating group living, educational services, and a clinical program based upon a comprehensive, interdisciplinary clinical assessment and an individualized treatment plan that meets the needs of the child and family.

QI - Qualifying Individuals are individuals for whom Medicaid pays their Medicare Part B premium. Income must be between 120 percent and 135 percent of poverty level. They cannot be covered by other Medicaid to receive benefits. *See Medicare Savings Programs.*

QMB - Qualified Medicare Beneficiaries are persons for whom Medicaid pays the Medicare premiums, deductibles, and co-insurance. Income cannot exceed 100% of the poverty level. See Medicare Savings Programs.

Qualified Service Provider (QSP) - An agency or independent contractor that agrees to meet standards for services and operations established by the Department of Human Services to provide home and community based long term care services.

Quality Rating and Improvement System - A method to assess (initially and ongoing), improve, and communicate the level of quality in early childhood care and education settings.

RCCF - Residential Child Care Facility (foster care facility)

RCSEU - There are eight Regional Child Support Enforcement Units in North Dakota. These regional offices provide child support enforcement services.
Recipient Liability - This is the amount an individual who is eligible for Medicaid under the "Medically Needy" coverage group must contribute toward his or her monthly medical expenses before Medicaid pays for services.

Registered Providers - Child care providers who are eligible to participate in the Child Care Assistance Program and who are generally registered by Tribal entities. These child care providers may be licensed by Tribal entities and subject to their licensing criteria, but are not licensed by the state.

Refugee Cash Assistance - A benefit program available for the first eight months that qualifying refugees are living in the United States.

Rehabilitation Consulting and Services (RCS) - Associated with vocational rehabilitation (VR) services, these services are designed to assist business owners and employers in developing short and long term strategies regarding disability-related issues including staffing, education, tapping into financial incentives associated with hiring an individual who has a permanent injury, illness, or impairment; or ensuring accessibility to goods or services.

Rehabilitation Services - Medical, psychological, social, and vocational services, including physical items, which are necessary to assist persons with disabilities to engage in gainful activity.

Rehabilitation Services Administration - The federal oversight agency responsible for the Rehabilitation Act (Vocational Rehabilitation services).

Report of Suspected Child Abuse or Neglect - Information received by child protection services concerning the suspected maltreatment of a child.

Reserved Waiver Capacity - The state may reserve a portion of the participant capacity for specified purposes such as community transition of institutionalized persons or for individuals who may experience a crisis.

Residential Care - Services provided in a facility in which at least five (5) unrelated adults reside, and in which personal care, therapeutic, social, and recreational programming are provided in conjunction with shelter. This service includes 24-hour on-site response staff to meet scheduled and unpredictable needs and to provide supervision, safety, and security.

Respite Care - Temporary relief to a primary caregiver for a specified period of time. The caregiver is relieved of the stress and demands associated with continuous daily care.

Right Track - This Developmental Disabilities program works to identify infants or toddlers who may be at-risk for developmental delays. The program provides developmental screenings in environments natural and familiar to the child, refers families to appropriate supports and shares child development information with them. For this program, at-risk infants and toddlers are defined as children younger than three years of age who have environmental or biological risk factors for developmental delays or parental concern regarding development.

RIS - Regional Intervention Services provide community based intervention for individuals with serious mental health and/or substance abuse needs to determine appropriate level of care. RIS units at the department's human service centers conduct the admission screening for State Hospital admissions.

RMA - Refugee Medical Assistance provides up to eight months of Medical Assistance for qualifying newly arriving refugees. The program is 100 percent federally funded.

ROAP - The Regional Office Automation Project is a technology system that provides a comprehensive and integrated electronic medical records system to manage and support the business functions and requirements of the department's eight regional Human Service Centers and the Central Office.

RSA - Rehabilitation Services Administration is the federal oversight agency responsible for the Rehabilitation Act (Vocational Rehabilitation services).

RTC - Term is no longer used. *See Psychiatric Residential Treatment Facility (PRTF) entry.*

Safety, Strengths, Risk Assessment - Refers to State Form Number (SFN 455) that is used to document the Child Protection Services (CPS) assessment.

SAMHSA - Substance Abuse and Mental Health Services Administration is an agency of the U.S. Department of Health and Human Services (DHHS) that focuses on programs and providing funding to improve the lives of people with or at risk for mental and substance abuse disorders.

SAPT - Substance Abuse Prevention and Treatment block grant

SCHIP - State Children's Health Insurance Program, which is called Healthy Steps in North Dakota. (*See Healthy Steps definition.*)

SCHSC - South Central Human Service Center is located in Jamestown. (*See HSC definition.*)

SDU - The State Disbursement Unit is the unit within the department's Child Support Enforcement Division that receives, records, and distributes all child support payments in North Dakota.

SED - Serious Emotional Disorder (or Disturbance)

SEHSC - Southeast Human Service Center is located in Fargo. (*See HSC definition.*)

Self-Certified/Self-Declared Child Care Providers - Care for 5 or fewer children or 3 infants in the provider's home. These providers are not licensed or monitored; they are eligible to participate in the Child Care Assistance Program.

Senior Community Services Employment Program - Funded under the Older Americans Act, this program provides career counseling, training, and community service work experience to help low-income persons age 55 and older to secure meaningful employment.

Services Required - A Child Protection Services (CPS) assessment decision, which reflects the belief that a child has been abused or neglected and requires contact with the juvenile court.

SFY - State Fiscal Year is the period of time in the state budget cycle from July 1 to June 30.

Single Plan of Care (SPOC) – This is the computerized treatment/service plan that supports the Wraparound Process in the provision of mental health services to children.

SLA - Supported Living Arrangement is a residential service that provides support to people living in their own homes or apartments. Supportive services include help with budgeting, shopping, laundry, etc. and are provided on an intermittent basis, usually less than 20 hours per month. There is a fixed staff to client ratio. People receiving this service generally need less support than people receiving Individualized Supported Living Arrangement services.

Sliding fee scale – A system of cost sharing based on income and number of persons in the household.

SLMB - Specified Low-Income Medicare Beneficiaries are persons for whom Medicaid pays the Medicare Part B premium. Income must be between 100 percent and 120 percent of poverty level. See Medicare Savings Programs.

Slots - The maximum number of individuals who can be enrolled in the waiver at any one point in time. The number of waiver slots is tied to the amount of funding the state legislature has made available for waiver services. One 'slot' usually equals the average amount of money the state expects to spend for an individual for a full year of services.

SMI - Seriously mentally ill

SNAP - See Supplemental Nutrition Assistance Program (Formerly called the Food Stamp program.)

SPARCS- Structured Psychotherapy for Adolescents Responding to Chronic Stress is a group intervention specifically designed to address the needs of chronically traumatized adolescents who may still be living with ongoing stress and are experiencing problems in several areas of functioning. These include difficulties with regulation and impulsivity, self-perception, relationships, dissociation, numbing and avoidance, and struggles with their own purpose and meaning in life, as well as world views that make it difficult for them to see a future for themselves. Program goals include helping teens cope more effectively, enhance self-efficacy, connect with others and establish supportive relationships, cultivate awareness, and create meaning.

Special needs - Refers to the needs of children who have, or are at risk of developing, a developmental, emotional, behavioral, learning or physical condition that requires attention, services, and/or program modifications beyond what is generally needed by other children.

Special Needs Adoption - The classification of adoption for children who have a physical, emotional, and/or psychological disability (or are at risk for such a disability), are older than age seven, part of a sibling group, or are children whose race/ethnicity may be a barrier to placement.

Specialized Equipment and Supplies - Includes devices, controls, or appliances specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Specialized Placement - Refers to a residence for people who are diagnosed as both mentally retarded and mentally ill and whose individualized programs address residential, psychosocial and psychiatric development prior to entry into less restrictive settings.

SPED - Service Payments for Elderly and Disabled is authorized by state law to provide a number of home and community based services to functionally impaired older individuals and people with physical disabilities who require assistance to continue to live in a home-like setting.

SSA - Social Security Administration

SSBG - Social Service Block Grant

SSDI - Social Security Disability Insurance

SSI - Supplemental Security Income

State Child Protection Team - A multidisciplinary team of staff members from public and private agencies (determined by law) that makes the determination whether child abuse or neglect is indicated in cases of suspected institutional child abuse or neglect.

State Interagency Coordinating Council (ICC) - Is a council appointed by the Governor. Federal law under Part C of the Individuals with Disabilities Education Act (IDEA) requires the ICC to advise and assist the designated lead agency (ND Department of Human Services) in the performance of responsibilities set forth under Part C regarding early intervention services and to advise the Department of Public Instruction (DPI) regarding the transition of toddlers with disabilities to preschool and other appropriate services. The council is comprised of parents of infants and toddlers with disabilities and representatives of providers of early intervention services, the state legislature, the Department of Human Services, preschools, the State Insurance Department, Head Start, child care providers, and other members at large.

Subject - In child welfare terminology, the person who is suspected of abuse or neglect of a child or the person who has abused or neglected a child.

Supplemental Nutrition Assistance Program (SNAP) - Formerly called the Food Stamp program, this federally-funded USDA program is intended to raise levels of nutrition among low-income households by supplementing their food purchasing power with monthly benefits distributed through an electronic benefit card.

Supported Employment - Competitive work, in an integrated work environment, with ongoing support services for individuals with the most severe disabilities.

Swing Bed - A licensed hospital bed in a rural hospital that is used to provide nursing facility level of care services to an individual who is not in need of acute care services.

TANF - Temporary Assistance for Needy Families is a federal block grant program established under Title IV-A of the Social Security Act. It serves many needs, such as meeting some of the costs of Foster Care and Child Care Assistance programs. TANF also provides temporary cash assistance to needy families primarily to facilitate the return to or preparation for work.

TBI - Traumatic Brain Injury

TCC - Transitional Child Care provides partial payment of child care to families who lose TANF assistance eligibility.

TCLF - Transitional Community Living Facility is a community waiver group home that provides training for individuals in community integration, social, leisure, and daily living skills in a group living environment. It is preliminary to entry into a lesser restrictive setting.

TECS - Technical Eligibility Computer System is the computer system currently used by county social service boards to manage Supplemental Nutrition Assistance Program cases and some Medicaid cases.

TPL - Third Party Liability describes potential resources that may be available to offset claims against the Medicaid program. They include health insurance, accident insurance, court settlements, and decrees stemming from accidents of various kinds.

Transitional Living Service - Services that train people to live with greater independence in their own homes. This includes training, supervision, or assistance to the individual with self-care, communication skills, socialization, sensory/motor development, reduction/elimination of maladaptive behavior, community living, and mobility.

Transition Services - Services provided to assist students with disabilities as they move from school to adult services and/or employment.

Transitional Medicaid Benefits - Provides up to 12 months of Medicaid coverage for families who lose eligibility under the Family Coverage group due to earnings.

Tribal NEW - Tribal Native Employment Works program is the tribal equivalent of the Job Opportunities and Basic Skills (JOBS) program. The job placement and education program is available to American Indian TANF recipients.

Tribal TANF - Tribal governments have the option of direct administration of TANF programs. No Tribe in North Dakota has yet exercised this option.

Uniform Interstate Family Support Act (UIFSA) - is a model Act, enacted at the state level, to provide mechanisms for establishing and enforcing child support obligations in interstate cases (cases in which a noncustodial parent lives in a different state than the custodial parent and child).

UPA - Either the Uniform Parentage Act or Unreimbursed Public Assistance. The **Uniform Parentage Act** refers to laws, based on model legislation drafted by the National Conference of Commissioners on Uniform State Laws (NCCUSL), enacted at the state level to provide mechanisms for establishing paternity. **Unreimbursed Public Assistance** refers to money paid in the form of public assistance (for example, Temporary Assistance for Needy Families expenditures), which has not been recovered by retaining assigned child support.

URM - Unaccompanied Refugee Minor is a child between the ages of birth and 18 who enters the United States with refugee immigration status and the parents are deceased or their whereabouts unknown, and the child is without a family connection. URM youth enter a foster care program specifically administered for their care through a voluntary agency with coordination of the Department. URM foster care meets state licensing requirements.

VIPR - The Very Intelligent Payment Recognition system is a computerized check processing system used by the Child Support Enforcement Division to process child support payments quickly and accurately. It interfaces with the Fully Automated Child Support Enforcement System (FACSES) computer system.

Vision - The computer system currently used by county social services to administer Temporary Assistance for Need Families (TANF) benefits and some Medicaid cases.

Vocational Development - A program of vocational preparation prior to competitive or extended employment.

VR - Vocational Rehabilitation provides training and employment services to individuals with disabilities so they can become and/or remain employed. For information about a related service provided by department VR professionals for businesses. See *Rehabilitation Consulting and Services.*

Vulnerable Adult Protective Services - Refers to remedial social, legal, health, mental health, and referral services provided for prevention, correction, or discontinuation of abuse or neglect which are necessary and appropriate under the circumstances to protect an abused or neglected vulnerable adult. Services also ensure that the least restrictive alternatives are provided, prevent further abuse or neglect, and promote self care and independent living. (Reference: North Dakota Century Code Chapter 50-25)

WCHSC - West Central Human Service Center is located in Bismarck. (*See HSC definition.*)

Wraparound - This is a strength-based philosophy of care that includes a definable process involving the child and family that results in a unique set of community services and supports individualized for that child and family. Wraparound is a process. It is not a program. It does not create new programs or services, but is the method of meeting the needs of families through the coordination and identification of natural supports and formal supports, which constitute the Child and Family Team. This process is team driven, focuses on least restrictive methods of care, and uses the family's strengths, preferences, and choices whenever possible. It is a continuum of intensity, which is driven by family needs, complexity, and level of risk.

YRBS - Youth Risk Behavioral Survey is conducted by the North Dakota Department of Health and the North Dakota Department of Public Instruction and monitors health-risk behaviors among youth and young adults including behaviors that contribute to injuries, tobacco use, alcohol and other drug use, sexual behaviors, dietary behaviors, and physical activity.

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DHS Overview

Testimony
House Bill 1012 – Department of Human Services
House Appropriations Committee
Representative Ken Svedjan, Chairman
January 9, 2009

Chairman Svedjan, members of the House Appropriations Committee, I am Carol K. Olson, Executive Director of the North Dakota Department of Human Services. Thank you for this opportunity to introduce the Department's budget request for the 2009-2011 biennium and to provide you with background about the Department and how human service related needs have been identified and incorporated into this budget.

The Department is an umbrella agency that serves vulnerable individuals by providing and funding health and human services. The Department's clients primarily include low-income and at-risk infants and children, pregnant low-income women, single-parent families, the elderly, and people with disabilities of all ages. When child support services are factored in, it has been estimated that the Department serves as many as one in five North Dakotans.

Our mission is to provide quality, efficient, and effective human services, which improve the lives of people.

To build the Department's budget, we actively seek out information about health and human service needs at the local level by hosting stakeholder meetings statewide each biennium. These public meetings are held in non-session years and participants include clients, providers, advocates, legislators, Tribal program representatives, interested members of the public, Department and county employees, and others. The Department

also receives, reviews, and considers written comments and requests submitted by many of these same entities. Based upon the comments and information received, plus numerous meetings with various groups and associations, we begin to set priorities and to develop the budget.

MAJOR PROGRAM CHANGES AND INITIATIVES

Behavioral Health Needs

During the public stakeholder meetings, we heard repeated concerns expressed about the state's capacity to serve individuals with behavioral health needs – which are those individuals with substance abuse or mental health needs. The State Hospital has been at capacity for some time, and there is a concerted effort nationally and in the state to serve all people with disabilities in the least restrictive setting.

Stakeholders told us that there were not sufficient resources at the community level to address the needs of those who need more structured and supervised care. Private hospitals that contract with the Department's regional human service centers were concerned about reimbursement levels and their costs for providing inpatient crisis stabilization services and care. Some hospitals closed or limited admissions to their behavioral health units, putting even more pressure on others and on the State Hospital.

In building the budget, we used consistent methods to set hospital reimbursement rates across all regions rather than negotiate different contracts, and we increased those rates to the same level as the inpatient hospital rebasing to encourage hospitals to continue to serve clients

locally. Rates for other providers are increased as well (seven percent inflationary increase each year of the biennium).

This budget also includes funding to increase the number of residential beds in Minot and Dickinson. It also provides for more client service hours in the Grand Forks region and extra staffing in Fargo as a result of the Cooper House project. Supported residential services help people with chronic serious mental illness or addictions break the cycle of evictions, crisis bed admissions, emergency room visits, jail, and inpatient hospitalization.

There is also funding for additional staff at the State Hospital. In short, this budget allows us to address capacity concerns and to provide behavioral health service in a variety of settings to meet individual needs.

In regard to other capacity issues in the mental and behavioral health arena – the Department is aware of the needs of returning National Guard soldiers and their families - especially those affected by traumatic brain injuries. We are working with other providers and organizations to address needs in a coordinated manner.

At the community level, the Department continues to support the implementation of the recovery model and evidence-based treatment methods shown to produce better outcomes such as the Matrix model of addiction treatment, integrated dual disorder treatment for people diagnosed with both mental illness and addiction, and peer support. The Department will continue to promote the use of effective treatment models, and to support training opportunities for both public and private treatment professionals.

Impact of Aging Population

The needs of North Dakota's aging population are already impacting service capacity. By the year 2020, it is projected that about one in four North Dakotans will be age 60 and older, and three in 100 will be age 85 and older – the group most likely to need services.

We know from AARP data that older adults prefer to receive services in their homes as long as possible. We need to be responsive to that by providing home and community based services along with a strong continuum of long term care options.

The Executive Budget for the Department provides a 52 percent increase for home and community based long term care services funded through the Service Payments for the Elderly and Disabled (or SPED) program, the Expanded SPED program, and Medicaid waivers, personal care, and hospice services. This increase of more than $21.5 million will help elderly individuals and people with disabilities in North Dakota maintain their independence.

In addition, this budget doubles funding for training in-home care providers known as Qualified Services Providers (QSP). It also includes $900,000 to address cost increases experienced by the Older Americans Act service providers who provide senior meals, outreach, and health maintenance services, and contains $600,000 to fund an Aging and Disability Resource Center that will help people locate and access needed long term care services.

This budget provides important inflationary increases to all long term care service providers. Qualified Service Providers (QSP) will also receive the seven percent inflationary increase.

Statewide, participants in our stakeholder meetings told us the state needs to raise the income levels for the Medicaid Medically Needy coverage group, which includes low-income children, people who are older, blind, disabled, and families with deprived children who do not have enough income to meet their medical needs. The Medicaid program requires them to pay for their medical costs until they reach the "Medically Needy Income Level." At that point, Medicaid pays their medical costs. This "income level" is supposed to be enough to cover food, shelter, utilities, and clothing needs. The Medically Needy income level was last changed in 2003. This budget includes funding to raise the income limit to 83 percent of the federal poverty level, and this will significantly help these Medicaid recipients.

Senior citizens and people with disabilities also need transportation to enjoy a higher quality of life. The Department continues to collaborate with the Department of Transportation to develop an effective and efficient transportation infrastructure to meet the needs of individuals served by our Medicaid and Aging Services Divisions.

Services for Children

To address the health needs of uninsured children, this budget increases the income eligibility level for the State Children's Health Insurance Program (SCHIP) to 200 percent of the poverty level (uses net income).

This will allow North Dakota to cover an average of 6,021 children per month who would otherwise be uninsured.

Many working parents also struggle with the cost of child care. This budget increases child care assistance for low-income working families. It also funds child care provider training and other quality initiatives, which along with mandatory criminal background checks for child care workers, will help working families find safe and accessible child care.

This budget also increases Family Foster Care payments to the nationally recommended level. Other than inflationary increases supported by the Legislature, rates for these important caregivers have not been adjusted since 1999.

Children often come into the foster care system as a result of abuse or neglect. Establishing whether abuse occurred requires special expertise, and Child Advocacy Centers also receive important continued financial support in this budget. These centers work to reduce additional trauma to children while ensuring that those involved in investigating, providing services, and enforcing the law, can effectively address the physical and sexual abuse of children.

During our stakeholder meetings, we also heard about the need to be more effective serving young people transitioning from foster care or other services into adulthood and adult services. Often these young people do not have a place to live and are not ready to live on their own. In response to this identified need, the Department's budget includes funding for youth facilities in Bismarck and Fargo, each providing eight residential beds for youth in transition. In addition to shelter,

participating youth will have access to counseling, case management, and other services through the regional human service centers.

Effectively serving youth involves collaboration. We are working with other agencies including the Department of Public Instruction, Juvenile Services, and other organizations at the state and local level to identify services provided through the different agencies, to reduce duplication, and to address gaps in service so that together we can foster independence and promote leadership among youth.

Efficiency and Effectiveness

The Department utilizes a management team known as the Cabinet, which includes representatives of the eight regional human service centers, the State Hospital and Developmental Center, program and policy divisions, economic assistance programs, Medicaid and medical services, and administrative support services.

Our management team and our Department's culture support innovation. I have already mentioned our efforts to provide effective evidence-based treatment services.

Our Child Support Enforcement Division continues to identify and find efficiencies following the change to state administration of the regional enforcement offices. The program has earned national recognition as a top-performing program, and has also been recognized for innovation and innovative partnerships along with other Department divisions.

Our Children and Family Services Division continues to collaborate on training and coordination with the court system to ensure that the children and families involved in the child welfare system receive quality services.

Through contracts with public and private providers, North Dakota is exceeding the work participation rate goals for parents involved in the state's Temporary Assistance for Needy Families program.

The Department has a history of working effectively with other organizations to address shared concerns and will continue to do so. The Department and its staff are responsive to changing needs and emerging opportunities.

Long term, we intend to continue hosting stakeholder meetings and other public meetings and to communicate with and be accessible to clients, their family members, legislators, advocates, providers, and other stakeholders in order to identify needs and concerns and effectively address them.

Overview of Department Budget Changes

The Department's 2009-2011 budget request totals $2.26 billion – an increase of $352.8 million in total funds. The state general fund increase is $125.8 million. This general fund increase is due to the inflationary and other increases to providers, the Governor's salary and benefit package for state employees, and the decrease in the Federal Medical Assistance Percentage (FMAP).

In closing, this budget meets the needs identified in communities across the state. It sustains important existing services, increases Medicaid payments for hospitals, doctors, dentists, chiropractors, and ambulance service providers, and provides an inflationary increase for all providers. It also allows North Dakota to provide important health coverage for uninsured children that is comparable to other states. It truly does improve the quality of life of our citizens.

Thank you for your time. Allow me now to introduce the Department's Chief Financial Officer Brenda Weisz who will be providing a detailed overview of the Department's 2009-2011 budget.

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations Committee
Senator Raymond Holmberg, Chairman
March 3, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, I am Carol K. Olson, Executive Director of the North Dakota Department of Human Services. Thank you for this opportunity to introduce the Department's budget, after House amendments for the 2009-2011 biennium and to provide you with background about the Department and how human service related needs were identified and incorporated into the Executive Budget.

The Department is an umbrella agency that serves vulnerable individuals by providing and funding health and human services. The Department's clients primarily include low-income and at-risk infants and children, pregnant low-income women, single-parent families, the elderly, and people with disabilities of all ages.

Our mission is to provide quality, efficient, and effective human services, which improve the lives of people.

To build the Department's budget, we actively seek out information about health and human service needs at the local level by hosting stakeholder meetings statewide each biennium. These public meetings are held in non-session years and participants include clients, providers, advocates, legislators, Tribal program representatives, interested members of the public, Department and county employees, and others. The Department also receives, reviews, and considers written comments and requests submitted by many of these same entities. Based upon the comments

and information received, plus numerous meetings with various groups and associations, we begin to set priorities and to develop the budget.

Behavioral Health Needs

During the public stakeholder meetings, we heard repeated concerns expressed about the state's capacity to serve individuals with behavioral health needs – which are those individuals with substance abuse or mental health needs. The State Hospital has been at capacity for some time, and there is a concerted effort nationally and in the state to serve all people with disabilities in the least restrictive setting.

Stakeholders told us that there were not sufficient resources at the community level to address the needs of those who need more structured and supervised care. Private hospitals that contract with the Department's regional human service centers were concerned about reimbursement levels and their costs for providing inpatient crisis stabilization services and care. Some hospitals closed or limited admissions to their behavioral health units, putting even more pressure on others and on the State Hospital.

In building the budget, we used consistent methods to set hospital reimbursement rates across all regions rather than negotiate different contracts, and we increased those rates to the same level as the inpatient hospital rebasing in the Medicaid budget to encourage hospitals to continue to serve clients locally. Rates for other providers are increased as well. The Executive Budget recommended a seven percent inflationary increase each year of the biennium. The House changed that to six percent.

The Executive Budget also included funding to increase the number of residential beds in Minot and Dickinson. It also provided for more client service hours in the Grand Forks region and extra staffing in Fargo as a result of the Cooper House project. Supported residential services help people with chronic serious mental illness or addictions break the cycle of evictions, crisis bed admissions, emergency room visits, jail, and inpatient hospitalization. The House removed all funds associated with these capacity needs except for the 24/7 contract program assistant at the Cooper House project.

There was also funding for additional staff at the State Hospital, which was removed by the House as well. In short, the Executive Budget would have allowed us to address capacity concerns and to provide behavioral health services in a variety of settings to meet individual needs.

Impact of Aging Population

The needs of North Dakota's aging population are already impacting service capacity. By the year 2020, it is projected that about one in four North Dakotans will be age 60 and older, and three in 100 will be age 85 and older – the group most likely to need services.

The budget funds training in-home care providers known as Qualified Services Providers (QSP). It also includes $900,000 to address cost increases experienced by the Older Americans Act service providers who provide senior meals, outreach, and health maintenance services, and contained $600,000 to fund an Aging and Disability Resource LINK that will help people locate and access needed long term care services

(Attachment A), which was removed by the House. The budget also provides important inflationary increases to all long term care service providers. Qualified Service Providers (QSP) were recommended to receive a seven percent inflationary increase proposed by the Executive Budget. As the budget stands, this is now at six percent.

Statewide, participants in our stakeholder meetings told us the state needs to raise the income levels for the Medicaid Medically Needy coverage group, which includes low-income children, people who are older, blind, disabled, and families with deprived children who do not have enough income to meet their medical needs. The Medicaid program requires them to pay for their medical costs until they reach the "Medically Needy Income Level." At that point, Medicaid pays their medical costs. This "income level" is supposed to be enough to cover food, shelter, utilities, and clothing needs. The Medically Needy Income Level was last changed in 2003. The Executive Budget included funding to raise the income limit to 83 percent of the federal poverty level in order to significantly help these Medicaid recipients. The House modified this to 75 percent of the federal poverty level.

Services for Children

To address the health needs of uninsured children, this budget increases the income eligibility level for the State Children's Health Insurance Program (SCHIP) to 200 percent of the poverty level (uses net income). The House amended the Governor's recommendation to 160 percent.

The Department continues to support the Executive Budget request to increase the income level to 200% of the poverty level. As part of the

Department's monitoring of the trend change that Maggie Anderson will cover in more detail, we have reprojected the SCHIP enrollment expectations for 2009-2011. Because of the decline in SCHIP enrollment that we are experiencing, our estimates now indicate:

Executive Budget (with SCHIP at 200%)	$35.2 million
Reprojected Cost to increase SCHIP to 200%	$25.7 million
Funds currently in HB 1012 to increase to 160%	$32.6 million

Summary: Increasing SCHIP back to the Governor's recommendation at 200%, based on the reprojected enrollment, compared to the current funding in HB 1012 to increase SCHIP to 160% will be a decrease of $6.9 million, of which $1.7 million are general funds.

During our stakeholder meetings, we also heard about the need to be more effective serving young people transitioning from foster care or other services into adulthood and adult services. Often these young people do not have a place to live and are not ready to live on their own. In response to this identified need, the Executive Budget included funding for youth facilities in Bismarck and Fargo, each providing eight residential beds for youth in transition. In addition to shelter, participating youth will have access to counseling, case management, and other services through the regional human service centers. These facilities were removed by House amendments.

Overview of Department Budget Changes

The House modified the Executive Budget by a net decrease of $60.8 million in total with $29.2 million from the general fund. This results in a budget of $2.2 billion in total funds. This budget before you retains inflationary and other increases to providers, the Governor's salary and benefit package for state employees, along with the priorities of the House.

In closing, the Executive Budget was developed to meet the needs identified in communities across the state. It sustains important existing services, increases Medicaid payments for hospitals, doctors, dentists, chiropractors, and ambulance service providers, and provides an inflationary increase for all providers. It also allowed North Dakota to provide important health coverage for uninsured children that would have been comparable to other states. It truly was developed to improve the quality of life of our citizens.

Thank you for your time. Allow me now to introduce the Department's Chief Financial Officer Brenda Weisz who will be providing a detailed overview of the Department's 2009-2011 budget.

1-9-09
(B)

Testimony
House Bill 1012 – Department of Human Services
House Appropriations Committee
Representative Svedjan, Chairman
January 9, 2009

Chairman Svedjan, members of the House Appropriations Committee, I am Brenda M. Weisz, Chief Financial Officer for the Department of Human Services. I will be providing an overview of the Department's 2009 – 2011 budget request included in HB 1012 along with related fiscal information.

2007 – 2009 One-time Funding

The Department's 2007 – 2009 budget includes one-time funding of $11.9 million with $3.6 million devoted to the Medicaid Management Information System (MMIS) and $8.3 million for Capital Improvements and Extraordinary Repairs at the State Hospital and the Developmental Center. The Department anticipates utilizing the entire $3.6 million appropriated to complete the MMIS project. Regarding the funding for the projects at the Institutions, all funding will be utilized except for the $3.1 million appropriated for a fifth addition to the Sex Offender Treatment Program. As reported at the September 25, 2008 Budget Section meeting, the fifth unit will not be constructed. After approval of alternate projects, only $1.75 million of the $3.1 million will be spent this biennium.

2007 – 2009 - Current Estimates of Overall Expenditures as Compared to General Fund Appropriation Authority (Turnback)

When comparing the current biennium expenditures in the major program areas to the amount of general fund appropriated, as very recent as

December 23, the Department is estimating unexpended general fund or turnback of $22.4 million. The breakdown is as follows:

- Areas we have been aware of for a good part of the biennium:
  - Human Service Centers - estimated turnback of $2.0 million as a result of staff turnover and difficulty in filling psychology and psychiatry positions;
  - State Hospital - estimated turnback of $2.7 million when including the $1.3 million unspent one-time capital project funds as discussed above;
  - Long Term Care – estimated turnback of $4 million - primarily from Nursing Facilities as the bed utilization has been down the entire biennium compared to the beds budgeted;
  - Medicare Drug Clawback – estimated turnback of $1.6 million; and
  - Healthy Steps Program shortfall of just over $500,000 offsets the above amounts.
- Areas we have most recently been able to identify - Medicaid Traditional grants – estimated turnback of $12.6 million. In November reports generated from the old MMIS indicated utilization and cost data that needed further analysis. This analysis work was completed in December, and the remaining turnback can be attributed to three areas:
  - Drug Costs – when we prepared the budget for the current 2007 – 2009 biennium, we had decreased the drug budget in consideration of the implementation Medicare Part D. However, we had limited information on the impact of Medicare Part D when that budget was prepared. We now know the impact is greater than anticipated. Also there is a much higher usage of generic drugs than anticipated.

- Medicare premiums – the federal government sets these premiums and the federal increases were not at the level anticipated when the budget was developed.
- Inpatient Hospital / Physician Services – our antiquated MMIS plus two federally required changes – 1) the implementation of the National Provider Identification (NPI) and 2) the implementation of Coordination of Benefit Administration (COBA), essentially the crossover of Medicare claims, resulted in a high backlog of claims and cashflow problems for providers. The Department paid claims to alleviate the cashflow problems through a process known as a "payout." These payments started to be made at the end of the 2005 – 2007 biennium and continued through December 2007. These payouts covered all claims that had been submitted from providers where normally there is often a 30 day or more lag in processing claims. Essentially, what resulted were claims being paid in 2005 – 2007 as they were legitimate expenditures for that time frame, with the budget for those payments located in the 2007 – 2009 biennium. The delay in determining this impact on our "general fund need" is a result of the actual processing of those claims. When processing those claims, the system needs to consider what has already been paid as a payout. This process is called a "recoupment." This constant payout and recoupment situation then impacted our ability to properly track cost and utilization information. We continue to analyze and watch this situation.

As point of comparison the turnback for the 2005 – 2007 biennium was $5.6 million. The general fund appropriation was $484.7 million.

Major Policy Changes in Developing 2009 – 2011 Budget

The 2009 – 2011 Executive Budget includes the following program changes:

- Increasing the allowed funeral set-aside under the Medicaid Program from the current level of $5,000 to $7,000. Section 6 of the Department's appropriation bill provides the statutory changes to implement this increase.

- Increasing eligibility for the Healthy Steps Program from 150% net of poverty to 200% net of poverty. This change is included in Section 7 of the Department's appropriation bill.

- Increases the foster care payment made to family foster care homes. This increase will bring North Dakota rates to a level of payment known nationally as the MARC (Minimum Adequate Rates for Children). This change is expected to assist in the recruitment and retention of family foster homes.

- Changes the administrative payment structure to Providers of services for those with Developmental Disabilities (DD). The Department's budget provides for administrative reimbursement based on the level of capability of the client (Progress Assessment Review [PAR] level) rather than two flat levels of reimbursement for the Individualized Supported Living Arrangements (ISLA) and the Family Care Option III programs.

Current Budget / Budget Request

The 2009 – 2011 Executive Budget request compared to the current 2007 – 2009 biennial budget is as follows:

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / Decrease
Salary and Wages	50,741,266	63,968,091	13,226,825
Operating	153,961,819	119,790,606	(34,171,213)
Capital Assets	1,837,987	13,000	(1,824,987)
Grants	343,699,648	456,965,308	113,265,660
HSCs / Institutions	241,868,720	276,528,142	34,659,422
Grants - Medical Assistance	1,117,187,821	1,344,821,814	227,633,993
Total	1,909,297,261	2,262,086,961	352,789,700
General Funds	595,736,533	721,512,545	125,776,012
Federal Funds	1,212,943,782	1,434,591,720	221,647,938
Other Funds	100,616,946	105,982,696	5,365,750
Total	1,909,297,261	2,262,086,961	352,789,700
FTE	2,223.38	2,237.38	14.00

Explanation of Major Budget Changes

As noted above, the **general fund increase** is **$125.8** million and can be explained as follows:

$38.9 million – Net cost changes in the grant programs of the Department including traditional Medicaid grants, nursing facilities, Developmental Disability grants, Home and Community Based Services, and child welfare grants. Changes are the result of several factors such as rate setting rules, federal mandates, continuation of the year two 5% inflationary increase granted during the current biennium, along with

costs which cannot be controlled by the Department (drugs, premiums - Medicare, Healthy Steps premium).

($13.9) million – net decrease in caseload / utilization. The largest impact of change in this area is a decrease in the utilization in the Medicaid Program and in the Nursing Home budget along with a decrease in the Foster Care caseload. These decreases are offset by increases primarily in Home and Community Based Services and the Healthy Steps Program.

$21.9 million – increase attributed to the Governor's salary and benefit package.

$37.1 million – increase to fund a 7% inflationary increase to most providers in each year of the biennium. Hospitals, Physicians, Chiropractors, and Ambulance providers will see a 7% increase in year two only as a result of the changes reflected in adopting a version of the rebasing reports completed during the interim.

$14.8 million – increase related to rebasing Hospitals, Physicians, Chiropractors, and Ambulance providers. Also included in this amount is an increase in Dental rates to pay at an average of 75% of average billed charges. This action was a result of legislation included in the Department's current appropriation bill where the rates paid to these providers were to be studied.

$10.2 million – increase in state funds as a result of the decrease in the Federal Medical Assistance Percentage (FMAP). This percentage is based

on per capita income of North Dakota in relation to other states. The FMAP rates for the upcoming biennium are as follows:

- FFY 2009 – 63.15% Final – in effect now
- FFY 2010 – 63.01% Final
- FFY 2011 - 63.01% Estimated (preliminary number usually issued in April)

($15.0) million – decrease in one-time capital projects, extraordinary repairs, and bond payments ($11.4 million) along with the decrease for one-time funding for the Medicaid system project - ($3.6 million).

$5.2 million – to fund bond payments, capital projects, extraordinary repairs and major equipment needs at the Institutions for repair and maintenance of infrastructure and operations. ($3.9 million - State Hospital and $1.3 million – Developmental Center)

$4.0 million – increased Information Technology costs in both the rates charged by the Information Technology Department and to support ongoing operational costs of the new MMIS, Point of Sale, and Decision Support systems often referred to as the Medicaid system project.

$7.0 million – Funding Changes – see **Attachment A** for additional detail.

$4.4 million – Changes in Home and Community Based Services – see **Attachment A** for additional detail.

$1.4 million – Select changes at the Human Service Centers – see **Attachment A** for additional detail.

$1.0 million – Changes in the grants for those with Developmental Disabilities. See **Attachment A** for additional detail.

$4.3 million – increase to address capacity issues at the Human Service Centers and the State Hospital which we have come to refer to as "global behavioral health" capacity issues. This reflects a consistent fee paid to the psychiatric hospitals in the regions for our clients that are indigent, enhanced residential services in the Minot, Grand Forks, and Dickinson regions, four FTE and a contracted program assistant as a result of the Cooper House Residential Unit in the Fargo region, an addiction case manager in the Jamestown region, and six additional FTE at the State Hospital as they are currently staffed to handle a capacity of 85%. During the biennium, capacity at the State Hospital has often been at 100%.

$2.0 million – increase to move the medically needy income level to 83% of the poverty level. Medically Needy is an eligibility category under the Medicaid program. This change will allow those eligible to retain more of their income to meet such expenses as food, shelter, utilities, and clothing. Currently a household size of one is able to retain $500 per month, while this change will increase that amount to $720 per month.

$1.1 million – increase needed to cover children under the Healthy Steps Program at 200% net poverty level.

$0.6 million – increase needed to provide a rate increase to Child Care providers and to complete mandatory background checks.

The remaining **$0.8** million or 0.6% of the general fund increase - is tied to miscellaneous net increases throughout the Department, which will be addressed by each division in the upcoming days.

FTE CHANGES

The net increase of 14 FTE in the Department's budget is attributed to the following:

- 11 FTE in the area of Global Behavioral Health discussed previously.
- 6 additional FTE at the Human Service Centers (HSCs). 1.0 FTE to address capacity needs in the Partnership Program at Southeast HSC, 1.0 FTE to address the aging population and additional need for staff regarding vulnerable adult protective services at South Central HSC, and 4.0 FTE for DD case managers (one each at North Central HSC, Northeast HSC, Southeast HSC and West Central HSC). The addition of these DD case managers is a result of federal requirements.
- 1.5 FTE to handle the increased eligibility in the Healthy Steps program.
- 1.0 FTE in response to the efforts related to the implementation of an Autism waiver.
- 1.0 FTE to implement the Statement on Auditing Standards (SAS) 112 which was issued in response to Enron and other such activities found in other companies.
- Two .5 or half-time FTE (1.0 in total) to address the efforts related to mandatory background checks for Child Care Providers.
- Offsetting the additional FTE is the reduction of 7.5 FTE in the Child Support area.

Key Points in Developing the Budget

Traditional Medicaid grants – The traditional Medicaid grants budget was built using utilization and cost data by services. The number of estimated eligibles for the 2009 – 2011 budget is 51,308, which is down from the estimate of 52,308 for the current budget.

Healthy Steps Program – The budget is based on an average caseload of 6,021 children along with a premium increase of 20.52%. This is the largest premium increase since the 2003 – 2005 biennium. (Last biennium – 11.39% increase; 2005 – 2007 biennium – 17.76% increase.)

Foster Care grants – The first time in at least five budget cycles, the Foster Care caseload included in the 2009 – 2011 budget for Family and Residential care is estimated to be lower than the budget for the current biennium.

Home and Community Based Services – When considering the cost and caseload changes, along with the other program changes, the Executive Budget reflects a 52% increase in this area of the budget. See **Attachment B and C** for a breakdown among Long Term Care services for the upcoming biennium.

Institutions – The budget request for the State Hospital is based on 222 beds for the traditional population, which includes 90 beds for the Tompkins program. Additionally, the budget includes 85 beds for the civilly committed sex offender program. The budget request for the Developmental Center is based on a population of 115.

Finally, I would like to direct your attention to **Attachment D**, which indicates "Where the Money Goes" in the Department. 83% of the budget goes directly "out the door" to providers or grant recipients. This compares to 80% of the budget for the 2007 -2009 biennium. Another 11% is expended on direct client services at the Human Services Centers and the Institutions, which remains the same as the 2007 – 2009 budget. Finally 6% of the budget is dedicated to the administrative costs, which has also remained unchanged from the current budget.

The budget before you is a strong budget for the most vulnerable citizens of the State of North Dakota for which this budget is designated to serve. In the upcoming days and weeks, we will be ready to answer your questions as we work through the details of this budget.

This concludes my testimony. At this time I would be willing to address your remaining questions and will also be available for any budget questions that may come to mind in the upcoming months.

Thank you.

ATTACHMENT A

Department of Human Services
2009 - 2011 Budget To House
Detail of Specific Increases

Program Detail of Changes	Total Funds	General Funds	Other Funds
(Expressed in millions)			
Funding Changes			
IGT Funding Switch	0.0	(2.5)	2.5
Line of Credit for DD grants funding switch	0.0	3.5	(3.5)
Child Support - loss of ability to use incentive funds as match - replace with general fund	0.0	1.5	(1.5)
Regional Child Support Enforcement - replace county dollars	0.0	3.4	(3.4)
Decrease in Retained Child Support Collections for TANF MOE	0.0	1.1	(1.1)
TOTAL	0.0	7.0	(7.0)
Home and Community Based Services Changes			
Hospice for Children Waiver	0.9	0.3	0.6
Revising the SPED sliding fee scale	0.6	0.6	0.0
Removal of Cap in services for Adult Family Foster Care	0.2	0.1	0.1
Increase Personal Needs allowance for SSI only- $30 to $50	0.1	0.1	0.0
Add 3rd Tier to Personal Care services	2.7	1.0	1.7
Aging and Disability Resource Center	0.6	0.6	0.0
Increase for Centers for Independent Living	0.8	0.8	0.0
Increase to Senior Service Providers	0.9	0.9	0.0
TOTAL	6.8	4.4	2.4
Human Service Center Changes			
Move drug court budget from DOCR to SEHSC	0.2	0.2	0.0
Addition of 4 DD Case Managers - CMS changes	0.4	0.2	0.2
Add 1.0 FTE for Partnership Program at SEHSC	0.1	0.1	0.0
Addition of contracted Young Adult Transition Residential Facilities - SEHSC and WCHSC	1.2	0.8	0.4
Add 1.0 FTE for Vulnerable Adult Protective Services - SCHSC	0.1	0.1	0.0
TOTAL	2.0	1.4	0.6
DD Grant Changes			
Funding for Intense Medical Needs - Family Homes	0.6	0.2	0.4
Funding for Intense Medical Needs - Adult Residential Facility	0.8	0.3	0.5
Increase Personal Needs allowance for ICF/MR - $50 to $60	0.1	0.0	0.1
Autism Waiver for those under 5 years of age	1.2	0.5	0.7
TOTAL	2.7	1.0	1.7

Department of Human Services
2009 - 2011 Budget to House
Where Does the Money Go?
Long Term Care Continuum (Excluding DD Grants)
Total Funds $501,986,472

.03
Basic Care

.13
Home & Community Based Services

.84
Nursing Homes

Attachment B

FA-12/22/08-cj\0911legis\house dollar

Department of Human Services
2009 - 2011 Budget to House
Where Does the Money Go?
Long Term Care Continuum (Including DD Grants)
Total Funds $825,042,515

.02
Basic Care

.39
Developmental Disabilties Grants

.51
Nursing Homes

.08 Home & Community
Based Services

FA-12/22/08-cj\0911legis\house dollar

Attachment C

Department of Human Services
2009 - 2011 Budget to House
Where Does the Money Go?
Department-Wide
Total Funds $2,262,086,961

.04	.05	.06	.06	.14	.19	.23	.23
HCBS & Basic Care	Insti-tutions	Admin-istration	Human Service Centers	Developmental Disabilities Grants	Nursing Homes	Direct Client Services *	Traditional Medical Grants & CHIP

* Includes TANF, JOBS, Child Care, Food Stamps, Heating Assistance, IV-D Tribal, IV-D Judicial, Child Welfare, Aging, Mental Health, Substance Abuse, Vocational Rehabilitation, and Non-Medicaid Developmental Disability grants and services.

FA-12/22/08-cj\0911legis\house dollar

Attachment D

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations Committee
Senator Holmberg, Chairman
March 3, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, I am Brenda M. Weisz, Chief Financial Officer for the Department of Human Services. I will be providing an overview of the Department's 2009 – 2011 budget request included in HB 1012 along with related fiscal information and then finally the changes made by the House Appropriations Committee.

2007 – 2009 General Fund (Turnback)

When comparing the current biennium expenditures in the major program areas to the amount of general fund appropriated, the turnback as included in OMB's Revised Revenue Forecast could be as much as approximately $22 million. The estimated breakdown is as follows:

- Areas we have been aware of for a good part of the biennium:
  - Human Service Centers - estimated turnback of $2.0 million as a result of staff turnover and difficulty in filling psychology and psychiatry positions;
  - State Hospital - estimated turnback of $2.7 million, which includes $1.3 million of unspent one-time capital project funds;
  - Long Term Care – estimated turnback of $4.6 million - primarily from Nursing Facilities as the bed utilization has been down the entire biennium compared to the beds budgeted;

- Areas most recently identified - Medicaid Traditional grants – estimated turnback of $12.6 million. In November reports generated from the old MMIS indicated utilization and cost data that needed further analysis. This analysis work was completed in December, and the remaining turnback can be attributed to three areas:
    - Drug Costs – ($6.7 million) when we prepared the budget for the current 2007 – 2009 biennium, we had decreased the drug budget in consideration of the implementation of Medicare Part D, which occurred in January 2006. However, we had limited information on the impact of Medicare Part D when that budget was prepared (beginning in April 2006). We now know the impact is greater than initially projected. Also there is an increased usage of generic drugs than had been anticipated. Finally, there was a change in the method used to claim drug rebates. This federal change resulted in our ability to claim drug rebates from prior periods. This will not continue into the future. Drug rebates offset our drug expenditures. The Executive Budget reflects a request for drugs at a lower level than the budget for 2007 – 2009.
    - Medicare premiums – ($1.6 million) the federal government sets these premiums and the federal increases were not at the level anticipated when the budget was developed.
    - Inpatient Hospital / Physician Services – ($4.3 million) our antiquated MMIS plus two federally required changes – 1) the implementation of the National Provider Identified (NPI) and 2) the implementation of Coordination of Benefit Agreement (COBA), essentially the crossover of Medicare claims, resulted in a high backlog of claims and cashflow problems for

providers. The Department paid claims to alleviate the cashflow problems through a process known as a "payout." These payments started to be made at the end of the 2005 – 2007 biennium and continued through December 2007. These payouts covered all claims that had been submitted from providers where normally there is often a 30 day or more lag in processing claims. Essentially, what resulted were claims being paid in 2005 – 2007 as they were legitimate expenditures for that time frame, with the budget for those payments located in the 2007 – 2009 biennium. This too is a one-time situation that will not continue.

When you exclude the unique circumstances with the Medicaid program this biennium, the turnback is only 1.6%. With Medicaid Traditional grants that percentage increases to 3.8%, which means we are estimated to be 96% on target. As point of comparison the turnback for the 2005 – 2007 biennium was $5.6 million or 1.2%. The general fund appropriation was $484.7 million.

Major Policy Changes in Developing 2009 – 2011 Budget

The 2009 – 2011 Executive Budget included the following program changes:

- Increased the allowed funeral set-aside under the Medicaid Program from the current level of $5,000 to $7,000. The House passed HB 1477 which set the level at $6,000.

- Increased eligibility for the Healthy Steps Program from 150% net of poverty to 200% net of poverty. The House passed HB 1478 which set eligibility at 160% net of poverty.

- Increases the foster care payment made to family foster care homes. This increase will bring North Dakota rates to a level of payment known nationally as the MARC (Minimum Adequate Rates for Children). This change is expected to assist in the recruitment and retention of family foster homes.

- Changes the administrative payment structure to Providers of services for those with Developmental Disabilities (DD). The Department's budget provides for administrative reimbursement based on the level of capability of the client (Progress Assessment Review [PAR] level) rather than two flat levels of reimbursement for the Individualized Supported Living Arrangements (ISLA) and the Family Care Option III programs.

Current Budget / Budget Request / House Changes

The 2009 – 2011 Executive Budget request compared to the current 2007 – 2009 biennial budget along with the changes made by the House is as follows:

Description	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget	House Changes	To Senate
Salary and Wages	50,741,266	13,226,825	63,968,091	(6,479,666)	57,488,425
Operating	153,961,819	(34,171,213)	119,790,606	(1,086,455)	118,704,151
Capital Assets	1,837,987	(1,824,987)	13,000		13,000
Grants	343,699,648	113,265,660	456,965,308	(1,834,504)	455,130,804
HSCs / Institutions	241,868,720	34,659,422	276,528,142	(13,097,981)	263,430,161
Grants - MA	1,117,187,821	227,633,993	1,344,821,814	(38,253,110)	1,306,568,704
Total	1,909,297,261	352,789,700	2,262,086,961	(60,751,716)	2,201,335,245
General Funds	595,736,533	125,776,012	721,512,545	(29,152,111)	692,360,434
Federal Funds	1,212,943,782	221,647,938	1,434,591,720	(31,434,045)	1,403,157,675
Other Funds	100,616,946	5,365,750	105,982,696	(165,560)	105,817,136
Total	1,909,297,261	352,789,700	2,262,086,961	(60,751,716)	2,201,335,245
FTE	2,223.38	14.00	2,237.38	(20.50)	2,216.88

Explanation of Major Budget Changes in the Executive Budget

As noted above, the Executive Budget included a **general fund increase** of **$125.8** million and can be explained as follows:

$38.9 million – Net cost changes in the grant programs of the Department including traditional Medicaid grants, nursing facilities, Developmental Disability grants, Home and Community Based Services, and child welfare grants. Changes are the result of several factors such as rate setting rules, federal mandates, continuation of the year two 5% inflationary increase granted during the current biennium, along with

costs which cannot be controlled by the Department (drugs, premiums - Medicare, Healthy Steps premium).

($13.9) million – net decrease in caseload / utilization. The largest impact of change in this area is a decrease in the utilization in the Medicaid Program and in the Nursing Home budget along with a decrease in the Foster Care caseload. These decreases are offset by increases primarily in Home and Community Based Services and the Healthy Steps Program. The House further reduced funding in this area.

$21.9 million – increase attributed to the Governor's salary and benefit package, the cost to continue this biennium's year two salary increases along with the equity funding initially included in the Executive Budget. The House removed the equity funding from all agency budgets and underfunded salaries department-wide by $6.1 million. In the Executive Budget we had already included $1.3 million of underfunding. The House amendment brings that number to $7.4 million.

$37.1 million – increase to fund a 7% inflationary increase to most providers in each year of the biennium. Hospitals, Physicians, Chiropractors, and Ambulance providers will see a 7% increase in year two only as a result of the changes reflected in adopting a version of the rebasing reports completed during the interim. The House modified this to 6% inflationary increases.

$14.8 million – increase related to rebasing Hospitals, Physicians, Chiropractors, and Ambulance providers. Also included in this amount is an increase in Dental rates to pay at an average of 75% of average billed charges. This action was a result of legislation included in the

Department's current appropriation bill where the rates paid to these providers were to be studied. The House modified the rebasing for all groups except the Hospitals.

$10.2 million – increase in state funds as a result of the decrease in the Federal Medical Assistance Percentage (FMAP). This percentage is based on per capita income of North Dakota in relation to other states. The FMAP rates for the upcoming biennium are as follows:

- FFY 2009 – 63.15% Final – in effect now
- FFY 2010 – 63.01% Final
- FFY 2011 - 63.01% Estimated (preliminary number usually issued in April)

($15.0) million – decrease in one-time capital projects, extraordinary repairs, and bond payments ($11.4 million) along with the decrease for one-time funding for the Medicaid system project - ($3.6 million).

$5.2 million – to fund bond payments, capital projects, extraordinary repairs and major equipment needs at the Institutions for repair and maintenance of infrastructure and operations. ($3.9 million - State Hospital and $1.3 million – Developmental Center)

$4.0 million – increased Information Technology costs in both the rates charged by the Information Technology Department and to support ongoing operational costs of the new MMIS, Point of Sale, and Decision Support systems often referred to as the Medicaid system project.

$7.0 million – Funding Changes – see **Attachment A** for additional detail.

$4.4 million – Changes in Home and Community Based Services – see **Attachment A** for additional detail.

$1.4 million – Select changes at the Human Service Centers – see **Attachment A** for additional detail.

$1.0 million – Changes in the grants for those with Developmental Disabilities. See **Attachment A** for additional detail.

$4.3 million – increase to address capacity issues at the Human Service Centers and the State Hospital which we have come to refer to as "global behavioral health" capacity issues. This reflects a consistent payment methodology for the psychiatric hospitals in the regions for our clients that are indigent and was based on the same payment rates included in the rebasing amount for hospitals in the Medicaid budget, enhanced residential services in the Minot, Grand Forks, and Dickinson regions, four FTE plus a contracted program assistant as a result of the Cooper House Residential Unit in the Fargo region, an addiction case manager in the Jamestown region, and six additional FTE at the State Hospital as they are currently staffed to handle a capacity of 85%. During the biennium, capacity at the State Hospital has often been at 100%. The House removed all costs except for the contracted program assistant for the Cooper House Residential Unit. This will result in psychiatric hospitals in Minot, Grand Forks, Fargo and Bismarck receiving one level of payment if the Human Service Center client is Medicaid eligible as compared to the rate they will receive if the Human Service Center client does not have insurance and is not Medicaid eligible.

$2.0 million – increase to move the medically needy income level to 83% of the poverty level. Medically Needy is an eligibility category under the Medicaid program. This change will allow those eligible to retain more of their income to meet such expenses as food, shelter, utilities, and clothing. Currently a household size of one is able to retain $500 per month, while this change would have increased that amount to $720 per month. For a household size of two, currently the amount that can be retained is $516. 83% of poverty equates to a monthly amount of $969. The House amended this level to 75% of the poverty level which results in a household size of one being able to retain $650 per month and a household size of two being able to retain $875 per month.

$1.1 million – increase needed to cover children under the Healthy Steps Program at 200% net poverty level. The House reduced this level to 160% net of poverty.

$0.6 million – increase needed to provide a rate increase to Child Care providers and to complete mandatory background checks.

The remaining **$0.8** million or 0.6% of the general fund increase - is tied to miscellaneous net increases throughout the Department, which will be addressed by each division in the upcoming days.

FTE CHANGES

The Executive Budget included a net increase of 14 FTE in the following areas (all added FTE have been removed by the House amendments except for the FTEs attributed to the child care background checks):

- 11 FTE in the area of Global Behavioral Health discussed previously.

- 6 additional FTE at the Human Service Centers (HSCs). 1.0 FTE to address capacity needs in the Partnership Program at Southeast HSC, 1.0 FTE to address the aging population and additional need for staff regarding vulnerable adult protective services at South Central HSC, and 4.0 FTE for DD case managers (one each at North Central HSC, Northeast HSC, Southeast HSC and West Central HSC). The addition of these DD case managers is a result of federal requirements.
- 1.5 FTE to handle the increased eligibility in the Healthy Steps program.
- 1.0 FTE in response to the efforts related to the implementation of an Autism waiver.
- 1.0 FTE to implement the Statement on Auditing Standards (SAS) 115 which was issued in response to Enron and other such activities found in other companies.
- Two .5 or half-time FTE (1.0 in total) to address the efforts related to mandatory background checks for Child Care Providers.
- Offsetting the additional FTE is the reduction of 7.5 FTE in the Child Support area.

Key Points in Developing the Budget

Traditional Medicaid grants – The traditional Medicaid grants budget was built using utilization and cost data by services. The number of estimated eligibles for the 2009 – 2011 budget is 51,308, which is down from the estimate of 52,308 for the current budget.

Healthy Steps Program – The premium increase this biennium is 20.52%. This is the largest premium increase since the 2003 – 2005 biennium. (Last biennium – 11.39% increase; 2005 – 2007 biennium – 17.76% increase.) Maggie Anderson's testimony this afternoon will address more specifically the impact of the changes made by the House.

Foster Care grants – The first time in at least five budget cycles, the Foster Care caseload included in the 2009 – 2011 budget for Family and Residential care is estimated to be lower than the budget for the current biennium.

Home and Community Based Services – When considering the cost and caseload changes, along with the other program changes, the Executive Budget initially reflected a 52% increase in this area of the budget. The House dropped this increase by almost 10% with the amendments they passed before considering the reduction they made for utilization/caseload. See **Attachment B and C** for a breakdown among Long Term Care services for the upcoming biennium.

Institutions – The budget request for the State Hospital is based on 222 beds for the traditional population, which includes 90 beds for the Tompkins program. Additionally, the budget includes 85 beds for the civilly committed sex offender program for a total of 307 beds. The budget request for the Developmental Center is based on a population of 115.

Attachment D includes a summary of the House amendments.

Finally, I would like to direct your attention to **Attachment E**, which indicates "Where the Money Goes" in the Department. 83% of the budget goes directly "out the door" to providers or grant recipients. This compares to 80% of the budget for the 2007 -2009 biennium. Another 11% is expended on direct client services at the Human Services Centers and the Institutions, which remains the same as the 2007 – 2009 budget. Finally 6% of the budget is dedicated to the administrative costs, which has also remained unchanged from the current budget.

The Executive Budget was a strong budget for the most vulnerable citizens of the State of North Dakota for which this budget is designated to serve. The House amendments will primarily impact our clients directly and present challenges for the Department. In the upcoming days, we will be ready to explain in detail the impact of the House changes and answer your questions as we work through the details of this budget.

This concludes my testimony. At this time I would be willing to address your remaining questions and will also be available for any budget questions that may come to mind in the upcoming months.

Thank you.

Department of Human Services
2009 - 2011 Budget to Senate
Where Does the Money Go?
Long Term Care Continuum (Excluding DD Grants)
Total Funds $492,296,812

.03
Basic Care

.12
Home & Community Based Services

.85
Nursing Homes

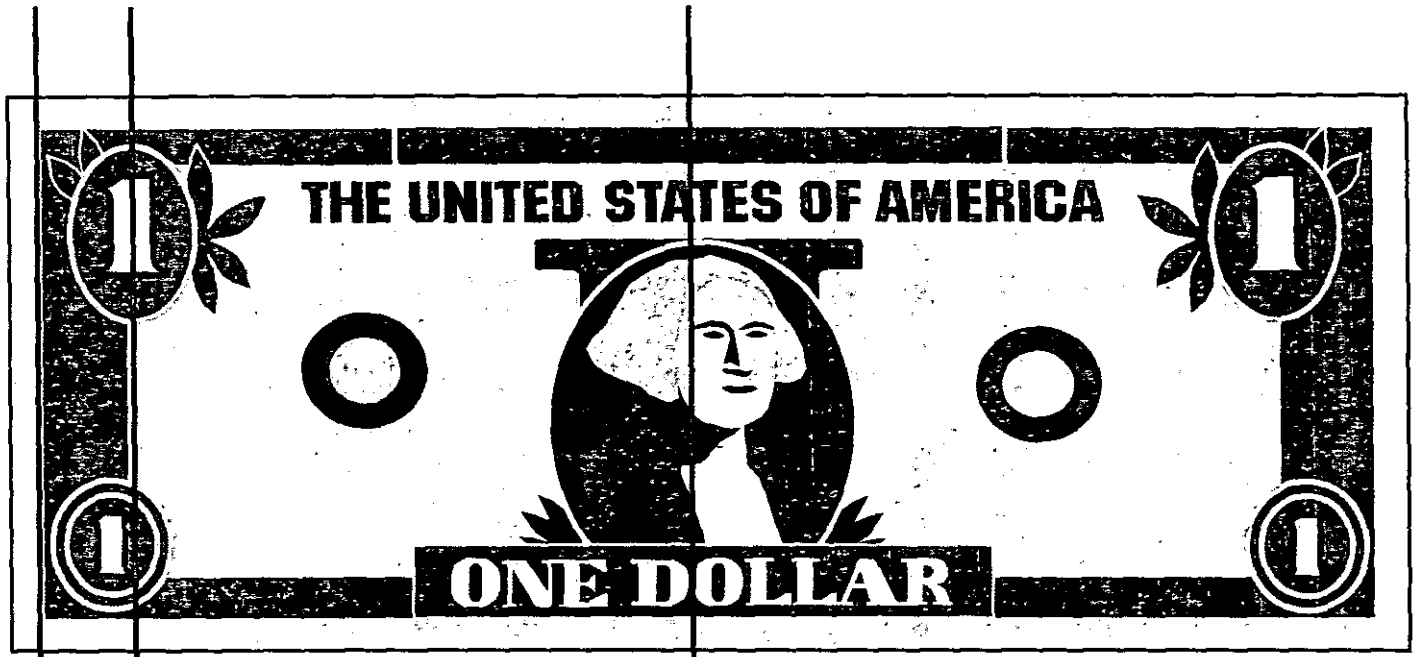
The House made decreases to Long Term Care for caseload/utilization. The Developmental Disability Grants were decreased by $6.7 million and the other LTC areas, with the exception of SPED were decreased by $15.1 million. The $15.1 million decrease was allocated to the applicable areas based upon the 2009-2011 budget "To Senate" before consideration of this adjustment.

FA-2/26/09-cj\0911legis\senate dollar

Attachment A - See testimony for Jan 9th 2009

Attachment B

Department of Human Services
2009 - 2011 Budget to Senate
Where Does the Money Go?
Long Term Care Continuum (Including DD Grants)
Total Funds $824,792,856



.02
Basic Care

.07 Home & Community
Based Services

.40
Developmental Disabilties Grants

.51
Nursing Homes

The House made decreases to Long Term Care for caseload/utilization. The Developmental Disability Grants were decreased by $6.7 million and the other LTC areas, with the exception of SPED were decreased by $15.1 million. The $15.1 million decrease was allocated to the applicable areas based upon the 2009-2011 budget "To Senate" before consideration of this adjustment.

FA-2/26/09-cj\0911legis\senate dollar

Attachment C

Attachment D

Department of Human Services
HB 102
Summary of House Changes

Division/Description	FTE	General Fund	Federal / Other Funds	Total
Department-wide				
Remove funding for salaries and wages		(2,000,000)	(4,090,893)	(6,090,893)
Remove equity funds		(3,458,506)	(1,575,064)	(5,033,570)
Remove 1/2 of travel increase		(153,344)	(232,913)	(386,257)
Reduce Inflation from 7/7 to 6/6		(5,484,468)	(8,541,509)	(14,025,977)
Management				
Remove SAS Position	(1.00)	(56,724)	(72,331)	(129,055)
Add expenses for ealy childhood advisory board		20,776		20,776
Medical Services				-
Reduce SCHIP to 160% net and remove FTE	(1.50)	(727,025)	(2,082,197)	(2,809,222)
Reduce funding for funeral setaside from Executive Budget of $7,000 to $6,000		(103,922)	(179,078)	(283,000)
Medically Needy from 83% to 75% of poverty		(376,947)	(642,379)	(1,019,326)
Rebasing Physicians at 20% of rebased amount		(979,970)	(1,670,030)	(2,650,000)
Rebased Chiropractors at 75% of rebased amount		(38,459)	(65,541)	(104,000)
Rebased Ambulance to 75% of funding in Executive Budget		(185,927)	(316,851)	(502,778)
Rebase dentist to 70% of average billed charges 0/7		(722,547)	(1,233,388)	(1,955,935)
Reduce Inflation for rebased services from 0/7% to 0/6%		(793,420)	(1,389,355)	(2,182,775)
Decrease funding for Medicaid Traditional grants for projected caseload/utilization		(9,600,000)	(16,359,978)	(25,959,978)
Long Term Care				
Increase Personal Needs Allowance from $60 to $75 for Basic Care		112,320		112,320
Increase nursing facility bed limit ($324,506 from the Health Care Trust Fund)			877,518	877,518
Nursing Homes and Basice Care salary increase - 80th percentile		4,950,451	9,788,677	14,739,128
Home and Community Based Care Waiver for Autism - Remove FTE only	(1.00)	(66,872)	(66,871)	(133,743)
Remove funding for Personal Care 3rd Tier		(1,021,922)	(1,741,524)	(2,763,446)
Decrease funding for long term care projected caseload/utilization - not SPED		(5,600,000)	(9,543,320)	(15,143,320)
Increase funding children / adults who are severely medically fragile and behaviorally challenged		438,900	747,957	1,186,857
Increase Personal Needs Allowance from $60 to $75 for DD		57,511	98,009	155,520
DD salary increase - 90th percentile		7,000,000	11,929,151	18,929,151

Attachment D

Department of Human Services
HB 102
Summary of House Changes

Division/Description	FTE	General Fund	Federal / Other Funds	Total
Decrease funding for DD grants projected caseload / utiliation		(2,476,000)	(4,219,511)	(6,695,511)
Aging Services				
Removes funding for ADRC		(600,000)		(600,000)
Mental Health and Substance Abuse				
Reduce funding increase from $300,000 to $150,000 for compulsive gambling treatment		(150,000)		(150,000)
Remove funding for Governor's Prevention and Advisory Council grants		(200,000)		(200,000)
Vocational Rehabilitation				
Reduce funding increase for Centers for Indepenent Living		(400,000)		(400,000)
State Hospital				
Decrease extraordinary repairs		(1,000,000)		(1,000,000)
Developmental Center				
Decrease extraordinary repairs		(150,000)		(150,000)
Human Service Centers				
Remove entire Global Behavioral Health - all Centers and State Hospital - except for Cooper House Project in Fargo Region	(11.00)	(4,181,604)	(426,106)	(4,607,710)
Remove DD Case Management positions - NC,NE,SE,WC	(4.00)	(235,172)	(209,416)	(444,588)
Remove Young adult transition residential facilities in SE and WC		(834,622)	(342,222)	(1,176,844)
Remove new FTE for Partnership Program - SE	(1.00)	(61,490)	(40,440)	(101,930)
Remove new FTE for Vulnerable Adult Protection Services - SC	(1.00)	(73,128)		(73,128)
NET CHANGE	(20.50)	(29,152,111)	(31,599,605)	(60,751,716)

Department of Human Services
2009 - 2011 Budget to Senate
Where Does the Money Go?
Department-Wide
Total Funds $2,201,335,245

.03	.05	.06	.06	.15	.19	.24	.22
HCBS & Basic Care	Insti-tutions	Admin-istration	Human Service Centers	Developmental Disabilities Grants	Nursing Homes	Direct Client Services *	Traditional Medical Grants & Healthy Steps

* Includes TANF, JOBS, Child Care, Food Stamps, Heating Assistance, IV-D Tribal, IV-D Judicial, Child Welfare, Aging, Mental Health, Substance Abuse, Vocational Rehabilitation, and Non-Medicaid Developmental Disability grants and services.

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Attachment E

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Department of Human Services
HB 1012
House Bills with Fiscal Impact
Supported by the Department

HB 1307	Nursing Home Ratesetting (education - ACT funds for match)
HB 1476	ADRC
HB 1477	Funeral Set Aside ~~$5~~3,000 to ~~$5~~7,000
HB 1478	SCHIP to 200% net of poverty

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north dakota
department of
human services

Fiscal Administration

(701) 328-1980
Fax (701) 328-2359
Toll Free 1-800-472-2622
ND Relay TTY 1-800-366-6888

John Hoeven, Governor
Carol K. Olson, Executive Director

DATE: March 10, 2009

TO: Senator Holmberg, Chairman
Senate Appropriations Committee

FROM: Brenda M. Weisz, CFO
Department of Human Services

RE: Requests for Information made during HB 1012 Overview Testimony

Attached please find the following information requests:

1. Percentage increase by major areas of the DHS budget since the 2001 – 2003 biennium
2. Inflationary increases granted to provider groups since 1997
3. Write-offs for the Department for the fiscal year ended June 30, 2008
4. Status of the MMIS project

Department of Human Services
HB 1012 to the Senate
Percentage Increase for major categories

Expressed in Millions

	Nursing Homes	% Change	Basic Care	% Change	Home & Community Based Services	% Change	Medicaid - Traditional	% Change	Healthy Steps	% Change	DD Grants	% Change
2001 - 2003												
General	81.0				10.2		68.0		1.5		53.7	
Federal / Other	218.2		8.9		15.9		207.3		5.7		110.4	
Total	299.2		8.9		26.1		275.3		7.2		164.1	
Increase												
General	21.1	26.0%	0.7	N/A	9.4	92.2%	7.8	11.5%	0.6	40.0%	8.2	15.3%
Federal / Other	(1.9)	-0.9%	(1.2)	-13.5%	(4.3)	-27.0%	49.9	24.1%	1.7	29.8%	18.3	16.6%
Total	19.2	6.4%	(0.5)	-5.6%	5.1	19.5%	57.7	21.0%	2.3	31.9%	26.5	16.1%
2003 - 2005												
General	102.1		0.7		19.6		75.8		2.1		61.9	
Federal / Other	216.3		7.7		11.6		257.2		7.4		128.7	
Total	318.4		8.4		31.2		333.0		9.5		190.6	
Increase												
General	18.7	18.3%	4.7	671.4%	1.6	8.2%	11.4	15.0%	0.8	38.1%	12.6	20.4%
Federal / Other	5.9	2.7%	0.2	2.6%	4.9	42.2%	25.3	9.8%	1.8	24.3%	8.1	6.3%
Total	24.6	7.7%	4.9	58.3%	6.5	20.8%	36.7	11.0%	2.6	27.4%	20.7	10.9%
2005 - 2007												
General	120.8		5.4		21.2		87.2		2.9		74.5	
Federal / Other	222.2		7.9		16.5		282.5		9.2		136.8	
Total	343.0		13.3		37.7		369.7		12.1		211.3	
Increase												
General	12.0	9.9%	0.7	13.0%	1.3	6.1%	25.2	28.9%	1.8	62.1%	21.5	28.9%
Federal / Other	15.1	6.8%	0.1	1.3%	2.2	13.3%	(0.1)	0.0%	6.3	68.5%	41.6	30.4%

Department of Human Services
HB 1012 to the Senate
Percentage Increase for major categories

Expressed in Millions

	Nursing Homes	% Change	Basic Care	% Change	Home & Community Based Services	% Change	Medicaid Traditional	% Change	Healthy Steps	% Change	DD Grants	% Change
Total	27.1	7.9%	0.8	6.0%	3.5	9.3%	25.1	6.8%	8.1	66.9%	63.1	29.9%
2007 - 2009												
General	132.8		6.1		22.5		112.4		4.7		96.0	
Federal / Other	237.3		8.0		18.7		282.4		15.5		178.4	
Total	370.1		14.1		41.2		394.8		20.2		274.4	
Increase												
General	21.9	16.5%	2.7	44.3%	9.8	43.6%	12.8	11.4%	3.7	78.7%	26.4	27.5%
Federal / Other	37.8	15.9%	1.5	18.8%	8.3	44.4%	39.2	13.9%	8.7	56.1%	31.7	17.8%
Total	59.7	16.1%	4.2	29.8%	18.1	43.9%	52.0	13.2%	12.4	61.4%	58.1	21.2%
2009 - 2011 To Senate												
General	154.7		8.8		32.3		125.2		8.4		122.4	
Federal / Other	275.1		9.5		27.0		321.6		24.2		210.1	
Total	429.8		18.3		59.3		446.8		32.6		332.5	

North Dakota Department of Human Services
Inflationary Increases Compared to Consumer Price Index (CPI) ^
HB 1012

			CPI for Specific Categories					
						CPI Medical Categories		
Fiscal Year Beginning	Inflationary Increases Granted by Legislature	**Overall CPI**	Food	Transportation	Fuels & Utilities	Medical Commodities	Professional Services	Hospital & Related Services
July 1, 2008	5.0%	**5.6%**	6.0%	13.4%	16.0%	1.6%	3.6%	6.8%
July 1, 2007	4.0%	**2.4%**	4.2%	-0.7%	3.8%	1.1%	3.9%	6.4%
July 1, 2006	2.65%	**4.1%**	2.2%	8.4%	10.2%	3.9%	2.5%	6.4%
July 1, 2005	2.65%	**3.2%**	2.1%	6.3%	8.1%	2.4%	3.8%	5.2%
July 1, 2004	No Inflation ~	**3.0%**	4.0%	4.6%	4.5%	2.4%	4.0%	6.2%
July 1, 2003	No Inflation ~	**2.1%**	2.1%	2.0%	8.6%	2.4%	2.7%	7.4%
July 1, 2002	No Inflation * ~	**1.5%**	1.4%	-0.5%	-5.2%	3.6%	3.3%	8.8%
July 1, 2001	2.2%	**2.7%**						
July 1, 2000	2.0%	**3.5%**		*Information not obtained at this time.*				
July 1, 1999	2.0%	**2.1%**						
July 1, 1998	2.2%	**1.7%**						
July 1, 1997	2.2%	**2.2%**						

^ Consumer Price Index for all Urban Consumers (CPI-U) information was obtained from the US Bureau of Labor Statistics

~ Nursing Facilities did receive an inflationary increase since it was required by NDCC. That section was amended by the 2005 Legislative Assembly.

*** Although a 2.2% increase was appropriated, sufficient funding did not exist to provide the increase.**

Department of Human Services
Uncollectible Accounts to be Written Off June 30, 2008

Northwest Human Service Center	$13,532.22
North Central Human Service Center	$82,183.17
Lake Region Human Service Center	$51,524.05
Northeast Human Service Center	$140,608.62
Southeast Human Service Center	$324,659.40
South Central Human Service Center	$52,310.06
West Central Human Service Center	$132,999.42
Badlands Human Service Center	$54,418.24
Subtotal	**$852,235.18**
State Hospital	$5,124,040.43
Developmental Center	$51,877.08
TOTAL TO BE WRITTEN OFF	**$6,028,152.69**

Department of Human Services
Information Technology Services Division

Medicaid System Project Cost Summary

Description	Total Project Budget	2005-2007 Expenditures	2007-2009 Expenditures Through January 2009	Total Budget Remaining
Total Medicaid System Project	62,529,371	8,789,784	15,500,175	38,239,412
General Funds	3,643,133		1,781,785	1,861,348
Federal Funds	55,218,418	7,782,187	13,718,390	33,717,841
Other Funds	3,667,820	1,007,597		2,660,223
Total	62,529,371	8,789,784	15,500,175	38,239,412

Department of Human Services
HB 1012
Priorities

Division/Description	FTE	General Fund	Federal / Other Funds	Total
Aging Services				
ADRL funding		600,000		600,000
FMAP drop to 60.69% the last 7 months of 2009 - 2011		9,500,000	(9,500,000)	-
Roof Leak Issue at the State Hospital		270,000		270,000
Young adult transition services - SE and WC Human Service Centers		834,622	342,222	1,176,844

4-8-09 PM 2

Department of Human Services
2009-2011 Selected General Fund Increases

Rebasing of Selected Medicaid Services	13,144,292
7/7 Inflationary Increases for Medicaid & LTC	27,665,980
7/7 Inflationary Increases for Children & Family Services & HSC	5,262,892
Nursing Home Property Limits	3,000,000
$1 Wage Increase for Nursing Home, Basic Care & QSPs	15,867,327
Global Behavioral Health	4,232,045
DHS Salary Increases	15,693,872
DHS Equity	3,255,719
	88,122,127

HB 1012
Section 2 - One-Time Funding
2007 - 2009

DESCRIPTION	General Fund	Federal / Other Funds	Total Funds
MMIS	3,643,133	50,096,454	53,739,587
State Hospital - Sex Offender treatment addiction project	3,100,000	-	3,100,000
State Hospital - Capital Improvements	3,062,757		3,062,757
State Hospital - Extraordinary Repairs	1,153,500		1,153,500
Developmental Center - Capital Improvements	300,000		300,000
Developmental Center - Extraordinary Repairs	547,092	51,108	598,200
Developmental Center - Equipment	80,782	11,858	92,640
Total	11,887,264	50,159,420	62,046,684

A

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

QUARTERLY BUDGET INSIGHT

BIENNIUM TO DATE INFORMATION ON SELECTED DEPARTMENT PROGRAMS

JULY 2007 - SEPTEMBER 2008

Section 1: TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

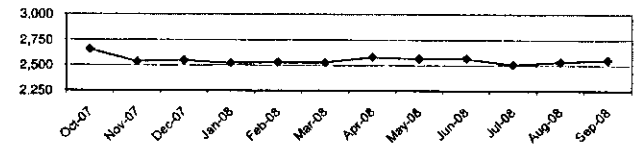
APPROPRIATION 2007-2009 BIENNIUM $25,337,350

BUDGET (7/07-9/08)		ACTUAL (7/07-9/08)			
Monthly Avg Cases	Monthly Avg Cost per Case	Monthly Avg Cases	Monthly Avg Cost per Case	Spent to Date	Percent of Appropriation Used*
2,959	$ 356	2,579	$ 332	$ 12,839,705	50.7%

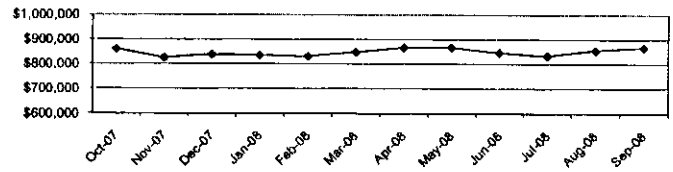
PROGRAM NOTES:

Average monthly TANF recipients:	6,806
Average number of children receiving TANF benefits:	4,818
Average number of child only cases:	660
Average number of individuals participating in work activities:	Not Aavailable
Amount of Child Support Collections used to pay TANF grants (see section 6):	$2,194,731

TANF Caseload for Last 12 Months



TANF Expenditures for Last 12 Months



Section 2: CHILD CARE ASSISTANCE (CCA)

APPROPRIATION 2007-2009 BIENNIUM $19,730,448

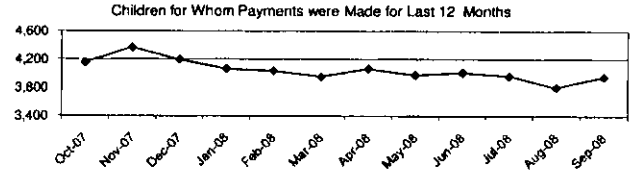
BUDGET (8/07-9/08)		ACTUAL (8/07-9/08)			
Monthly Avg Children for whom CCA paid	Monthly Avg Cost per Child	Monthly Avg Children for whom CCA paid	Monthly Avg Cost per Child	Spent to Date	Percent of Appropriation Used**
4,116	$ 199	4,028	$ 212	$ 11,972,214	60.7%

PROGRAM NOTES:

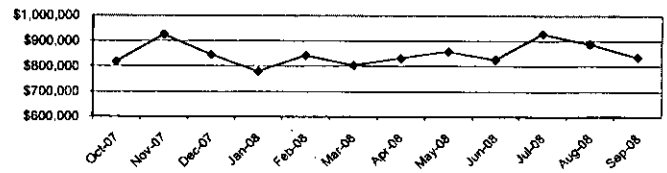
Average number of Non-TANF children:	3,150
Average number of TANF children:	792
Average number of families receiving payments:	2,502
Average payment per family:	$342

The certificate process started in June 2007 and allows a client to participate in the program for three to six months, with limited reporting requirements. All clients had to be on the certificate process for services incurred in October 2007.

Children for Whom Payments were Made for Last 12 Months



Child Care Expenditures Paid for Last 12 Months



Section 3: SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

APPROPRIATION 2007-2009 BIENNIUM $107,017,992

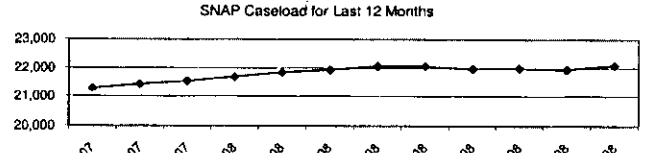
BUDGET (7/07-9/08)		ACTUAL (7/07-9/08)			
Monthly Avg Cases	Monthly Avg Cost per Case	Monthly Avg Cases	Monthly Avg Cost per Case	Spent to Date	Percent of Appropriation Used*
20,351	$ 214	21,661	$ 224	$ 72,654,189	67.9%

PROGRAM NOTES:

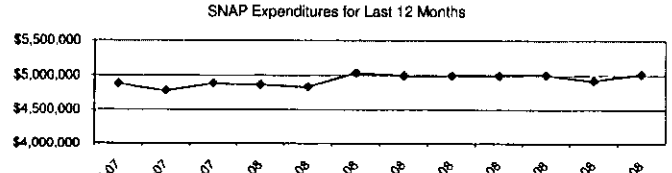
Average number of individuals receiving SNAP:	48,086
Average number of children under 18 receiving SNAP:	21,822
Average number of cases with an elderly person (60 or older) :	3,837
Average number of cases with earned income:	9,115

Simplified reporting began on November 1, 2006 which allows a household to be approved to participate in the program for 12 months, with limited reporting requirements.

SNAP Caseload for Last 12 Months



SNAP Expenditures for Last 12 Months



*Percent of Biennium Expired 62.5% - Payments for TANF, Food Stamps, and Adoption are made at the beginning of the month for the current month. Payments for Foster Care are made the last day of the month for the current month. Therefore 15 months of payments have been made or 62.5% (15/24) of the biennium has expired.

**Percent of Biennium Expired 58.3% - Payments for Child Care, Developmental Disabilities, Long Term Care, Medical Assistance and Medicare Clawback are made when a billing for the previous month's services have been received. Therefore, approximately 14 months of payments have been made or 58.3% (14/24) of the biennium has expired.

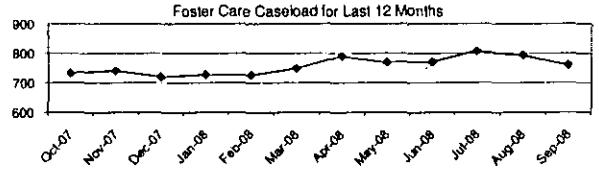
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
QUARTERLY BUDGET INSIGHT
BIENNIUM TO DATE INFORMATION ON SELECTED DEPARTMENT PROGRAMS
JULY 2007 - SEPTEMBER 2008 (continued)

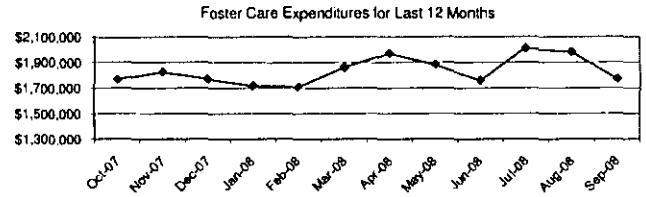
Section 4: FOSTER CARE (MAINTENANCE AND REHAB)
APPROPRIATION 2007-2009 BIENNIUM $60,897,869

BUDGET (7/07-9/08)		ACTUAL (7/07-9/08)			
Monthly Avg Cases	Monthly Avg Cost	Monthly Avg Cases	Monthly Avg Cost	Spent to Date	Percent of Appropriation Used *
1,082	*Varied by placement*	$ 766	*See program notes*	$ 32,513,420	53.4%

PROGRAM NOTES:

Average monthly cost foster care family homes (41% of caseload):	$759
Average monthly cost therapeutic family foster care (26% of caseload):	$3,319
Average monthly cost Residential Child Care Facilities/Group Homes (33% of caseload):	$4,643
Amount of Child Support Collections used to pay Foster Care grants (see section 6):	$2,456,232



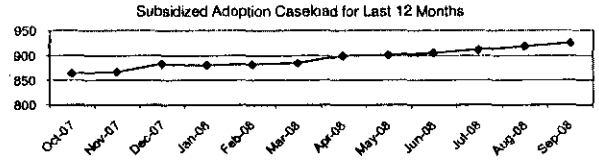


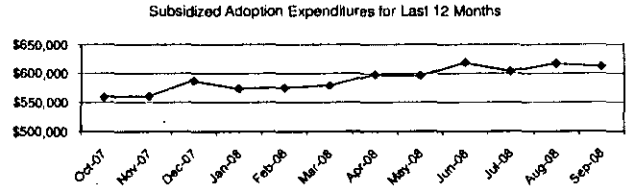
Section 5: SUBSIDIZED ADOPTION FOR SPECIAL NEEDS CHILDREN
APPROPRIATION 2007-2009 BIENNIUM $13,894,075

BUDGET (7/07-9/08)		ACTUAL (7/07-9/08)			
Monthly Avg Cases	Monthly Avg Cost	Monthly Avg Cases	Monthly Avg Cost	Spent to Date	Percent of Appropriation Used*
883	$ 636	886	$ 656	$ 8,720,784	62.8%

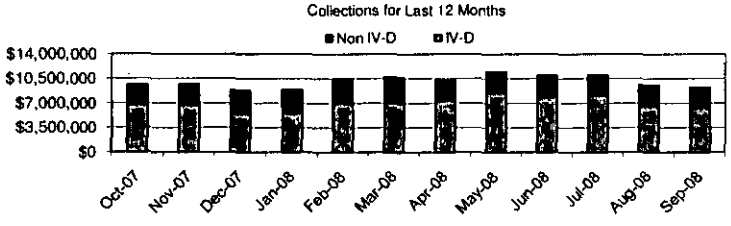
PROGRAM NOTES:

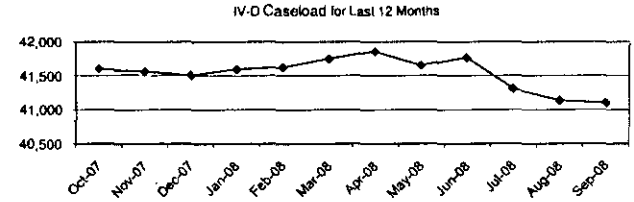
A special needs child is a child legally available for adoptive placement and who is seven years of age or older; under eighteen years of age with a physical, emotional, or mental disability or has been ...sed to be a high risk for such a disability; a member of a minority; or a member of a sibling





Section 6 - CHILD SUPPORT ENFORCEMENT





Total Collections for Last 12 Months	$121,831,435
% of Collections Received from	
-IV-D clients	68.3%
-Non-IV-D clients	31.7%
	100.0%
Collections Distributed to	
-TANF Grant Program (see section 1)	1.6%
-Foster Care Program (see section 4)	1.7%
-Federal government reimbursement	3.2%
-IV-D Familes	57.0%
-Non-IV-D Families	31.7%
-Other States	5.8%
-Other	-1.0%
	100.0%

PROGRAM NOTES:

A IV-D case is any case in which the custodial parent has assigned their rights to receive support payments to the State as a condition of receiving public assistance or has filed as application for services provided by the Child Support Enforcement Agency

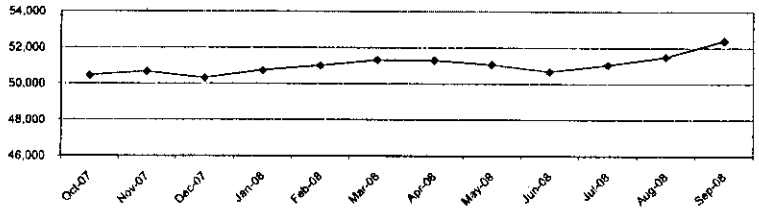
A Non-IV-D case is any case in which the custodial parent has neither assigned their right to receive support over to the State nor has filed an application for services provided by the Child Support Enforcement Agency or once had a IV-D case which was subsequently closed.

*Percent of Biennium Expired 62.5% - Payments for TANF, Food Stamps, and Adoption are made at the beginning of the month for the current month. Payments for Foster Care are made the last day of the month for the current month. Therefore 15 months of payments have been made or 62.5% (15/24) of the biennium has expired.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
QUARTERLY BUDGET INSIGHT
BIENNIUM TO DATE INFORMATION ON SELECTED DEPARTMENT PROGRAMS
JULY 2007 - SEPTEMBER 2008 (continued)

Section 7 - MEDICAID ELIGIBLES
2007 - 2009 BIENNIUM

Medicaid Eligibles for the Last 12 Months



Note: Eligibles include all Medical Assistance and Long Term Care Continuum Medicaid eligibles with the exception of SPED, Expanded SPED and Basic Care.

Approximately 52% of the above eligibles are under the age of 21, 16% are disabled and 11% are classified as Aged.

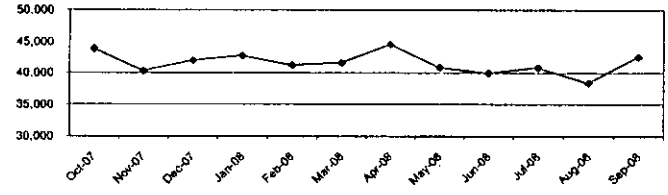
The growth in eligibles since June 2008 has been in the Under 21 category.

Section 8 - MEDICAL ASSISTANCE
APPROPRIATION 2007 - 2009 BIENNIUM $415,014,799

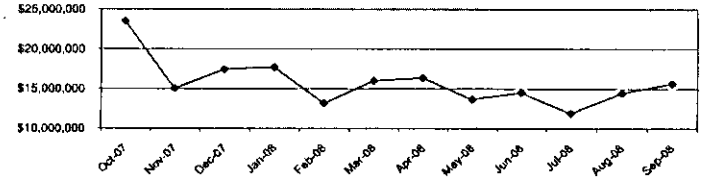
	Actual Paid (8/07-9/08)			
Service	Monthly Average Number of People Receiving	Monthly Average Cost Per Person	Spent to Date	Percentage of Appropriation Used to Date**
Inpatient Hospital	1,202	3,732	62,794,448	60.3%
Outpatient Hospital	7,688	265	30,629,963	62.5%
Physician	20,057	116	32,649,466	54.5%
Drugs (Includes Rebates)	--	--	22,805,366	39.5%
	2,985	191	7,961,974	61.0%
Clinics	4,001	202	11,328,581	56.1%
	--	--	56,404,988	50.8%
Total Medical Assistance Expenditures to Date [1]			224,574,386	54.1%

[1] **Due to system problems payouts were issued to Providers. The recoupment of these payouts will be completed during this biennium. These transactions may result in the Expenditures to Date and the Cost Per Person being misstated.**

Recipient Claims Paid for Medical Assistance for the Last 12 Months



Medical Assistance Expenditures for the Last 12 Months

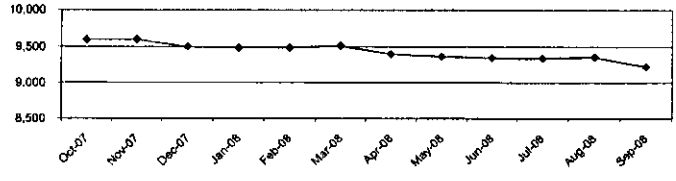


PROGRAM NOTES:

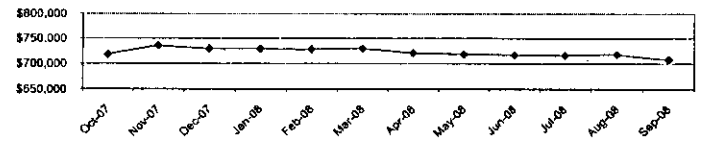
Section 9 - MEDICARE CLAWBACK
APPROPRIATION 2007 - 2009 BIENNIUM $19,149,615

Budget (8/07-9/08)		Actual Paid (8/07-9/08)			
Monthly Average Number of People Receiving	Monthly Average Cost Per Person	Monthly Average Number of People Receiving	Monthly Average Cost Per Person	Spent to Date	Percentage of Appropriation Used to Date**
9,667	81	9,448	76	10,093,543	52.7%

Number of Dual Eligibles Medicare Clawback Paid for in the Last 12 Months



Medicare Clawback Expenditures for the Last 12 Months



PROGRAM NOTES:

Percent of Biennium Expired 58.3% - Payments for Child Care, Developmental Disabilities, Long Term Care, Medical Assistance and Medicare Clawback are made when a billing for the previous month's services have been received. Therefore, approximately 14 months of payments have been made or 58.3% (14/24) of the biennium has expired.

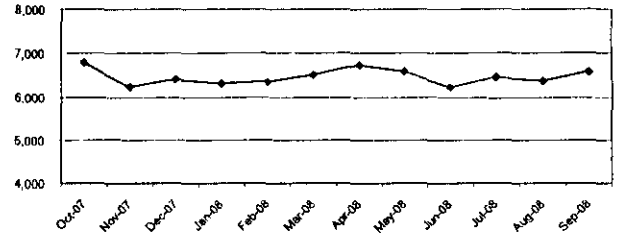
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
QUARTERLY BUDGET INSIGHT
BIENNIUM TO DATE INFORMATION ON SELECTED DEPARTMENT PROGRAMS
JULY 2007 - SEPTEMBER 2008 (continued)

Section 10 - LONG TERM CARE CONTINUUM
APPROPRIATION 2007 - 2009 BIENNIUM $425,356,941

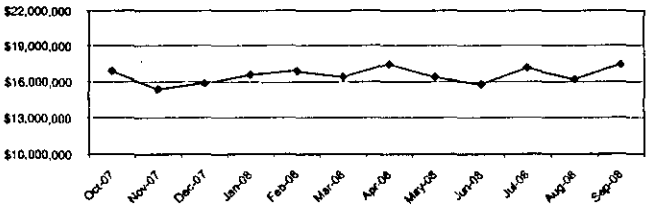
	Budget (8/07-9/08)		Actual Paid (8/07-9/08)			
Service	Monthly Average Number of People Receiving	Monthly Average Cost Per Person	Monthly Average Number of People Receiving	Monthly Average Cost Per Person	Spent to Date	Percentage of Appropriation Used to Date**
Nursing Homes (& Hospice)	3,494	4,322	3,294	4,424	204,033,460	54.9%
Basic Care	457	1,260	402	1,482	6,339,734	59.2%
SPED	1,323	362	1,433	371	7,437,513	62.3%
Expanded SPED	141	222	109	195	283,573	37.2%
TBI - Waiver	28	2,745	27	2,923	1,107,663	61.2%
Aged & Disabled Waiver	141	1,926	219	620	1,666,176	60.2%
Targeted Case Management	347	111	434	106	645,717	69.9%
Personal Care Option	609	1,259	569	1,221	9,735,203	50.3%
Tech. Dep. Waiver	3	10,584	1	7,701	100,114	13.1%
Medically Fragile Waiver	15	3,738	1	1,355	1,355	0.0%
Total Long-Term Care Continuum Expenditures to Date [1]					233,572,508	54.9%

[1] Due to system problems payouts were issued to Providers. The recoupment of these payouts will be completed during this biennium. These transactions may result in the Expenditures to Date and the Cost Per Person being misstated.

Recipient Claims Paid for the Long Term Care Continuum for the Last 12 Months



Long Term Care Continuum Expenditures for the Last 12 Months



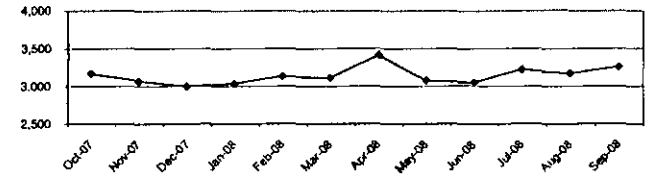
PROGRAM NOTES:

Section 11 - DEVELOPMENTAL DISABILITIES
APPROPRIATION 2007 - 2009 BIENNIUM $273,312,975

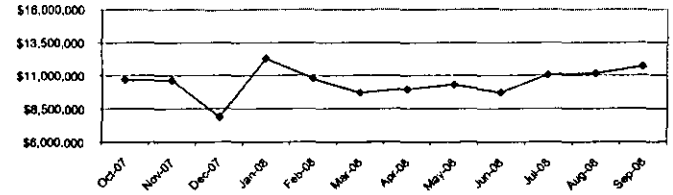
	Actual Paid (8/07-9/08)			
Service	Monthly Average Number of People Receiving	Monthly Average Cost Per Person	Spent to Date	Percentage of Appropriation Used to Date**
ICF/MR	426	9,041	53,664,793	53.4%
ISLA	697	9,296	31,879,594	54.0%
MSLA	177	4,453	11,026,502	68.2%
Day Supports	868	1,248	16,912,198	43.1%
Other	--	--	31,787,972	54.9%
Total Developmental Disabilities Expenditures to Date [1]			145,471,059	53.2%

[1] Due to system problems payouts were issued to Providers. The recoupment of these payouts will be completed during this biennium. These transactions may result in the Expenditures to Date and the Cost Per Person being misstated.

Recipient Claims Paid for Developmental Disabilities for the Last 12 Months



Developmental Disabilities Expenditures for the Last 12 Months



PROGRAM NOTES:

The December 2007 decrease in recipient claims and expenditures is specifically related to system problems and not representative of an actual program trend.

Percent of Biennium Expired 58.3% - Payments for Child Care, Developmental Disabilities, Long Term Care, Medical Assistance and Medicare Clawback are made when a billing for the previous month's services have been received. Therefore, approximately 14 months of payments have been made or 58.3% (14/24) of the biennium has expired.

A.

HB 1012
Inflation Scenario
11-Feb-09

Total	General	Fed / Other	
(16,386,089)	(6,343,353)	(10,042,736)	6% / 6% - 0%/6% scenario
2,360,112	858,885	1,501,227	rebasing at Gov Budget
(14,025,977)	(5,484,468)	(8,541,509)	Net Savings from 7% 7%

North Dakota Department of Human Services

Inflation Scenarios *

2009-2011 Budget "To House"

Provider Groups	Budget "To House" - Provider Inflation 7.0% / 7.0% *				Provider Inflation 6.0% / 6.0% *				Difference			
	Total	General	Federal	Other	Total	General	Federal	Other	Total	General	Federal	Other
Inflation for Medicaid grant providers	21,035,670	6,734,524	14,275,519	25,627	18,003,173	5,764,591	12,216,603	21,979	3,032,497	969,933	2,058,916	3,648
Inflation for DD grant providers	28,538,117	10,508,471	18,029,646	-	24,402,101	8,985,481	15,416,620		4,136,016	1,522,990	2,613,026	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	26,859,492	9,935,325	16,924,167	-	20,289,544	7,505,100	12,784,444		6,569,948	2,430,225	4,139,723	-
Inflation for Other LTC providers	6,484,061	4,061,006	2,341,038	82,017	5,542,149	3,469,637	2,002,450	70,062	941,912	591,369	338,588	11,955
Inflation for Children and Family Service grant providers	7,338,428	1,764,636	4,353,978	1,219,814	6,269,856	1,507,650	3,720,040	1,042,166	1,068,572	256,986	633,938	177,648
Inflation for Mental Health/Substance Abuse and Disability Services contracted providers and Family Preservation Services	1,803,731	1,698,438	98,236	7,057	1,549,462	1,455,596	87,625	6,241	254,269	242,842	10,611	816
Inflation for the Human Service Center contracted providers	2,680,125	2,454,358	225,767	-	2,297,250	2,125,350	171,900		382,875	329,008	53,867	-
Total Inflation	**94,739,624**	**37,156,758**	**56,248,351**	**1,334,515**	**78,353,535**	**30,813,405**	**46,399,682**	**1,140,448**	**16,386,089**	**6,343,353**	**9,848,669**	**194,067**

Provider Groups	Budget "To House" - Provider Inflation 7.0% / 7.0% *				Provider Inflation 5.0% / 5.0% *				Difference			
	Total	General	Federal	Other	Total	General	Federal	Other	Total	General	Federal	Other
Inflation for Medicaid grant providers	21,035,670	6,734,524	14,275,519	25,627	14,966,972	4,793,221	10,155,429	18,322	6,068,698	1,941,303	4,120,090	7,305
Inflation for DD grant providers	28,538,117	10,508,471	18,029,646	-	20,256,845	7,459,046	12,797,799		8,281,272	3,049,425	5,231,847	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	26,859,492	9,935,325	16,924,167	-	16,616,646	6,146,506	10,470,140		10,242,846	3,788,819	6,454,027	-
Inflation for Other LTC providers	6,484,061	4,061,006	2,341,038	82,017	4,606,664	2,883,879	1,664,580	58,205	1,877,397	1,177,127	676,458	23,812
Inflation for Children and Family Service grant providers	7,338,428	1,764,636	4,353,978	1,219,814	5,207,886	1,252,223	3,089,987	865,676	2,130,542	512,413	1,263,991	354,138
Inflation for Mental Health/Substance Abuse and Disability Services contracted providers and Family Preservation Services	1,803,731	1,698,438	98,236	7,057	1,292,988	1,210,339	77,209	5,440	510,743	488,099	21,027	1,617
Inflation for the Human Service Center contracted providers	2,680,125	2,454,358	225,767	-	1,914,375	1,771,125	143,250		765,750	683,233	82,517	-
Total Inflation	**94,739,624**	**37,156,758**	**56,248,351**	**1,334,515**	**64,862,376**	**25,516,339**	**38,398,394**	**947,643**	**29,877,248**	**11,640,419**	**17,849,957**	**386,872**

Provider Groups	Budget "To House" - Provider Inflation 7.0% / 7.0% *				Provider Inflation 4.0% / 4.0% *				Difference			
	Total	General	Federal	Other	Total	General	Federal	Other	Total	General	Federal	Other
Inflation for Medicaid grant providers	21,035,670	6,734,524	14,275,519	25,627	11,939,266	3,823,359	8,101,284	14,623	9,096,404	2,911,165	6,174,235	11,004
Inflation for DD grant providers	28,538,117	10,508,471	18,029,646	-	16,168,009	5,953,519	10,214,490		12,370,108	4,554,952	7,815,156	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	26,859,492	9,935,325	16,924,167	-	13,297,539	4,918,755	8,378,784		13,561,953	5,016,570	8,545,383	-
Inflation for Other LTC providers	6,484,061	4,061,006	2,341,038	82,017	3,673,322	2,298,424	1,328,509	46,389	2,810,739	1,762,582	1,012,529	35,628
Inflation for Children and Family Service grant providers	7,338,428	1,764,636	4,353,978	1,219,814	4,152,939	998,575	2,464,059	690,305	3,185,489	766,061	1,889,919	529,509
Inflation for Mental Health/Substance Abuse and Disability Services contracted providers and Family Preservation Services	1,803,731	1,698,438	98,236	7,057	1,043,494	972,263	66,598	4,633	760,237	726,175	31,638	2,424
Inflation for the Human Service Center contracted providers	2,680,125	2,454,358	225,767	-	1,531,502	1,416,901	114,601		1,148,623	1,037,457	111,166	-
Total Inflation	**94,739,624**	**37,156,758**	**56,248,351**	**1,334,515**	**51,806,071**	**20,381,796**	**30,668,325**	**755,950**	**42,933,553**	**16,774,962**	**25,580,026**	**578,565**

*** Hospitals and Chiropractors, Physicians and Ambulance Services are inflated at 0 % / 7%, Dental Services were rebased to a minimum of 75% of averaged billed charges and were inflated at 7% / 7%.**

North Dakota Department of Human Services
Inflationary Increases Compared to Consumer Price Index (CPI) ^
HB 1012

			CPI for Specific Categories					
						CPI Medical Categories		
Fiscal Year Beginning	Inflationary Increases Granted by Legislature	**Overall CPI**	Food	Transportation	Fuels & Utilities	Medical Commodities	Professional Services	Hospital & Related Services
July 1, 2008	5.0%	**5.6%**	6.0%	13.4%	16.0%	1.6%	3.6%	6.8%
July 1, 2007	4.0%	**2.4%**	4.2%	-0.7%	3.8%	1.1%	3.9%	6.4%
July 1, 2006	2.65%	**4.1%**	2.2%	8.4%	10.2%	3.9%	2.5%	6.4%
July 1, 2005	2.65%	**3.2%**	2.1%	6.3%	8.1%	2.4%	3.8%	5.2%
July 1, 2004	No Inflation ~	**3.0%**	4.0%	4.6%	4.5%	2.4%	4.0%	6.2%
July 1, 2003	No Inflation ~	**2.1%**	2.1%	2.0%	8.6%	2.4%	2.7%	7.4%
July 1, 2002	No Inflation * ~	**1.5%**	1.4%	-0.5%	-5.2%	3.6%	3.3%	8.8%
July 1, 2001	2.2%	**2.7%**						
July 1, 2000	2.0%	**3.5%**		*Information not obtained at this time.*				
July 1, 1999	2.0%	**2.1%**						
July 1, 1998	2.2%	**1.7%**						
July 1, 1997	2.2%	**2.2%**						

^ Consumer Price Index for all Urban Consumers (CPI-U) information was obtained from the US Bureau of Labor Statistics

~ Nursing Facilities did receive an inflationary increase since it was required by NDCC. That section was amended by the 2005 Legislative Assembly.

*** Although a 2.2% increase was appropriated, sufficient funding did not exist to provide the increase.**

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North Dakota Department of Human Services
2009-2011 Budget To House
7/7 Inflationary Increase (0/7 on Rebased Services @)

Provider Groups	Provider Inflation of 7.0% / 7.0% (0/7 on Rebased Services @)			
	Total	General	Federal	Other
Inflation for Medicaid grant providers	21,035,670	6,734,524	14,275,519	25,627
Inflation for DD grant providers	28,538,117	10,508,471	18,029,646	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	26,859,492	9,935,325	16,924,167	-
Inflation for Other LTC providers	6,484,061	4,061,006	2,341,038	82,017
Inflation for Children and Family Service grant providers	7,338,428	1,764,636	4,353,978	1,219,814
Inflation for Mental Health/Substance Abuse, Aging, Disability Services contracted providers and Family Preservation Services	1,803,731	1,698,438	98,236	7,057
Inflation for the Human Service Center contracted providers	2,680,125	2,454,358	225,767	-
Total Inflation	**94,739,624**	**37,156,758**	**56,248,351**	**1,334,515**

@ Hospitals and Chiropractors, Physicians and Ambulance Services are inflated at 0/7, Dentist Services which were rebased to a minimun of an average of 75% of billed charges are inflated at 7/7.

Department of Human Services OARs for the 2009-2011 Biennium

as of December 3, 2008

Cabinet Priority	Cabinet Category	Description	FTE	General	Federal	Other	Total
01	Global Behavioral Health	Additional Capacity at the HSCs and State Hospital	11.00	4,324,776	491,611	4,081	4,820,468
02	Capacity	DD Case Management - HSCs	4.00	201,252	201,252		402,504
02	Capacity	Partnership Care Coordinator - SE HSC	1.00	53,484	38,730	-	92,214
		Total Capacity Category	5.00	254,736	239,982	-	494,718
03	Inflation	Provider Inflation - Medical Services		12,142,596	23,932,868	76,865	36,042,429
03	Inflation	Provider Inflation - Long-Term Care		13,996,331	19,265,205	82,017	33,343,553
03	Inflation	Provider Inflation - Long-Term Care DD Grants		10,508,471	18,029,646		28,538,117
03	Inflation	Provider Inflation - Aging Services		106,400			106,400
03	Inflation	Provider Inflation - Children and Family Services		3,040,109	4,452,214	1,226,871	8,719,194
03	Inflation	Provider Inflation - Mental Health and Substance Abuse		145,810			145,810
03	Inflation	Provider Inflation - Disability Services		170,755			170,755
03	Inflation	Provider Inflation - NW HSC		193,462	1,064		194,526
03	Inflation	Provider Inflation - NC HSC		387,170	21,789		408,959
03	Inflation	Provider Inflation - LR HSC		208,670			208,670
03	Inflation	Provider Inflation - NE HSC		443,799	169,774		613,573
03	Inflation	Provider Inflation - SE HSC		405,117	1,172		406,289
03	Inflation	Provider Inflation - SC HSC		325,991			325,991
03	Inflation	Provider Inflation - WC HSC		490,149	6,751		496,900
03	Inflation	Provider Inflation - BL HSC	-	25,217	-	-	25,217
		Total Inflation Category	-	42,590,047	65,770,583	1,385,753	109,746,383
04	Expansion/Enhancement	SAS 112 Employee	1.00	49,619	66,659	1,172	117,450
04	Expansion/Enhancement	Increase Child Care Provider Rates		274,408			274,408
04	Expansion/Enhancement	Increase Medically Needy Income Levels		2,041,614	3,479,245		5,520,859
04	Expansion/Enhancement	Hospital Cost Rebasing		8,140,450	13,872,664		22,013,114
04	Expansion/Enhancement	Physician Cost Rebasing		19,599,400	33,400,600		53,000,000
04	Expansion/Enhancement	Chiropractor Cost Rebasing		153,836	262,164		416,000
04	Expansion/Enhancement	Ambulance Services Cost Rebasing		1,998,158	3,405,192		5,403,350
04	Expansion/Enhancement	Dental Services		214,764	365,994		580,758
04	Expansion/Enhancement	Increase Healthy Steps to 200% Net Income	1.50	1,141,611	3,269,566		4,411,177
04	Expansion/Enhancement	Revising SPED Fee Schedule		571,472		30,077	601,549
04	Expansion/Enhancement	Remove HCBS Cap (Point Split)		84,082	87,604	1,607	173,293
04	Expansion/Enhancement	Hospice for Children Waiver		316,700	539,710		856,410
04	Expansion/Enhancement	Personal Care - 3rd Tier		1,021,922	1,741,524		2,763,446
04	Expansion/Enhancement	Personal Needs Allowance - SSI Only Individuals		148,068			148,068
04	Expansion/Enhancement	Intense Medical Needs - Family Homes		238,274	406,056		644,330
04	Expansion/Enhancement	Intense Medical Needs - Residential Facility		297,842	507,570		805,412
04	Expansion/Enhancement	Personal Needs Allowance - Decoupling ICF/MR		38,341	65,339		103,680
04	Expansion/Enhancement	Autism Spectrum Disorder - Under 5 Years	1.00	444,670	714,960		1,159,630
04	Expansion/Enhancement	Coordination of After School Supervision		65,707	111,977		177,684
04	Expansion/Enhancement	Aging & Disability Resource Center		600,000			600,000
04	Expansion/Enhancement	Family Group Conferencing		2,342,810	238,295	18,077	2,599,182
04	Expansion/Enhancement	Peer Support		2,777,505	1,835,103		4,612,608
04	Expansion/Enhancement	Prevention Coordinators	8.00				-

Department of Human Services OARs for the 2009-2011 Biennium

as of December 3, 2008

Cabinet Priority	Cabinet Category	Description	FTE	General	Federal	Other	Total
04	Expansion/Enhancement	DD Quality Assurance Specialists	2.00	153,275	153,272		306,547
04	Expansion/Enhancement	Young Adult Transition Residential Services - SE		184,622	213,422	28,800	426,844
04	Expansion/Enhancement	Case Manager for Jail Intervention Grant - SE	1.00	34,580	23,054	34,580	92,214
04	Expansion/Enhancement	Activity Assistant for DWAC Program - SE	1.00	70,072			70,072
04	Expansion/Enhancement	Vulnerable Adult Protective Services -SC	1.00	64,872			64,872
04	Expansion/Enhancement	Young Adult Transition Residential Services - WC		650,000	100,000		750,000
04	Expansion/Enhancement	State Hospital Extraordinary Repairs	-	1,025,000	-	-	1,025,000
		Total Expansion/Enhancement Category	16.50	44,743,674	64,859,970	114,313	109,717,957
05	Provider Requested Enhancements	Eligibility System Replacement	1.00	9,316,140	9,316,140		18,632,280
05	Provider Requested Enhancements	Assisted Living Room & Board Subsidy		2,160,000			2,160,000
05	Provider Requested Enhancements	Increase Nursing Facility Bed Limits		324,506	553,012		877,518
05	Provider Requested Enhancements	Infant Development Salary Increase		628,736	1,071,471		1,700,207
05	Provider Requested Enhancements	DD Provider Wage Increase		14,194,510	24,189,780		38,384,290
05	Provider Requested Enhancements	DD Provider Benefit Increase		2,383,667	4,062,161		6,445,828
05	Provider Requested Enhancements	DD Staffing to meet Critical Needs		2,336,365	3,981,551		6,317,916
05	Provider Requested Enhancements	Increase Safety Permanency Funds		102,400			102,400
05	Provider Requested Enhancements	Increase parent Aid Services		934,742			934,742
05	Provider Requested Enhancements	Family Preservation Services for Tribes		300,000			300,000
05	Provider Requested Enhancements	Expand Healthy Families		385,000			385,000
05	Provider Requested Enhancements	Centers for Independent Living Enhancement		1,850,000			1,850,000
		Total Provider Requested Enhancements Category	1.00	34,956,066	43,174,115	-	78,130,181
		Report Totals	33.50	126,869,299	174,536,261	1,504,147	302,909,707

Fully funded in Governor's budget.

Partially funded in Governor's budget.

Funded at a level different than OAR.

Prepared by the North Dakota Legislative Council
staff for Senator Mathern
March 2009

LISTING OF PROPOSED CHANGES TO ENGROSSED HOUSE BILL NO. 1012

Department - Department of Human Services (325)

Proposed funding changes:

Description	FTE	General Fund	Special Funds	Total
1 Change the funding source for Medicaid, foster care, and adoption payments due to the enhanced FMAP included in the federal American Recovery and Reinvestment Act of 2009		($66,500,000)	$66,500,000	$0
2 Option A - Replace a portion of the $900,000 general fund increases included in the executive budget for funding for senior service providers to supplement Older Americans Act fund with federal funds received through the American Recovery and Reinvestment Act of 2009 for elderly nutrition services		(500,000)	500,000	0
Option B - Provide for increased funding for elderly nutrition services to reflect federal funds received through the American Recovery and Reinvestment Act of 2009			500,000	500,000
3 Change the funding source for increased funding for child support enforcement activities to reflect federal funds received through the American Recovery and Reinvestment Act of 2009		(3,200,000)	3,200,000	0
4 Provide for increased funding for vocational rehabilitation services to reflect federal funds received through the American Recovery and Reinvestment Act of 2009			1,800,000	1,800,000
5 Option A - Replace a portion of the $800,000 general fund increase included in the executive budget for centers for independent living with federal funds received through the American Recovery and Reinvestment Act of 2009 for independent living		(243,000)	243,000	0
Option B - Provide for increased funding for independent living to reflect federal funds received through the American Recovery and Reinvestment Act of 2009			243,000	243,000
6 Provide for increased funding for developmentally delayed infants aged 0 to 3 to reflect federal funds received through the American Recovery and Reinvestment Act of 2009 for Individuals With Disabilities Education Act - Part C		0	2,140,000	2,140,000
7 Provide for increased funding for Supplemental Nutrition Assistance Program benefits and related additional administrative expenses to reflect federal funds received through the American Recovery and Reinvestment Act of 2009		0	7,304,747	7,304,747
8 Provide for increased funding for child care assistance to reflect federal funds received through the American Recovery and Reinvestment Act of 2009 for the child care development block grant		0	3,644,000	3,644,000
9 Provide funding for senior employment program to reflect federal funds received through the American Recovery and Reinvestment Act of 2009		0	143,288	143,288
10 Provide funding for older blind services to reflect federal funds received through the American Recovery and Reinvestment Act of 2009		0	3,170	3,170

3-25-09

[redacted]proposed funding changes	0.00	($70,443,000)	$86,221,205	[redacted]78,205

Other proposed changes:

1 Add a section to the bill to recognize additional general fund turnback of $30.3 million from the 2007-09 biennium.

99798

Prepared by the North Dakota Legislative Council staff for Senator Mathern
March 2009

LISTING OF PROPOSED CHANGES TO ENGROSSED HOUSE BILL NO. 1012

Department - Department of Human Services (325)

Proposed funding changes:

Description	FTE	General Fund	Special Funds	Total
1 Long-term care - Increase funding for a salary and benefit supplemental payment for individuals employed by a basic care and nursing home facility added by the House to provide a $2 per hour increase to all employees		$11,664,974	$18,539,682	$30,204,656
2 Long-term care - Increase funding for a salary and benefit supplemental payment for individuals employed by developmental disabilities providers added by the House to provide a $2 per hour increase to all employees		9,930,186	15,218,506	25,148,692
3 Children and family services - Provide additional funding for adoption services contract funding		200,000	0	200,000
4 Children and family services - Provide additional funding for a family group conferencing initiative		2,342,810	256,372	2,599,182
5 Vocational rehabilitation - Increase funding for centers for independent living by $1,490,000 from the general fund to restore funding of $400,000 from the general fund removed by the House and provide additional funding of $1,090,000		1,490,000	0	1,490,000
6 Human service centers - Restore funding removed by the House for additional staff at the Southeast Human Service Center due to the Cooper House project	4.00	309,469	104,906	414,375
7 Children and family services - Increase funding for the Healthy Families initiative by $200,000 from the general fund, from $300,000 from the general fund as provided for the 2007-09 biennium to $500,000 from the general fund for the 2009-11 biennium		200,000	0	200,000
8 Long-term care - Provide additional funding for developmental disabilities providers who are serving severely medically fragile and behaviorally challenged individuals residing at the Anne Carlsen Center		1,897,465	3,233,594	5,131,059
9 Long-term care - Provide funding for increasing payment rates for all qualified service providers to provide a $2 per hour increase		1,825,206	1,807,384	3,632,590
10 Information technology program - Provide funding for eligibility system replacement project planning, including $100,000 for temporary salaries, $85,000 for assistance from county staff, and $500,000 for contract services		342,500	342,500	685,000
11 Aging services - Restore funding removed by the House for pilot aged and disabled resource centers		600,000	0	600,000

3-25-09
2

[redacted]Aging services - Increase funding for Older Americans Act meal [redacted] providers. The executive budget included additional funding of $900,000 from the general fund for senior service providers to supplement Older Americans Act funds.		1,900,000	0	[redacted],900,000
Total proposed funding changes	4.00	$32,702,610	$39,502,944	$72,205,554

Other proposed changes:

1 Revise Section 10 of the engrossed bill relating to screening required prior to admission or readmission at the Developmental Center as recommended by representatives of The Arc (A copy of the recommended revisions are attached.)

2 Add a section of legislative intent to provide that the Department of Human Services consider the changes necessary to reimburse home health agencies for home telemonitoring services under the Medicaid program at the same rates as skilled nursing visits provided in person

ATTACH:1

Department of Human Services
Comparison of Current 2007-2009 Budget to the 2009-2011 Budget to the Senate

Subdivision	Fund	Current Budget	To the Senate	$ Change	Pct Change
100-15 ADMINISTRATION - SUPPORT	1 General	6,117,034	6,573,708	$456,674	7.47%
00-15 ADMINISTRATION - SUPPORT	2 Federal	5,498,938	6,058,565	$559,627	10.18%
100-15 ADMINISTRATION - SUPPORT	3 Other	784,931	1,028,590	$243,659	31.04%
100-15 ADMINISTRATION - SUPPORT Total		**12,400,903**	**13,660,863**	**$1,259,960**	**10.16%**
100-20 INFORMATION TECHNOLOGY SRVCS	1 General	18,999,178	19,574,001	$574,823	3.03%
100-20 INFORMATION TECHNOLOGY SRVCS	2 Federal	63,199,145	25,348,948	($37,850,197)	-59.89%
100-20 INFORMATION TECHNOLOGY SRVCS	3 Other	4,343,365	1,605,158	($2,738,207)	-63.04%
100-20 INFORMATION TECHNOLOGY SRVCS Total		**86,541,688**	**46,528,107**	**($40,013,581)**	**-46.24%**
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS	1 General	7,784,373	9,777,814	$1,993,441	25.61%
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS	2 Federal	191,369,536	302,640,307	$111,270,771	58.14%
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS	3 Other	19,258,224	18,038,981	($1,219,243)	-6.33%
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS Total		**218,412,133**	**330,457,102**	**$112,044,969**	**51.30%**
300-02 CHILD SUPPORT ENFORCEMENT	1 General	491,698	6,296,258	$5,804,560	1180.51%
300-02 CHILD SUPPORT ENFORCEMENT	2 Federal	15,571,363	14,203,786	($1,367,577)	-8.78%
300-02 CHILD SUPPORT ENFORCEMENT	3 Other	5,439,913	2,747,542	($2,692,371)	-49.49%
300-02 CHILD SUPPORT ENFORCEMENT Total		**21,502,974**	**23,247,586**	**$1,744,612**	**8.11%**
300-03 MEDICAL SERVICES	1 General	140,880,119	157,080,141	$16,200,022	11.50%
300-03 MEDICAL SERVICES	2 Federal	284,324,572	326,959,951	$42,635,379	15.00%
300-03 MEDICAL SERVICES	3 Other	23,067,642	29,468,467	$6,400,825	27.75%
300-03 MEDICAL SERVICES Total		**448,272,333**	**513,508,559**	**$65,236,226**	**14.55%**
300-10 LONG TERM CARE	1 General	257,332,905	312,586,264	$55,253,359	21.47%
300-10 LONG TERM CARE	2 Federal	435,566,053	504,676,741	$69,110,688	15.87%
300-10 LONG TERM CARE	3 Other	6,907,215	7,529,851	$622,636	9.01%
300-10 LONG TERM CARE Total		**699,806,173**	**824,792,856**	**$124,986,683**	**17.86%**
300-42 DD COUNCIL	2 Federal	991,084	1,013,495	$22,411	2.26%
300-42 DD COUNCIL Total		**991,084**	**1,013,495**	**$22,411**	**2.26%**
300-43 AGING SERVICES	1 General	1,480,994	2,560,651	$1,079,657	72.90%
300-43 AGING SERVICES	2 Federal	12,378,752	12,414,887	$36,135	0.29%
300-43 AGING SERVICES	3 Other	410,000	307,960	($102,040)	-24.89%
300-43 AGING SERVICES Total		**14,269,746**	**15,283,498**	**$1,013,752**	**7.10%**
300-46 CHILDREN AND FAMILY SERVICES	1 General	21,918,091	26,228,520	$4,310,429	19.67%
300-46 CHILDREN AND FAMILY SERVICES	2 Federal	81,146,301	79,481,236	($1,665,065)	-2.05%
300-46 CHILDREN AND FAMILY SERVICES	3 Other	18,056,543	19,503,495	$1,446,952	8.01%
300-46 CHILDREN AND FAMILY SERVICES Total		**121,120,935**	**125,213,251**	**$4,092,316**	**3.38%**
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE	1 General	5,700,420	5,555,397	($145,023)	-2.54%
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE	2 Federal	6,345,413	6,390,047	$44,634	0.70%
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE	3 Other	505,056	404,404	($100,652)	-19.93%
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE Total		**12,550,889**	**12,349,848**	**($201,041)**	**-1.60%**
300-51 DEVELOPMENTAL DISABILITIES DIVISION	1 General	2,440,426	2,767,919	$327,493	13.42%
300-51 DEVELOPMENTAL DISABILITIES DIVISION	2 Federal	3,636,725	3,554,865	($81,860)	-2.25%
300-51 DEVELOPMENTAL DISABILITIES DIVISION	3 Other	-	-	$0	#DIV/0!
300-51 DEVELOPMENTAL DISABILITIES DIVISION Total		**6,077,151**	**6,322,784**	**$245,633**	**4.04%**
300-51 VOC REHAB	1 General	4,259,542	4,780,943	$521,401	12.24%
300-51 VOC REHAB	2 Federal	19,295,687	20,666,958	$1,371,271	7.11%
300-51 VOC REHAB	3 Other	107,000	79,234	($27,766)	-25.95%
300-51 VOC REHAB Total		**23,662,229**	**25,527,135**	**$1,864,906**	**7.88%**

Department of Human Services
Comparison of Current 2007-2009 Budget to the 2009-2011 Budget to the Senate

Subdivision	Fund	Current Budget	To the Senate	$ Change	Pct Change
410-71 NORTHWEST HSC	1 General	4,279,976	4,737,136	$457,160	10.68%
410-71 NORTHWEST HSC	2 Federal	2,851,727	3,143,638	$291,911	10.24
410-71 NORTHWEST HSC	3 Other	345,120	328,358	($16,762)	-4.86
410-71 NORTHWEST HSC Total		**7,476,823**	**8,209,132**	**$732,309**	**9.79%**
410-72 NORTH CENTRAL HSC	1 General	8,755,623	10,500,926	$1,745,303	19.93%
410-72 NORTH CENTRAL HSC	2 Federal	7,285,751	7,605,526	$319,775	4.39%
410-72 NORTH CENTRAL HSC	3 Other	852,994	811,321	($41,673)	-4.89%
410-72 NORTH CENTRAL HSC Total		**16,894,368**	**18,917,773**	**$2,023,405**	**11.98%**
410-73 LAKE REGION HSC	1 General	5,304,226	6,116,357	$812,131	15.31%
410-73 LAKE REGION HSC	2 Federal	4,129,219	4,124,033	($5,186)	-0.13%
410-73 LAKE REGION HSC	3 Other	451,431	400,677	($50,754)	-11.24%
410-73 LAKE REGION HSC Total		**9,884,876**	**10,641,067**	**$756,191**	**7.65%**
410-74 NORTHEAST HSC	1 General	9,758,051	11,587,742	$1,829,691	18.75%
410-74 NORTHEAST HSC	2 Federal	11,785,869	12,891,772	$1,105,903	9.38%
410-74 NORTHEAST HSC	3 Other	781,127	1,137,391	$356,264	45.61%
410-74 NORTHEAST HSC Total		**22,325,047**	**25,616,905**	**$3,291,858**	**14.75%**
410-75 SOUTHEAST HSC	1 General	11,548,288	14,572,467	$3,024,179	26.19%
410-75 SOUTHEAST HSC	2 Federal	13,823,577	13,861,542	$37,965	0.27%
410-75 SOUTHEAST HSC	3 Other	1,218,661	1,326,846	$108,185	8.88%
410-75 SOUTHEAST HSC Total		**26,590,526**	**29,760,855**	**$3,170,329**	**11.92%**
410-76 SOUTH CENTRAL HSC	1 General	8,005,783	8,557,071	$551,288	6.89%
410-76 SOUTH CENTRAL HSC	2 Federal	5,860,748	6,013,539	$152,791	2.61%
410-76 SOUTH CENTRAL HSC	3 Other	768,645	686,710	($81,935)	-10.66%
410-76 SOUTH CENTRAL HSC Total		**14,635,176**	**15,257,320**	**$622,144**	**4.25%**
410-77 WEST CENTRAL HSC	1 General	10,172,407	12,108,447	$1,936,040	19.03%
410-77 WEST CENTRAL HSC	2 Federal	9,940,424	11,097,524	$1,157,100	11.64
410-77 WEST CENTRAL HSC	3 Other	916,027	1,156,497	$240,470	26.25
410-77 WEST CENTRAL HSC Total		**21,028,858**	**24,362,468**	**$3,333,610**	**15.85%**
410-78 BADLANDS HSC	1 General	4,911,935	5,580,825	$668,890	13.62%
410-78 BADLANDS HSC	2 Federal	4,096,595	4,375,282	$278,687	6.80%
410-78 BADLANDS HSC	3 Other	896,869	806,889	($89,980)	-10.03%
410-78 BADLANDS HSC Total		**9,905,399**	**10,762,996**	**$857,597**	**8.66%**
420-00 STATE HOSPITAL	1 General	36,423,429	38,029,171	$1,605,742	4.41%
420-00 STATE HOSPITAL	2 Federal	4,467,669	4,162,992	($304,677)	-6.82%
420-00 STATE HOSPITAL	3 Other	11,343,946	14,314,863	$2,970,917	26.19%
420-00 STATE HOSPITAL Total		**52,235,044**	**56,507,026**	**$4,271,982**	**8.18%**
421-00 SH SECURED SERVICES	1 General	14,331,656	10,371,601	($3,960,055)	-27.63%
421-00 SH SECURED SERVICES	3 Other	159,631	33,299	($126,332)	-79.14%
421-00 SH SECURED SERVICES Total		**14,491,287**	**10,404,900**	**($4,086,387)**	**-28.20%**
430-00 DEVELOPMENTAL CENTER	1 General	14,840,379	16,417,075	$1,576,696	10.62%
430-00 DEVELOPMENTAL CENTER	2 Federal	29,378,634	32,472,041	$3,093,407	10.53%
430-00 DEVELOPMENTAL CENTER	3 Other	4,002,606	4,100,603	$97,997	2.45%
430-00 DEVELOPMENTAL CENTER Total		**48,221,619**	**52,989,719**	**$4,768,100**	**9.89%**
999-99 DEPARTMENT OF HUMAN SERVICES	1 General	595,736,533	692,360,434	96,623,901	16.22%
999-99 DEPARTMENT OF HUMAN SERVICES	2 Federal	1,212,943,782	1,403,157,675	190,213,893	15.68%
999-99 DEPARTMENT OF HUMAN SERVICES	3 Other	100,616,946	105,817,136	5,200,190	5.17%
999-99 DEPARTMENT OF HUMAN SERVICES Total		**1,909,297,261**	**2,201,335,245**	**292,037,984**	**15.30%**

Prepared by the North Dakota Legislative Council staff for Senator Mathern
March 11, 2009

LISTING OF PROPOSED CHANGES TO ENGROSSED HOUSE BILL NO. 1012

Department - Department of Human Services (325)

Proposed funding changes:

Description	FTE	General Fund	Special Funds	Total
1 Departmentwide - Restore funding removed by the House for anticipated savings from vacant positions and employee turnover		$2,000,000	$4,090,893	$6,090,893
2 Departmentwide - Restore funding removed by the House for travel costs		153,344	232,913	386,257
3 Departmentwide - Restore funding for inflationary increases to the level recommended in the executive budget of 7 percent for the second year of the biennium for rebased services and 7 percent annual increases for all other services		6,277,888	9,930,864	16,208,752
4 Administration Support - Restore new full-time equivalent (FTE) position added in the executive budget and removed by the House to perform additional duties required by Statement on Auditing Standards No. 115 regarding communicating internal control matters, including $126,265 for salaries and wages and $2,790 for operating expenses	1.00	56,724	72,331	129,055
5 Administration Support - Restore funding removed by the House for state employee salary equity adjustments		3,458,506	1,575,064	5,033,570
6 Medical Services - Restore funding for medically needy to reflect income levels of 83 percent of the federal poverty level as recommended in the executive budget (The House decreased funding for medically needy to reflect income levels of 75 percent of the federal poverty level.)		376,947	642,379	1,019,326
7 Medical Services - Restore funding for rebasing physician payment rates to 25 percent of the amount needed to rebase to 100 percent of cost as recommended in the executive budget (The House decreased funding for rebasing rates to 20 percent of the amount needed to rebase to 100 percent of cost.)		979,970	1,670,030	2,650,000
8 Medical Services - Restore funding for rebasing chiropractor payment rates to 100 percent of cost as recommended in the executive budget (The House decreased funding for rebasing rates to 75 percent of the cost report.)		38,459	65,541	104,000
9 Medical Services - Restore funding for rebasing ambulance payment rates to Medicare rates as recommended in the executive budget (The House decreased funding to provide funding equal to 75 percent of the funding provided in the executive budget.)		185,927	316,851	502,778
10 Medical Services - Restore funding for rebasing dentist payment rates to 75 percent of average billed charges with inflation increases of 7 percent each year as recommended in the executive budget (The House decreased funding to provide a minimum of 70 percent of average billed charges with inflation increases of 0 percent for the first year and 7 percent the second year.)		722,547	1,233,388	1,955,935
11 Medical Services - Restore funding for medical services (The House reduced funding to reduce projected caseload/utilization rates.)		9,600,000	16,359,978	25,959,978

3-11-09

11

29 [redacted]n Service Centers - Restore funding removed by the House for an [redacted]sition for the partnership program	1.00	61,490	40,440	[redacted]1,930
Total proposed funding changes	21.50	$41,732,069	$55,040,917	$96,772,986

Other proposed changes:

1 Amend sections 8 and 9 of the engrossed bill relating to supplemental payments to basic care and nursing home facilities and developmental disabilities providers to remove the restrictions to which employees are eligibile for the supplemental payment

MANAGEMENT SUBDIVISION	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	108.35	$29,814,818	$36,027,838	$65,842,656
Management - House changes:				
Administration Support Program				
1 Remove 1 new FTE position added in the executive budget to perform additional duties required by Statement on Auditing Standards No. 112 regarding communicating internal control matters, including $126,265 for salaries and wages and $2,790 for operating expenses	(1.00)	($56,724)	($72,331)	($129,055)
2 Reduce funding for salaries and wages department wide for anticipated savings from vacant positions and employee turnover in addition to the $1,917,041 reduction included in the executive budget		(2,000,000)	0	(2,000,000)
3 ~~Remove funding included in the executive budget for handheld communication devices~~		(13,281)	(22,949)	(36,230)
Division of Information Technology Program				
4 Add funding for eligibility system replacement project planning, including $100,000 for temporary salaries, $85,000 for assistance from county staff, and $500,000 for contract services		342,500	342,500	685,000
Total House changes - Management	(1.00)	($1,727,505)	$247,220	($1,480,285)

5 **Other changes affecting Management programs or multiple programs of the department:**

Add a section to provide for a Legislative Council study of the Department of Human Services child support enforcement program including the review of arrearages in terms of total owned and interest accrued and the review of child support enforcement in other states.

PROGRAM AND POLICY SUBDIVISION	FTE	General Fund	Estimated Income	Total
[redacted]ecutive budget recommendation	363.50	$544,526,484	$1,375,189,679	$1,919,716,163
[redacted]rogram and Policy - House changes:				
Decrease funding for department travel		($153,344)	($232,913)	($386,257)
Economic Assistance Policy Program				
No changes				
Child Support Program				
No changes				
Medical Services Program				
Medically needy - The executive budget adds funding of $5,520,859, of which $2,041,614 is from the general fund to increase medically needy income levels to 83 percent of the federal poverty level.				
Alternative A - Decrease funding for medically needy to reflect income levels of 75 percent of the federal poverty level		(376,947)	(642,379)	(1,019,326)
Alternative B - Decrease funding for medically needy to reflect income levels of 65 percent of the federal poverty level		(969,919)	(1,652,900)	(2,622,819)
Rebasing of hospital payment rates - The executive budget includes funding of $22,013,114, of which $8,140,450 is from the general fund, for rebasing hospital payment rates to 100 percent of cost.				
Alternative A - Reduce funding for rebasing to 90 percent of cost		(2,621,400)	(4,467,294)	(7,088,694)
Alternative B - Reduce funding for rebasing to 80 percent of cost		(5,081,446)	(8,659,616)	(13,741,062)
[redacted]basing of physician payment rates - The executive budget includes funding of $13,250,000, of which $4,899,850 is from the general fund, for rebasing physician payment rates to 25 percent of the amount needed to rebase to 100 percent of cost.				
Alternative A - Reduce funding for rebasing to 20 percent of the amount needed to rebase to 100 percent of cost		(979,970)	(1,670,030)	(2,650,000)
Alternative B - Reduce funding for rebasing to 15 percent of the amount needed to rebase to 100 percent of cost		(1,959,940)	(3,340,060)	(5,300,000)
[redacted]Rebasing of chiropractor payment rates - The executive budget includes funding of $416,000, of which $153,836 is from the general fund, for rebasing chiropractor payment rates to 100 percent of cost.				
Alternative A - Reduce funding for rebasing to 75 percent of the cost report		(38,459)	(65,541)	(104,000)
Alternative B - Reduce funding for rebasing to 50 percent of the cost report		(76,918)	(131,082)	(208,000)
Rebasing ambulance payment rates - The executive budget includes funding of $2,011,114, of which $743,710 is from the general fund, to rebase rates to the Medicare rates.				
Alternative A - Reduce funding to provide funding equal to 75 percent of the funding provided in the executive budget		(185,927)	(316,851)	(502,778)
Alternative B - Reduce funding to provide funding equal to 60 percent of the funding provided in the executive budget		(297,484)	(506,962)	(804,446)
Rebasing dentist payment rates - The executive budget includes funding of [redacted]$2,445,138 of which $904,167 from the general fund, to rebase rates to a [redacted]inimum of 75 percent of average billed charges and funding of $1,738,698, of which $641,918 is from the general fund, for 7 percent per year inflation increases.				
Alternative A - Reduce funding to provide funding at a minimum of 60 percent of average billed charges and a 7 percent inflation payment for only the second		(1,147,704)	(1,958,077)	(3,105,781)

year of the biennium				
Alternative B - Reduce funding to provide funding at a minimum of 65 percent of average billed charges (No change to inflation)		(511,466)	(871,742)	(1,383,208)
Alternative C - Reduce funding to provide funding at a minimum of 70 percent of average billed charges (No change to inflation)		(278,333)	(474,445)	(752,778)
Inflation - The executive budget provides funding of $94,739,624, of which $37,156,758 from the general fund, for 7 percent inflation increases for the second year of the biennium for rebased services and 7 percent per year increases for all other services.				
Alternative A - Reduce funding to provide inflation increases of 6 percent per year		(6,343,353)	(10,042,736)	(16,386,089)
Alternative B - Reduce funding to provide inflation increases of 5 percent per year		(11,640,419)	(18,236,829)	(29,877,248)
Alternative C - Reduce funding to provide inflation increases of 4 percent per year		(16,774,962)	(26,158,591)	(42,933,553)
Decrease funding for medical services projected caseload/utilization rates		(9,600,000)	0	(9,600,000)
Long Term Care Program				
Provide funding for assisted living room and board subsidies		2,160,000	0	2,160,000
Add funding to increase the personal needs allowance for individuals in basic care facilities from $60 to $75 per month (Funding for a January 1, 2010 start date)		112,320	0	112,320
Add funding to increase nursing facility bed limits in the formula for nursing home payments from $138,907 to $169,098 for single rooms and $92,604 to $112,732 for double rooms		324,506	553,012	877,518
Basic care and nursing home facilities - Salary and benefit supplemental payments				
Alternative A - Provide funding of $37,128,713, of which $14 million is from the general fund, $1 million is from the health care trust fund and $22,128,713 is from federal funds, to allow a $2 per hour salary and benefit increase for individuals employed by basic care and nursing care faculties currently making $15 per hour or less		14,000,000	23,128,713	37,128,713
Alternative B - Provide funding to allow a $2 per hour salary and benefit increase for all individuals employed by basic care and nursing care facilities		17,615,425	27,328,359	44,943,784
Provide funding to allow for a $2 per hour salary and benefit increase for all DD providers		14,194,510	24,189,780	38,384,290
Home and community-based care waiver - Autism spectrum disorder				
Alternative A - Remove funding included in the 2009-11 executive budget to implement a home and community-based care waiver to provide intensive support for young children who have a diagnosis of autism spectrum disorder	(1.00)	(450,724)	(721,019)	(1,171,743)
Alternative B - Remove the FTE position included in the 2009-11 executive budget relating to the implementation of a home and community-based care waiver to provide support for children who have a diagnosis of autism spectrum disorder	(1.00)	(66,872)	(66,871)	(133,743)
DD critical needs				
Alternative A - Provide funding for enhanced staffing needs for medically fragile and behaviorally challenged individuals		1,168,183	1,990,775	3,158,958
Alternative B - Provide funding for increasing the payment rates for children who are severely medically fragile residing at the Anne Carlsen Center for Children		438,900	747,957	1,186,857
Remove funding included in the executive budget for the addition of a third tier of personal care that would allow a maximum of 1,200 units of care per month		(1,021,922)	(1,741,524)	(2,763,446)
Decrease funding for long-term care projected caseload/utilization rates		(5,600,000)	0	(5,600,000)
Decrease funding for DD grants projected caseload/utilization rates		(2,476,000)	0	(2,476,000)

Aging Services Program			
~~Decrease funding added in the executive budget for senior service providers~~ to supplement Older ~~Americans~~ Act funds from ~~$900,000 to $577,883~~	(322,117)	0	(322,117)
Children and Family Services Program			
Increase funding for Healthy Families initiative by $200,000 from the general fund, from $300,000 from the general fund as provided for the 2007-09 biennium to $500,000 from the general fund for the 2009-11 biennium	200,000	0	200,000
~~Decrease funding for a new FTE position added in the executive budget for background checks for child care providers by $15,921 from the general fund from $323,921 to $308,000~~	(15,921)	0	(15,921)
Mental Health and Substance Abuse Program			
Increase funding for peer support program by $4,612,608, of which $2,777,505 is from the general fund	2,777,505	1,835,103	4,612,608
Decrease funding for compulsive gambling services by $200,000 from the general fund, from $700,000, of which $300,000 is from the general fund and $400,000 is from special funds from lottery proceeds, as provided for in the executive budget to $500,000, of which $100,000 is from the general fund and $400,000 is from special funds from lottery proceeds. The 2007-09 legislative appropriation for compulsive gambling services is $400,000 of special funds from lottery proceeds.	(200,000)	0	(200,000)
Remove funding for Governor's Prevention and Advisory Council grants	(200,000)	0	(200,000)
Developmental Disabilities Council			
No changes			
Developmental Disabilities Division			
No changes			
Vocational Rehabilitation			
Centers for Independent Living			
Alternative A - Increase funding for centers for independent living by $1,090,000 from the general fund from $2,144,539, of which $1,330,958 is from the general fund, as included in the executive budget to $3,234,539, of which $2,420,958 is from the general fund	1,090,000	0	1,090,000
Alternative B - Decrease funding for centers for independent living by $400,000 from the general fund from $2,144,539, of which $1,330,958 is from the general fund, as included in the executive budget to $1,744,539, of which $930,958 is from the general fund	(400,000)	0	(400,000)
Total House changes - Program and Policy	(1.00)	($11,081,954)	($4,949,203)	($16,031,157)

Other changes affecting Program and Policy programs:

Add a section of legislative intent regarding the funding for basic care and nursing home facility salary and benefit increases

Amend NDCC Section 50-30-02 relating to the health care trust fund to provide that moneys in the fund may not be included in drafts of appropriation bills introduced as part of the executive budget

Amend NDCC Section 50-06-29 regarding an aging and disability resource center

~~Amend NDCC Section 50-29-04 to increase eligibility for SCHIP from 150 percent to 200 percent of poverty~~

~~Amend NDCC Section 50-24.1-02 to increase the funeral set-aside from $5,000 to $7,000~~

Add a section of legislative intent to provide that the Department of Human Services consider the changes necessary to reimburse home tele-monitoring services under the Medicaid program at the same rates as skilled nurse visits provided in person.

STATE HOSPITAL	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	472.51	$50,437,933	$19,563,594	$70,001,527
State Hospital - House changes:				
37 Decrease one-time funding for extraordinary repairs from $3,231,017 to $2,231,017		($1,000,000)	$0	($1,000,000)
38 Decrease one-time funding for extraordinary repairs by $300,000 to remove funding for resurfacing and paving		(300,000)	0	(300,000)
39 Remove funding included in the executive budget for the global health initiative, including 6 new FTE positions	(6.00)	(516,815)	0	(516,815)
Total House changes - State Hospital	(6.00)	($1,816,815)	$0	($1,816,815)

Other changes affecting the State Hospital:

None

DEVELOPMENTAL CENTER	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	445.54	$16,854,593	$37,160,672	$54,015,265
Developmental Center - House changes:				
40 Decrease one-time funding for extraordinary repairs from $712,675 to $562,675		($150,000)	$0	($150,000)
Total House changes - Developmental Center	0.00	($150,000)	$0	($150,000)

Other changes affecting the Developmental Center:

41 Amend NDCC Section 23-04-05 regarding admissions to the Developmental Center

NORTHWEST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	44.75	$4,881,955	$3,680,172	$8,562,127
Northwest Human Service Center - House changes:				
No changes				
Total House changes - Northwest Human Service Center	0.00	$0	$0	$0

NORTH CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	117.78	$12,098,437	$8,825,362	$20,923,799
North Central Human Service Center - House changes:				
42 Remove funding added in the executive budget for the global health initiative		($1,358,307)	($100,000)	($1,458,307)
43 Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Total House changes - North Central Human Service Center	(1.00)	($1,417,100)	($152,354)	($1,569,454)

LAKE REGION HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	62.00	$6,263,550	$4,747,559	$11,011,109
Lake Region Human Service Center - House changes:				
No changes				
Total House changes - Lake Region Human Service Center	0.00	$0	$0	$0

NORTHEAST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	138.10	$12,056,316	$14,320,535	$26,376,851
Northeast Human Service Center - House changes:				
44 Remove funding added in the executive budget for the global health initiative		($280,663)	($81,200)	($361,863)
45 Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
Total House changes - Northeast Human Service Center	(1.00)	($339,456)	($133,554)	($473,010)

SOUTHEAST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	188.35	$16,054,906	$15,966,058	$32,020,964
Southeast Human Service Center - House changes:				
Global health initiative				
46 ~~Alternative A - Remove all funding added in the executive budget for the global health initiative.~~	(4.00)	($1,190,124)	($183,746)	($1,373,870)
Alternative B - ~~Remove all funding added in the executive budget for the global health initiative~~ except funding for contract staffing at the Cooperhouse of $315,360, of which $236,520 is from the general fund Add	(4.00)	(953,604)	(104,906)	(1,058,510)
47 Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental ~~disabilities cases~~	(1.00)	(58,793)	(52,354)	(111,147)
48 Remove funding added in the executive budget for young adult transition residential services		(184,622)	(242,222)	(426,844)
49 Remove funding and FTE position added in the executive budget for the partnership program	(1.00)	(61,490)	(40,440)	(101,930)
Total House changes - Southeast Human Service Center	(8.00)	($2,448,633)	($623,668)	($3,072,301)

SOUTH CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	87.50	$8,943,330	$6,970,002	$15,913,332
South Central Human Service Center - House changes:				
S0 Remove funding added in the executive budget for the global health initiative	(1.00)	($127,669)	$0	($127,669)
S1 Remove funding and FTE position added in the executive budget to complete vulnerable adult protection services	(1.00)	(73,128)	0	(73,128)
Total House changes - South Central Human Service Center	(2.00)	($200,797)	$0	($200,797)

WEST CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	136.30	$13,315,641	$12,693,292	$26,008,933
West Central Human Service Center - House changes:				
S2 Remove funding added in the executive budget for the global health initiative		($279,546)	$0	($279,546)
S3 Remove funding and FTE position added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	(1.00)	(58,793)	(52,354)	(111,147)
S4 Remove funding added in the executive budget for young adult transition residential services		(650,000)	(100,000)	(750,000)
Total House changes - West Central Human Service Center	0.00	($988,339)	($152,354)	($1,140,693)

BADLANDS HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	72.70	$6,264,582	$5,429,653	$11,694,235
Badlands Human Service Center - Senate changes:				
SS Remove funding added in the executive budget for the global health initiative		($665,000)	($140,000)	($805,000)
Total Senate changes - Badlands Human Service Center	0.00	($665,000)	($140,000)	($805,000)

Other changes affecting the Human Service Centers:
None

April 8, 2009 4PM

Prepared by the North Dakota Legislative Council staff for Senator Mathern
April 2009

4.06.09
4.08.09

LISTING OF PROPOSED CHANGES TO ENGROSSED HOUSE BILL NO. 1012

Department of Human Services

Proposed changes to restore House reductions:

	Description	FTE	General Fund	Special Funds	Total
1	Departmentwide - Restore funding removed by the House for anticipated savings from vacant positions and employee turnover		$2,000,000	$4,090,893	$6,090,893
2	Departmentwide - Restore funding removed by the House for travel costs		153,344	232,913	386,257
3	Departmentwide - Restore funding for inflationary increases to the level recommended in the executive budget of 7 percent for the second year of the biennium for rebased services and 7 percent annual increases for all other services		6,277,888	9,930,864	16,208,752
4	Administration support - Restore new full-time equivalent (FTE) position added in the executive budget and removed by the House to perform additional duties required by Statement on Auditing Standards No. 115 regarding communicating internal control matters, including $126,265 for salaries and wages and $2,790 for operating expenses	1.00	56,724	72,331	129,055
5	Administration support - Restore funding removed by the House for state employee salary equity adjustments		3,458,506	1,575,064	5,033,570
6	Medical services - Restore funding for medically needy to reflect income levels of 83 percent of the federal poverty level as recommended in the executive budget (The House decreased funding for medically needy to reflect income levels of 75 percent of the federal poverty level.)		376,947	642,379	1,019,326
7	Medical services - Restore funding for rebasing physician payment rates to 25 percent of the amount needed to rebase to 100 percent of cost as recommended in the executive budget (The House decreased funding for rebasing rates to 20 percent of the amount needed to rebase to 100 percent of cost.)		979,970	1,670,030	2,650,000
8	Medical services - Restore funding for rebasing chiropractor payment rates to 100 percent of cost as recommended in the executive budget (The House decreased funding for rebasing rates to 75 percent of the cost report.)		38,459	65,541	104,000
9	Medical services - Restore funding for rebasing ambulance payment rates to Medicare rates as recommended in the executive budget (The House decreased funding to provide funding equal to 75 percent of the funding provided in the executive budget.)		185,927	316,851	502,778
10	Medical services - Restore funding for rebasing dentist payment rates to 75 percent of average billed charges with inflation increases of 7 percent each year as recommended in the executive budget (The House decreased funding to provide a minimum of 70 percent of average billed charges with inflation increases of 0 percent for the first year and 7 percent the second year.)		722,547	1,233,388	1,955,935
11	Medical services - Restore funding for medical services (The House reduced funding to reduce projected caseload/utilization rates.)		9,600,000	16,359,978	25,959,978

12	[redacted]cal services - Restore funding for the funeral set-aside for Medicaid [redacted]ts to provide [redacted]an increase in the set-aside from $5,000 to $7,000 as recommended [redacted] the executive budget (The House decreased funding to provide for an increase in the set-aside from $5,000 to $6,000.)		103,922	179,078	[redacted],000
13	Medical services - Provide funding for the state children's health insurance program to increase the eligibility for the program from 150 percent to 200 percent of the federal poverty level and to add 1.5 new FTE positions as recommended in the executive budget (The House decreased funding to provide for increasing the eligibility of the program from 150 percent to 160 percent of the federal poverty level and removed 1.5 new FTE positions.) (Due to a decline in enrollment, the department estimates the total amount of funding needed to increase the eligibility for the program from 150 percent to 200 percent of the federal poverty level to be $6.9 million less than the amount provided by the House for the program.)	1.50	(2,187,383)	(6,263,826)	(8,451,209)
14	Long-term care - Restore funding for a new FTE position added in the executive budget relating to implementation of a home and community-based care waiver to provide support for children who have a diagnosis of autism spectrum disorder	1.00	66,872	66,871	133,743
15	Long-term care - Restore funding for the addition of a third tier of personal care that would allow a maximum of 1,200 units of care per month		1,021,922	1,741,524	2,763,446
16	Long-term care - Restore funding for long-term care (The House decreased funding to reduce projected caseload/utilization rates.)		5,600,000	9,543,320	15,143,320
17	Long-term care - Restore funding for developmental disabilities grants (The House decreased funding to reduce projected caseload/utilization rates.)		2,476,000	4,219,511	6,695,511
18	Aging services - Restore funding removed by the House for pilot aged and disabled resource centers		600,000	0	600,000
19	Mental health and substance abuse - Restore funding for compulsive gambling services to $700,000, of which $400,000 is from special funds and $300,000 is from the general fund (The House decreased funding for compulsive gambling services by $150,000 from the general fund.)		150,000	0	150,000
20	Mental health and substance abuse - Restore funding removed by the House for Governor's Prevention and Advisory Council grants		200,000	0	200,000
21	Vocational rehabilitation - Restore funding for centers for independent living to $1,744,539, of which $930,948 is from the general fund as recommended in the executive budget (The House decreased funding for centers for independent living by $400,000 from the general fund.)		400,000	0	400,000
22	State Hospital - Restore funding removed by the House for extraordinary repairs		1,000,000	0	1,000,000
23	State Hospital - Restore funding and 5 of the 6 FTE positions removed by the House for the global health initiative	5.00	424,084	0	424,084
24	Developmental Center - Restore funding removed by the House for extraordinary repairs		150,000	0	150,000
25	Human service centers - Restore funding removed by the House for the global health initiative	5.00	3,664,789	426,106	4,090,895
26	Human service centers - Restore funding and FTE positions added in the executive budget for providing additional oversight and monitoring of developmental disabilities cases	4.00	235,172	209,416	444,588

27	[redacted]ervice centers - Restore funding removed by the House for you[redacted]nsition [redacted]ntial services		834,622	342,222	[redacted]009
28	Human service centers - Restore funding removed by the House for vulnerable adult protection services	1.00	73,128	0	73,128
29	Human service centers - Restore funding removed by the House for an FTE position for the partnership program	1.00	61,490	40,440	101,930
	Total proposed changes to restore House reductions	19.50	$38,724,930	$46,694,894	$85,419,824

Proposed changes relating to federal fiscal stimulus funds

	Description	FTE	General Fund	Special Funds	Total
1	Change the funding source for Medicaid, foster care, and adoption payments due to the enhanced federal medical assistance percentage (FMAP) included in the American Recovery and Reinvestment Act of 2009		($66,500,000)	$66,500,000	$0
2	Replace a portion of the $900,000 general fund increases included in the executive budget for funding for senior service providers to supplement Older Americans Act funds with federal funds received through the American Recovery and Reinvestment Act of 2009 for elderly nutrition services		(485,000)	485,000	0
3	Change the funding source for increased funding for child support enforcement activities to reflect federal funds received through the American Recovery and Reinvestment Act of 2009		(3,200,000)	3,200,000	0
4	Provide for increased funding for vocational rehabilitation services to reflect federal funds received through the American Recovery and Reinvestment Act of 2009		0	1,800,000	1,800,000
5	Replace a portion of the $800,000 general fund increase included in the executive budget for centers for independent living with federal funds received through the American Recovery and Reinvestment Act of 2009 for independent living		(243,000)	243,000	0
6	Provide for increased funding for developmentally delayed infants aged 0 to 3 to reflect federal funds received through the American Recovery and Reinvestment Act of 2009 for Individuals With Disabilities Education Act - Part C		0	2,140,000	2,140,000
7	Provide for increased funding for supplemental nutrition assistance program benefits and related additional administrative expenses to reflect federal funds received through the American Recovery and Reinvestment Act of 2009		0	9,874,747	9,874,747
8	Provide for increased funding for child care assistance to reflect federal funds received through the American Recovery and Reinvestment Act of 2009 for the child care development block grant (This funding is currently appropriated in House Bill No. 1418.)		0	3,644,000	3,644,000
9	Provide funding for the senior employment program to reflect federal funds received through the American Recovery and Reinvestment Act of 2009		0	143,288	143,288
10	Provide funding for older blind services to reflect federal funds received through the American Recovery and Reinvestment Act of 2009		0	3,170	3,170

11	[redacted]nguage to provide that the department may seek Emergency Comm[redacted]and Budget S[redacted]n approval to spend any additional federal funds received under the American Recovery and Reinvestment Act of 2009 (A copy of the recommended language is attached as Appendix A.)		0	0	0
12	Add language to provide that federal fiscal stimulus funds are not to be included in the department's 2011-13 base budget (A copy of the recommended language is attached as Appendix A.)		0	0	0
Total proposed changes relating to federal fiscal stimulus funds		0.00	($70,428,000)	$88,033,205	$17,605,205
	Adjustment to recognize additional general fund turnback of $30.3 million from the 2007-09 biennium		$30,300,000	$0	($30,300,000)
	Restated total proposed changes relating to federal fiscal stimulus funds	0.00	($100,728,000)	$88,033,205	($12,694,795)

Other proposed funding enhancements:

	Description	FTE	General Fund	Special Funds	Total
1	Long-term care - Increase funding for a salary and benefit supplemental payment for individuals employed by a basic care and nursing home facility added by the House to provide a $2 per hour increase to all employees		$11,664,974	$18,539,682	$30,204,656
2	Long-term care - Increase funding for a salary and benefit supplemental payment for individuals employed by developmental disabilities providers added by the House to provide a $2 per hour increase to all employees		9,930,186	15,218,506	25,148,692
3	Children and family services - Provide additional funding for adoption services contract funding		200,000	0	200,000
4	Children and family services - Provide additional funding for a family group conferencing initiative		2,342,810	256,372	2,599,182
5	Vocational rehabilitation - Provide additional funding of $1,090,000 from the general fund for centers for independent living		1,090,000	0	1,090,000
6	Children and family services - Increase funding for the Healthy Families program by $200,000 from the general fund, from $300,000 from the general fund as provided for the 2007-09 biennium to $500,000 from the general fund for the 2009-11 biennium		200,000	0	200,000
7	Long-term care - Provide additional funding for developmental disabilities providers who are serving severely medically fragile and behaviorally challenged individuals and include a statement of legislative intent that the funding is to be provided directly to the Anne Carlsen Center and other like private providers serving individuals with developmental disabilities in proportion to the respective severity of the critical medical and behavioral needs of each individual served and that the funding is to become part of each providers annual base budget and shall not reduce a provider's entitlement to additional critical needs staffing in future ratesetting by the department		1,897,465	3,233,594	5,131,059
8	Long-term care - Provide funding for increasing payment rates for all qualified service providers to provide a $2 per hour increase		1,825,206	1,807,384	3,632,590

9	[redacted]n technology program - Provide funding for eligibility system re[redacted]project planning, including $100,000 for temporary salaries, $85,000 for assistance from county staff, and $500,000 for contract services	342,500	342,500	[redacted]0
10	Aging services - Increase funding for Older Americans Act meal service providers. The executive budget included additional funding of $900,000 from the general fund for senior service providers to supplement Older Americans Act funds.	1,900,000	0	1,900,000
11	Children and family services - Provide funding for parent aide services provided by county social services staff	934,742	0	934,742
12	Long-term care - Provide funding for assisted living room and board subsidies	2,160,000	0	2,160,000
13	Medical services - Increase funding for rebasing physician payment rates to 100 percent of cost	14,699,550	25,050,450	39,750,000
14	Medical services - Provide a contingent appropriation to expand medical assistance benefits for pregnant women if approved by the federal government (165 percent of poverty)	964,031	1,582,480	2,546,511
15	Mental health and substance abuse - Provide additional funding for the peer support program	600,000	0	600,000
16	Mental health and substance abuse - Provide additional funding for guardianship services	350,000	0	350,000
Total proposed funding enhancements		0.00 $51,101,464	$66,030,968	$117,132,432

Other proposed changes:

1 Amend Sections 8 and 9 of the engrossed bill relating to supplemental payments to basic care and nursing home facilities and developmental disabilities providers for salary and benefit increases to:

Revise the restrictions regarding which employees are eligible for the supplemental payment by removing the percentile restrictions and providing that basic care and nursing facilities may not use any money received for providing salary increases to administrators, contracted employees, or directors of nursing.

Provide that the Department of Human Services increases rates to provide for increases beginning July 1, 2009.

2 Add the following section to provide for a Legislative Council study regarding returning veterans and their families:

LEGISLATIVE COUNCIL STUDY - RETURNING VETERANS AND THEIR FAMILIES. During the 2009-10 interim, the legislative council shall consider studying the impact of veterans who are returning from the Iraq and Afghanistan wars and their families on the state's human services system. The study must include an analysis of the estimated cost of providing human service-related services to the returning veterans and their families, including treatment for traumatic head injury and mental illness. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly.

3 Add the following section relating to Medicaid provider payments:

STUDY - MEDICAID PROVIDER PAYMENTS. During the 2009-10 interim, the department of human services shall study the changes necessary to establish a common reimbursement system for medicaid provider payments. The department of human services shall incorporate the funding required to implement the reimbursement system in the department's budget request for the 2011-13 biennium.

4 Add the following section of legislative intent relating to a grant to the Family HealthCare Center:

LEGISLATIVE INTENT - GRANT - FAMILY HEALTHCARE CENTER. It is the intent of the sixty-first legislative assembly that the department of human services consider providing a grant to the family healthcare center for costs associated with the construction and renovation of additional space for the center from federal funds available to the department from the American Recovery and Reinvestment Act of 2009 during the biennium beginning July 1, 2009, and ending June 30, 2011. The department of human services may provide a grant to the extent that the family healthcare center has secured matching funds for the construction and renovation of additional space for the center from nonstate sources on a dollar-for-dollar basis. This section does not preclude the family healthcare center from applying for or receiving any federal stimulus money available directly from the federal government.

5 [redacted]e following section relating to salaries and wages for employees at [redacted]are and nursing home facilities, employees of developmental disabilities providers, and home health care providers:

STUDY - SALARIES AND WAGES. During the 2009-10 interim, the department of human services shall study salaries and related benefit levels provided in the state for employees of basic care and nursing home facilities, employees of developmental disabilities providers, and qualified service providers and shall consider the changes necessary to establish consistent salaries and wages among the groups. The department of human services shall incorporate the funding required to implement the changes necessary in the department's budget request for the 2011-13 biennium.

6 Revise Section 10 of the engrossed bill relating to screening required prior to admission or readmission at the Developmental Center. (A copy of the recommended revisions is attached as Appendix B.)

7 Add the following section of legislative intent to provide that the Department of Human Services consider the changes necessary to reimburse home health agencies for home telemonitoring services under the Medicaid program at the same rates as skilled nurse visits provided in person:

LEGISLATIVE INTENT - HOME TELEMONITORING SERVICES. It is the intent of the sixty-first legislative assembly that the department of human services consider the changes necessary to reimburse home telemonitoring services under the medicaid program at the same rate as skilled nurse visits provided in person.

8 Add the following section to provide for reports to the Budget Section regarding the status of the Developmental Center's transition plan:

DEVELOPMENTAL CENTER TRANSITION PLAN - REPORT TO THE BUDGET SECTION. The department of human services shall report to the budget section during the 2009-10 interim on the status of the developmental center's transition plan.

9 Consider adding funding of approximately $9.5 million from the general fund to account for the preliminary FMAP for federal fiscal year 2011 of 60.69 percent compared to the previ9ous estimate of 63.01 percent.

ATTACH:2

H

Testimony
House Bill 1012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
January 12, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, I am Brenda M. Weisz, Chief Financial Officer for the Department of Human Services. I am here today to provide you an overview of the Administration / Support area.

Programs

This area of the budget includes the Executive Office, Legal Advisory Unit, Human Resources, and Fiscal Administration. Each of these areas provides the needed support for the divisions within the Department to carry out their programs. This budget area includes centralized costs for department-wide expenditures such as program appeals, audit fees charged by the State Auditor's Office, and legal work provided by the Attorney General's Office. Also included are the centralized costs for the Central Office divisions such as motor pool expenses, postage for routine mailings such as federally required client TANF notices, along with the telephone services provided by the Information Technology Department.

Major Program Changes

There have not been any program changes in this area.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / Decrease
Salary and Wages	7,987,063	14,259,277	6,272,214
Operating	4,413,840	4,972,061	558,221
Total	12,400,903	19,231,338	6,830,435
General Funds	6,117,034	10,213,494	4,096,460
Federal Funds	5,498,938	7,953,224	2,454,286
Other Funds	784,931	1,064,620	279,689
Total	12,400,903	19,231,338	6,830,435

FTE	72.60	73.60	1.0

The Salary and Wages line item increased by $6,272,214 and can be attributed to the following:

- $843,921 in total funds of which $579,207 is general fund for the Governor's salary package for state employees.
- $5,033,569 in total funds of which $3,445,888 is general fund to address existing equity issues for employees throughout the Department including the Human Service Centers and Institutions.
- $186,905 in total funds of which $137,160 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- $114,660 in total funds of which $48,707 is general fund for the addition of 1.0 FTE in Fiscal Administration to address the requirements of SAS 112. This Statement of Audit Standard (SAS) is a response to Enron and other such activities found in other companies. Required under this standard is the emphasis on adequate internal controls and the requirement for detailed risk assessment analysis work. The implementation of SAS 112 was a

recommendation made by the State Auditor's Office during their last audit of the agency.

- $64,696 total funds with $49,602 from the general fund to provide funding for a .50 FTE position in the Executive Office that would focus on grant writing. With many of the federal grant sources moving toward a more competitive award process, the Department lacks a dedicated resource in this area.
- The remaining $28,463 decrease is a combination of increases and decreases needed to sustain the salary of the 73.6 FTE in this area of the budget.

The Operating line item increased by $558,221 and is a combination of increases and decreases expected next biennium. Outlined below are the significant areas of change:

- $354,425 increase in Professional Fees. $236,208 is a result of increased utilization of the services provided by the Attorney General's office coupled with their rate increase of 31% - $56.34 per hour to $73.81 per hour. $62,515 is attributed to services provided by the Office of Administrative Hearings. Our utilization in this area has increased along with a rate increase of 5% - $93.29 per hour to $97.95 per hour. The remainder of the increase, is essentially attributed to the expected increase in audit fees of $55,752.
- $147,445 increase in the operating fees and services area. $125,000 is due to additional centralized accounting costs being billed to the agency. These are all federal / other funds. The remainder of the increase in this area is a result of additional consultation and monitoring needs.

- $96,586 net increase in Building Rents / Leases. As a result of an oversight, our current budget did not include two years of rent expense to be paid to Facilities Management. This amounts to an additional $112,602 to be paid to Facilities Management which is federal/other funds and contains no general fund. This increase is offset by decreases amounting to $16,016.
- $64,732 increase in the IT Communications area of the budget to cover the costs of blackberries for 16 individuals along with an increase in phone utilization.
- $60,040 is attributed to the increase in the Travel category of the budget. $42,000 is related to state fleet usage and the rate increase established by DOT - $0.37 per mile to $0.40 per mile. The remainder of the increase is related to additional travel required by staff related to training in various areas.
- $29,379 for increases in Professional Development attributed to the FTE in this area of the budget.
- $17,981 increase in Printing costs as a result of a rate increase by OMB of 9% each year of the biennium.
- A decrease of $171,747 in the Postage budget is a combination of the postage increases anticipated for 2007 - 2009 which did not materialize along with negotiating lower rates with our shipping vendors.
- A decrease of $35,649 in the area of Equipment Rents / Leases as the result of statewide negotiated copier contracts completed by OMB.

The general fund request increased by $4,096,640 with 98% of the increase is associated with the salary changes indicated above. The remainder is a result of the changes in the operating line.

Likewise the majority of the increase or 87% in the federal and other funds is a result of the salary changes indicated above, while the remainder is a result of the changes in the operating line.

This concludes my testimony on the 2009 – 2011 budget request for Administration / Support area of the Department. I would be happy to answer any questions.

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
March 3, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, I am Brenda M. Weisz, Chief Financial Officer for the Department of Human Services. I am here today to provide you an overview of the Administration / Support area.

Programs

This area of the budget includes the Executive Office, Legal Advisory Unit, Human Resources, and Fiscal Administration. Each of these areas provides the needed support for the divisions within the Department to carry out their programs. This budget area includes centralized costs for department-wide expenditures such as program appeals, audit fees charged by the State Auditor's Office, and legal work provided by the Attorney General's Office. Also included are the centralized costs for the Central Office divisions such as motor pool expenses, postage for routine mailings such as federally required client TANF notices, along with the telephone services provided by the Information Technology Department.

Major Program Changes

There have not been any program changes in this area.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget	House Changes	To Senate
Salary and Wages	7,987,063	6,272,214	14,259,277	(5,559,021)	8,700,256
Operating	4,413,840	558,221	4,972,061	(11,454)	4,960,607
Total	12,400,903	6,830,435	19,231,338	(5,570,475)	13,660,863
General Funds	6,117,034	4,096,460	10,213,494	(3,639,786)	6,573,708
Federal Funds	5,498,938	2,454,286	7,953,224	(1,894,659)	6,058,565
Other Funds	784,931	279,689	1,064,620	(36,030)	1,028,590
Total	12,400,903	6,830,435	19,231,338	(5,570,475)	13,660,863
FTE	72.60	1.00	73.60	(1.00)	72.60

Budget Changes from Current Budget to Executive Budget:

The Salary and Wages line item increased by $6,272,214 and can be attributed to the following:

- $843,921 in total funds of which $566,589 is general fund for the Governor's salary package for state employees.
- $5,033,569 in total funds of which $3,458,506 is general fund to address existing equity issues for employees throughout the Department including the Human Service Centers and Institutions.
- $186,905 in total funds of which $137,160 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.

- $114,660 in total funds of which $48,707 is general fund for the addition of 1.0 FTE in Fiscal Administration to address the requirements of SAS 115. This Statement of Audit Standard (SAS) is a response to Enron and other such activities found in other companies. Required under this standard is the emphasis on adequate internal controls and the requirement for detailed risk assessment analysis work. The implementation of SAS 115 was a recommendation made by the State Auditor's Office during their last audit of the agency.
- $64,696 total funds with $49,602 from the general fund to provide funding for a .50 FTE position in the Executive Office that would focus on grant writing. With many of the federal grant sources moving toward a more competitive award process, the Department lacks a dedicated resource in this area.
- The remaining $28,463 decrease is a combination of increases and decreases needed to sustain the salary of the 73.6 FTE in this area of the budget.

The Operating line item increased by $558,221 and is a combination of increases and decreases expected next biennium. Outlined below are the significant areas of change:

- $354,425 increase in Professional Fees. $236,208 is a result of increased utilization of the services provided by the Attorney General's office coupled with their rate increase of 31% - $56.34 per hour to $73.81 per hour. $62,515 is attributed to services provided by the Office of Administrative Hearings. Our utilization in this area has increased along with a rate increase of 5% - $93.29 per hour to $97.95 per hour. The remainder of the increase, is

essentially attributed to the expected increase in audit fees of $55,752.

- $147,445 increase in the operating fees and services area. $125,000 is due to additional centralized accounting costs being billed to the agency. These are all federal / other funds. The remainder of the increase in this area is a result of additional consultation and monitoring needs.
- $96,586 net increase in Building Rents / Leases. As a result of an oversight, our current budget did not include two years of rent expense to be paid to Facilities Management. This amounts to an additional $112,602 to be paid to Facilities Management which is federal/other funds and contains no general fund. This increase is offset by decreases amounting to $16,016.
- $64,732 increase in the IT Communications area of the budget to cover an increase in phone and communication utilization.
- $60,040 is attributed to the increase in the Travel category of the budget. $42,000 is related to state fleet usage and the rate increase established by DOT - $0.37 per mile to $0.40 per mile. The remainder of the increase is related to additional travel required by staff related to training in various areas.
- $29,379 for increases in Professional Development attributed to the FTE in this area of the budget.
- $17,981 increase in Printing costs as a result of a rate increase by OMB of 9% each year of the biennium.
- A decrease of $171,747 in the Postage budget is a combination of the postage increases anticipated for 2007 - 2009 which did not materialize along with negotiating lower rates with our shipping vendors.

- A decrease of $35,649 in the area of Equipment Rents / Leases as the result of statewide negotiated copier contracts completed by OMB.

The general fund request increased by $4,096,640 with 98% of the increase is associated with the salary changes indicated above. The remainder is a result of the changes in the operating line.

Likewise the majority of the increase or 87% in the federal and other funds is a result of the salary changes indicated above, while the remainder is a result of the changes in the operating line.

House Changes:

The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $131,076 general fund and $268,110 federal funds for a total of $399,186.

The House reduced 50% of the department-wide travel increase. Administration / Support's share of this decrease is $29,440 total funds; $14,256 – general fund.

The salary equity funds were removed from the Department budgets. The amount reduced was $5,033,570 total funds with $3,458,506 from the general fund.

The House removed the new FTE added in the Executive Budget to address the requirements of SAS 115. This reduction was $129,055 total funds and $56,724 from the general fund after including the Governor's salary package and operating costs.

The House did add $20,776 all general fund for the expenses related to the newly created early childhood services advisory board outlined in House Bill 1472.

This concludes my testimony on the 2009 – 2011 budget request for Administration / Support area of the Department. I would be happy to answer any questions.

B

Department of Human Services
HB 1012
Salary Underfunding in 2007 - 2009

Management	200,000
Program and Policy	400,000
State Hospital	1,059,046
Developmental Center	1,047,908
Total	2,706,954

D

Department of Human Services
HB 1012
2009 - 2011 Budget

Current Biennium

		Monthly salary	Annual Cost
Beginning Salary June 30, 2007		1,000	
Year 1 increase 4% - July 1, 2007	$1,000 x 104%	1,040	12,480
Year 2 increase 4% - July 1, 2008	$1,040 x 104%	1,082	12,984
Salary Expense for 24 months - fully funded			$ 25,464

New Biennium	Monthly salary	Annual Cost
Beginning Salary July 1, 2009	1,082	12,984
Year 2 - no increase	1,082	12,984
Salary Expense for 24 months		$ 25,968

Difference $ 504

$1,082 - 1,040 = $42 / month

$42 / month x 12 months = cost to continue the year 2 increase

North Dakota Department of Human Services
Wage Comparison - (Benefits are not included)
2009-2011 Biennium

	Hourly Rate		
	Certified Nursing Assistant or Equivalent	Individual Qualified Service Provider	Agency Qualified Service Provider
Nursing Facilities	12.59 ^		
Developmental Disability Group Home/ICFMR	11.58 *		
Developmental Disability Other Waivered Services	11.73 *		
Home & Community Based Services		13.80 #	19.64 #

^ Based upon information contained in the 2008 Cost Reports, plus 5% inflation added by the 2007 Legislature.

* Based upon budgeted FTEs for SFY 2009

Based upon Medicaid Fee Schedule for SFY 2009. QSPs are paid based upon a 15 minute unit, for actual time spent providing services to a client. (Ex: They are not paid for their "windshield" time, or the time driving to and from a client's residence, completeing paperwork or etc.) In addition, Individual QSPs are self employed and must pay FICA accordingly.

See also Developmentally Disabled Providers category -

Department of Human Services
DD, Nursing Home, Basic Care and QSP Salary Scenarios
2009-2011 Biennium

	Total	General	Federal	County
Developmental Disabilities				
$1 Salary Increase	21,639,106	8,002,141	13,636,965	
$2 Salary Increase	43,077,843	15,930,186	27,147,657	
	64,716,949	23,932,327	40,784,622	-
Nursing Homes & Basic Care (All Staff)				
$1 Salary Increase	22,576,412	8,848,678	13,727,734	
$2 Salary Increase	44,943,784	17,615,425	27,328,359	
	67,520,196	26,464,103	41,056,093	-
QSP - Individual and Agency				
$1 Salary Increase	1,816,295	912,603	883,985	19,707
$2 Salary Increase	3,632,590	1,825,206	1,767,969	39,415
	5,448,885	2,737,809	2,651,954	59,122

North Dakota Department of Human Services
Wage Comparison - (Benefits are not included)
2009-2011 Biennium

REVISED

	Hourly Rate		
	Certified Nursing Assistant or Equivalent	Individual Qualified Service Provider	Agency Qualified Service Provider
Nursing Facilities	10.20 to 11.05 ^		
Basic Care	9.25		
Developmental Disability Group Home/ICFMR	11.58 *		
Developmental Disability Other Waivered Services	11.73 *		
Home & Community Based Services		13.80 #	19.64 #

^ Based upon the 2008 ND Long Term Care Association Wage Survey, plus 5% inflation added by the 2007 Legislature. Range includes the beginning salary to the average salary paid.

* Based upon budgeted FTEs for SFY 2009

Based upon Medicaid Fee Schedule for SFY 2009. QSPs are paid based upon a 15 minute unit, for actual time spent providing services to a client. (Ex: They are not paid for their "windshield" time, or the time driving to and from a client's residence, completeing paperwork or etc.) In addition, Individual QSPs are self employed and must pay FICA accordingly.

Department of Human Services
HB 1012
QSP Salary Scenarios
2009-2011 Biennium

QSP - Individual and Agency	Total	General	Federal	County
QSP - Agency $1	508,563	255,553	247,467	5,543
QSP - Individual $2	2,615,465	1,314,271	1,272,685	28,509
Total	3,124,028	1,569,824	1,520,152	34,052

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Department of Human Services
DD, Nursing Home, Basic Care and QSP Salary Scenarios
2009-2011 Biennium

	Total	General	Federal	County
Developmental Disabilities				
$1 Salary Increase	21,639,106	7,086,807	14,552,299	
Amount included by the House	18,929,151	7,000,000	11,929,151	
Increase needed	2,709,955	86,807	2,623,148	
Nursing Homes & Basic Care (All Staff)				
$1 Salary Increase	22,576,412	7,927,252	14,649,160	
Amount included by the House	14,739,128	4,950,451	9,788,677	
Increase needed	7,837,284	2,976,801	4,860,483	
QSP - Individual and Agency				
$1 Salary Increase	1,816,294	853,268	943,319	19,707
Amount added by the House	-	-	-	0
Increase needed	1,816,294	853,268	943,319	19,707

FMAP @ Enhanced Rate for Stimulus **67.25%**
(69.95 for 17 months and 60.69 for 7 months)

Department of Human Services
Summary by Subdivision of the Travel Budget Account Code
Per the 2009 - 2011 Budget to the House

Subdivision	Class	FB	Bgt_Acct	Bgt_Acct_Desc	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	To the House 2009-2011
100-15 ADMINISTRATION - SUPPORT	32530	B	521000	Travel	$311,203	$458,889	$174,683	$60,040	$518,929
100-20 INFORMATION TECHNOLOGY SRVCS	32530	B	521000	Travel	$53,200	$88,029	$45,112	($3,017)	$85,012
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS	32530	B	521000	Travel	$109,112	$203,607	$50,262	($4,638)	$198,969
300-02 CHILD SUPPORT ENFORCEMENT	32530	B	521000	Travel	$20,212	$173,972	$28,380	($22,867)	$151,105
300-03 MEDICAL SERVICES	32530	B	521000	Travel	$55,246	$106,470	$59,789	$78,494	$184,964
300-42 DD COUNCIL	32530	B	521000	Travel	$24,482	$27,105	$6,960	$10,045	$37,150
300-43 AGING SERVICES	32530	B	521000	Travel	$73,103	$56,976	$31,191	$29,971	$86,947
300-46 CHILDREN AND FAMILY SERVICES	32530	B	521000	Travel	$312,469	$387,091	$164,397	$7,895	$394,986
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE	32530	B	521000	Travel	$103,005	$98,395	$80,187	$131,884	$230,279
300-51 DEVELOPMENTAL DISABILITIES DIVISION	32530	B	521000	Travel	$141,593	$122,111	$68,741	$88,109	$210,220
300-51 VOC REHAB	32530	B	521000	Travel	$149,358	$164,638	$85,579	$157,935	$322,573
410-71 NORTHWEST HSC	32570	B	521000	Travel	$154,439	$154,776	$65,080	$54,549	$209,325
410-72 NORTH CENTRAL HSC	32570	B	521000	Travel	$257,017	$266,569	$101,400	$7,285	$273,854
410-73 LAKE REGION HSC	32570	B	521000	Travel	$153,509	$173,070	$90,702	$42,100	$215,170
410-74 NORTHEAST HSC	32570	B	521000	Travel	$378,992	$391,946	$207,054	$15,120	$407,066
410-75 SOUTHEAST HSC	32570	B	521000	Travel	$339,835	$384,951	$212,660	$6,276	$391,227
410-76 SOUTH CENTRAL HSC	32570	B	521000	Travel	$198,181	$222,501	$85,926	$33,344	$255,845
410-77 WEST CENTRAL HSC	32570	B	521000	Travel	$392,109	$438,513	$189,598	$46,142	$484,655
410-78 BADLANDS HSC	32570	B	521000	Travel	$161,083	$161,113	$85,325	$787	$161,900
420-00 STATE HOSPITAL	32570	B	521000	Travel	$304,034	$336,746	$145,896	$23,477	$360,223
421-00 SH SECURED SERVICES	32570	B	521000	Travel	$8,434	$3,500	$10,117	$8,799	$12,299
430-00 DEVELOPMENTAL CENTER	32570	B	521000	Travel	$363,763	$348,073	$200,502	$783	$348,856
					$4,064,379	**$4,769,041**	**$2,189,541**	**$772,513**	**$5,541,554**

D

Department of Human Services
HB1012
Travel Increase - Administration/Support

Department Wide Travel Rates used in Budget Preparation

Budgeted Travel Rates				
In-State Travel	07-09 Biennium	09-11 Biennium	Difference	% Difference
Meals	25	25	0	
IRS Meals Taxable	10	10	0	
Lodging (Includes Taxes)	55	61	6	9.84%
Mileage (Non-State Employee or Personal Vehicle)	0.375	0.45	0.075	16.67%
Motor Pool Mileage	0.37	0.40	0.03	7.50%
Out of State Travel				
Meals	64	64	0	
Lodging (Includes Taxes)	140	140	0	
Mileage	0.375	0.45	0.075	16.67%
Airfare	600	800	200	25.00%
Other Transportation (Taxi, parking, etc.)	60	60	0	

	07-09		09-11		Breakdown of Rate Increases			Rate	Utilization	Total
	Mileage/Trips	Budget	Mileage/Trips	Budget	Lodging	Mileage	Airfare	Increase	Increase*	
Motor Pool Miles	1,017,856	$ 376,607	1,050,011	$ 420,004		$ 30,536		$ 30,536	$ 12,861	$ 43,397
Total In-State Trips	205	$ 31,962	261	$ 36,485	$ 1,020			$ 1,020	$ 3,503	$ 4,523
Total Out-of-State Trips	34	$ 50,320	37	$ 62,440			$ 6,800	$ 6,800	$ 5,320	$ 12,120
Total		$ 458,889		$ 518,929	$ 1,020	$ 30,536	$ 6,800	$ 38,356	$ 21,684	$ 60,040

*Explanation of usage increases:

Motor Pool is for all Central Office divisions. The increase is a result of additional monitoring and licensure occurring within the Central Office divisions including Mental Health / Substance Abuse, Vocational Rehabilitation and others.

In-State Trips increased primarily due to 1) a change in the billing practices by the AG's office where we pay for the travel of their staff (change made in 2007 - 09 but no budget existed to accommodate the change) and 2) centralized Human Service Center Accounts Receivable staff for "hands on" training of new functions released in their computer system (ROAP) along with site visits to assist in maximizing revenue collections.

Out of state trips increased by three to allow Fiscal Administration staff training opportunities based on new federal regulations for the programs administered by the Central Office.

A

Agency - Dep ıt of Human Services

PMIS/Psft Position No.		FTE	Position Description	Date Vacated	Number of Months Vacant January 2009	Date Expected to Be Filled	Current Status	Salary and Fringe Benefit Amounts Included in the 2009-11 Executive Budget General Fund	Special Funds	Total
0052/3185	Exec Office	1.00	Administrative Assistant I	8/18/2008	5		Assessing	$65,240	$19,159	$84,399
0169/3300	Exec Office	1.00	Deputy - Not Classified	8/15/2005	41		Retaining for use in future administrations	$3,497	$469	$3,966
0711/3773	Exec Office	0.50	Administrative Assistant I	8/1/2008	5	7-1-09	Will be recruiting	$57,046	$16,602	$73,648
0797/3847	Exec Office	1.00	HSPA IV	10/15/2008	3		Assessing	$108,558	$31,737	$140,295
0058/3191	Human Resources	0.80	Office Assistant II	7/21/2008	6	2-1-09	Setting up interviews	$64,618	$23,726	$88,344
0971/4001	Fiscal	1.00	Accounting/Budget Specialist III	12/15/2008	1	2-15-09	Currently recruiting	$58,838	$74,207	$133,045
0139/3270	Fiscal	1.00	Auditor II	12/9/2008	1	2-1-09	Currently recruiting	$58,602	$56,447	$115,049
0044/3177	CFS	1.00	Director, CFS	10/17/2008	3	1-1-09	Filled 1-1-09	$86,101	$129,143	$215,244
0072/3205	CFS	1.00	HSPA V	12/31/2008	1	1-6-09	Filled 1-6-09	$54,826	$133,074	$187,900
0461/3582	DDS	1.00	Senior Disability Claims Analyst	12/31/2008	1	1-1-09	Filled 1-1-09	$0	$150,673	$150,673
0785/3836	DDS	1.00	Office Assistant III	12/5/2008	1	7-1-09	Will be recruiting; Need permission to fill from SSA	$0	$76,016	$76,016
0307/3434	EA Policy	1.00	Director of Economic Assistance	1/25/2008	12		Assessing	$86,566	$123,968	$210,534
0111/3243	Quality Control	1.00	Administrative Assistant II	12/31/2008	1	1-5-09	Filled 1-5-09	$49,225	$50,785	$100,010
0323/3450	LIHEAP	1.00	HSPA III	6/26/2008	7		Assessing	$59,872	$96,305	$156,177
2246/2245	Medical	1.00	HSPA IV (pending Classification)	9/1/2008	4	2-15-09	Currently recruiting	$72,185	$72,185	$144,370
0483/3603	Child Support	1.00	System Support Specialist I	11/7/2008	2	2-15-09	Job offered 1-16-09	$33,608	$65,238	$98,846
2447/4339	Child Support	1.00	HSPA III	11/1/2008	2	1-2-09	Filled 1-2-09	$2,391	$109,698	$112,089
3362/25810	Child Support	1.00	Child Support Investigator I	7/1/2007	18	3-1-09	Reclassifying and recruiting	$2,453	$112,052	$114,505
3380/25828	Child Support	1.00	Child Support Investigator I	11/13/2008	2	5-1-09	Will be recruiting	$34,723	$67,403	$102,125
3365/25813	Child Support	1.00	Child Support Investigator II	1/31/2008	12	6-1-09	Will be recruiting	$25,317	$92,751	$118,068
3378/25826	Child Support	1.00	Office Assistant II	11/14/2008	2	4-1-09	Will be recruiting	$14,609	$53,373	$67,982
3348/25796	Child Support	1.00	Administrative Assistant II	7/1/2007	18	4-1-09	Will be recruiting	$1,431	$73,621	$75,052
3354/25802	Child Support	1.00	Regional Child Support Administrator	3/31/2008	10	1-23-09	Job to be offered by 1-23-09 **see note**	$0	$0	$0
3361/23809	Child Support	1.00	Attorney I	8/13/2008	5	1-2-09	Filled 1-2-09 **see note**	$0	$0	$0
3281/25715	Child Support	0.50	Child Support Investigator I	12/5/2008	1	1-13-09	Job offered 1-13-09	$22,197	$43,089	$65,286
0206/3335	NWHSC	0.75	Human Service Aide II	8/29/2007	17	1-15-09	Filled 1-15-09	$46,512	$17,119	$63,631
0802/3850	NWHSC	1.00	Licensed Psychologist I	2/29/2008	11	7-1-09	Currently recruiting	$126,095	$79,265	$205,360
0821/3864	NWHSC	1.00	Addiction Counselor II	4/30/2008	9	2-2-09	Filled 2-2-09	$69,703	$25,710	$95,413
0923/3955	NWHSC	1.00	Licensed Psychologist I	10/31/2008	3	7-1-09	Currently recruiting	$133,343	$83,765	$217,108
0926/3957	NWHSC	0.50	Human Relations Counselor	12/24/2008	1	3-1-09	Will be recruiting	$57,713	$21,294	$79,007
0020/24853	NCHSC	0.50	DD Case Manager II	5/1/2006	32	7-1-09	Will be recruiting	$36,651	$27,295	$63,946
0999/4028	NCHSC	1.00	Human Service Aide II	11/3/2008	2	1-5-09	Filled 1-5-09	$52,685	$34,364	$87,049
2112/4122	NCHSC	1.00	Unclassified	1/1/2006	36	7-1-09	Currently recruiting	$233,551	$156,857	$390,408
2119/4129	NCHSC	1.00	Advanced Clinical Specialist	11/14/2008	2	2-1-09	Filled 2-1-09	$59,543	$79,172	$138,715
2126/4136	NCHSC	1.00	Addiction Counselor II	9/14/2007	16	2-1-09	Filled 2-1-09	$48,822	$61,717	$110,539
0289/3417	LRHSC	1.00	Advanced Clinical Specialist	3/1/2007	22	3-1-09	Currently recruiting	$55,848	$64,085	$119,933
0291/3419	LRHSC	1.00	Licensed Psychologist I	8/27/2008	5	7-1-09	Currently recruiting	$75,990	$86,611	$162,601
0317/3444	LRHSC	1.00	Addiction Counselor III	9/15/2008	4	4-1-09	Currently recruiting	$64,069	$76,431	$140,500
0948/3979	LRHSC	1.00	Advanced Clinical Specialist	11/7/2008	2	7-1-09	Currently recruiting	$59,923	$68,646	$128,569
0961/3991	LRHSC	1.00	Advanced Clinical Specialist	9/30/2008	4	7-1-09	Currently recruiting	$57,015	$65,392	$122,407
3154/4405	LRHSC	1.00	MI Case Manager II	11/5/2008	2	1-5-09	Filled 1-5-09	$48,665	$57,921	$106,586
0978/4008	NEHSC	1.00	Licensed Psychologist I	6/20/2008	7	1-8-09	Filled 1-8-09	$24,465	$138,136	$162,601
2323/4272	NEHSC	1.00	Community Home Counselor II	12/10/2008	1	1-5-09	Filled 1-5-09	$28,644	$48,282	$76,926
2515/4355	NEHSC	1.00	Licensed Exempt Psychologist I	9/10/2007	16	7-1-09	Using funds for contract	$21,574	$122,788	$144,362

Agency - Dep it of Human Services

PMIS/Psft Position No.		FTE	Position Description	Date Vacated	Number of Months Vacant January 2009	Date Expected to Be Filled	Current Status	Salary and Fringe Benefit Amounts Included in the 2009-11 Executive Budget General Fund	Special Funds	Total
0571/3667	SEHSC	1.00	Human Relations Counselor	11/28/2008	2	2-1-09	Currently recruiting	$56,574	$56,686	$113,260
0705/3767	SEHSC	1.00	Licensed Psychologist I	9/1/2008	4	2-1-09	Currently recruiting	$91,705	$90,949	$182,654
0922/3954	SEHSC	1.00	Administrative Assistant I	12/31/2008	1	2-1-09	Currently recruiting	$81,210	$10,277	$91,487
0963/3993	SEHSC	1.00	MI Case Manager II	11/28/2008	2	1-6-09	Filled 1-6-09	$54,372	$50,854	$105,226
2209/4181	SEHSC	1.00	MI Case Manager II	11/21/2008	2	1-12-09	Filled 1-12-09	$48,749	$54,455	$103,204
2226/4194	SEHSC	1.00	Office Assistant III	12/1/2008	1	2-1-09	Currently recruiting	$69,770	$8,832	$78,602
2247/4212	SEHSC	1.00	Human Relations Counselor	11/18/2008	2	1-1-09	Filled 1-1-09	$101,368	$19,589	$120,957
2263/4228	SEHSC	0.30	Registered Nurse II	1/11/2006	36		Assessing; to be added back to part-time FTE	$15,657	$13,741	$29,398
0232/3360	SCHSC	1.00	DD Case Manager III	7/15/2008	6	3-2-09	Will be recruiting	$79,975	$39,868	$119,843
0771/3822	SCHSC	1.00	Activity Therapist II	11/1/2008	2	2-2-09	Filled 2-2-09	$31,403	$77,508	$108,911
2406/4304	SCHSC	1.00	Unclassified	9/3/2003	64	7-1-09	Currently recruiting	$274,650	$182,101	$456,751
0467/10259	WCHSC	0.50	Office Assistant II	12/8/2008	1	1-1-09	Filled 1-1-09	$41,063	$7,863	$48,926
0995/4024	WCHSC	1.00	Addiction Counselor II	8/29/2008	5	2-1-09	Filled 2-1-09	$19,422	$91,117	$110,539
2037/4065	WCHSC	1.00	Addiction Counselor II	8/15/2008	5	1-12-09	Filled 1-12-09	$22,695	$105,333	$128,028
2240/4207	WCHSC	1.00	Occupational Therapist	3/31/2006	34	3-1-09	Currently recruiting	$62,823	$39,503	$102,326
2244/2249	WCHSC	1.00	Unclassified	9/1/2008	4	3-1-09	Currently recruiting	$236,893	$198,123	$435,016
0839/3878	BLHSC	1.00	Licensed Psychologist I	7/31/2007	18	1-1-09	Filled 1-1-09	$58,400	$112,628	$171,028
0359/3484	BLHSC	1.00	Vocational Evaluator I	10/31/2007	15	7-1-09	Funding used to pay temporary employee	$22,381	$82,694	$105,075
4733/2877	State Hospital	1.00	Office Assistant II	12/31/2008	1	2/1/2009	Assessing	$79,011	$0	$79,011
4857/2949	State Hospital	1.00	Administrative Assistant III	12/31/2008	1	1/1/2009	Filled 1-1-09	$98,246	$0	$98,246
4473/2729	State Hospital	1.00	Heating Plant Operator II	11/18/2008	2	1/5/2009	Filled 1-5-09	$99,406	$0	$99,406
4873/2959	State Hospital	0.50	Behavioral Health Technician II	6/20/2008	7	7/1/2009	Administrative hold; paying for salary underfund	$51,880	$167	$52,047
4830/2932	State Hospital	1.00	Behavioral Health Technician I	12/29/2008	1	1/1/2009	Filled 1-1-09	$74,086	$238	$74,324
4062/24597	State Hospital	1.00	Behavioral Health Technician II	12/1/2008	1	1/1/2009	Filled 1-1-09	$96,928	$312	$97,240
4113/25885	State Hospital	0.50	Security Officer I	5/1/2008	8	7/1/2009	Administrative hold; paying for salary underfund	$55,305	$177	$55,482
4115/25884	State Hospital	1.00	Safety/Security Supervisor	12/31/2008	1	2/1/2009	Will be recruiting	$126,763	$407	$127,170
4142/26534	State Hospital	0.50	Occupational Therapist	10/31/2008	3	5/1/2009	Will be recruiting	$1,664	$196	$1,860
4539/2764	State Hospital	1.00	Registered Nurse II	12/31/2008	1	1/1/2009	Filled 1-1-09	$92,676	$67,847	$160,523
4772/2896	State Hospital	1.00	Licensed Practical Nurse II	6/3/2007	19	2/1/2009	Currently recruiting	$52,807	$39,031	$91,838
4524/2755	State Hospital	1.00	Registered Nurse II	11/1/2008	2	2/1/2009	Currently recruiting	$75,920	$55,737	$131,657
4903/2980	State Hospital	1.00	Licensed Practical Nurse II	4/1/2008	9	2/1/2009	Currently recruiting	$101,284	$10,654	$111,938
4543/2767	State Hospital	1.00	Registered Nurse II	12/1/2008	1	2/1/2009	Currently recruiting	$76,375	$56,066	$132,441
4743/2883	State Hospital	1.00	Licensed Practical Nurse II	6/1/2008	7	7/1/2009	Administrative hold; paying for salary underfund	$71,694	$52,682	$124,376
4510/2742	State Hospital	0.46	Registered Nurse II	5/31/2006	32	7/1/2009	Administrative hold; paying for salary underfund	$27,461	$19,170	$46,631
4511/2743	State Hospital	1.00	Behavioral Health Supervisor	12/1/2008	1	2/1/2009	Filled 2-1-09	$49,890	$36,922	$86,812
4896/2975	State Hospital	1.00	Licensed Practical Nurse II	8/1/2008	5	2/1/2009	Currently recruiting	$71,694	$52,682	$124,376
4009/12394	State Hospital	0.50	Behavioral Health Technician II	12/1/2008	1	7/1/2009	Administrative hold; paying for salary underfund	$29,973	$22,074	$52,047
4688/2851	State Hospital	1.00	Registered Nurse II	10/8/2007	15	7/1/2009	Administrative hold; paying for salary underfund	$64,195	$47,261	$111,456
4061/2538	State Hospital	1.00	Behavioral Health Technician I	12/31/2008	1	2/1/2009	Currently recruiting	$41,746	$42,520	$84,266
4716/2868	State Hospital	1.00	Behavioral Health Technician II	12/31/2008	1	1/1/2009	Filled 1-1-09	$20,391	$57,877	$78,268
6340/2187	Developmental Center	1.00	Vocational Training Technician	9/1/2008	4	3/2/2009	Currently recruiting	$39,692	$56,390	$96,082
6217/2125	Developmental Center	1.00	Maintenance Worker II	12/1/2008	1	1/5/2009	Filled 1-5-09	$55,072	$88,029	$143,101
6219/2126	Developmental Center	1.00	Maintenance Mechanic II	6/1/2007	19	3/16/2009	Currently recruiting	$55,072	$88,029	$143,101
6233/2136	Developmental Center	1.00	Carpenter II	4/30/2005	45	3/16/2009	Currently recruiting	$564	$86,398	$86,962

Agency - Dep ıt of Human Services

PMIS/Psft Position No.		FTE	Position Description	Date Vacated	Number of Months Vacant January 2009	Date Expected to Be Filled	Current Status	Salary and Fringe Benefit Amounts Included in the 2009-11 Executive Budget General Fund	Special Funds	Total
6092/10253	Developmental Center	0.25	Activity Assistant II	12/20/2008	1	2/9/2009	Currently recruiting	$6,531	$13,533	$20,064
6319/2178	Developmental Center	0.50	Activity Assistant II	12/30/2008	1	2/17/2009	Currently recruiting	$17,977	$37,995	$55,972
6215/2123	Developmental Center	0.50	Account Technician I	5/7/2008	8	3/16/2009	Currently recruiting	$32,124	$51,346	$83,470
6672/2358	Developmental Center	0.50	Office Assistant III	12/31/2008	1	3/16/2009	Currently recruiting	$16,288	$34,603	$50,891
6499/2285	Developmental Center	1.00	Direct Training Technician I	10/14/2008	3	2/17/2009	Currently recruiting	$18,173	$53,884	$72,057
6602/2329	Developmental Center	1.00	Direct Training Technician I	10/10/2008	3	2/2/2009	Filled 2-2-09	$18,514	$54,930	$73,444
6650/2353	Developmental Center	1.00	Direct Training Technician I	12/3/2008	1	2/9/2009	Currently recruiting	$28,265	$45,179	$73,444
6300/2168	Developmental Center	1.00	Direct Training Technician I	9/19/2008	4	3/9/2009	Currently recruiting	$22,467	$47,470	$69,937
6428/2240	Developmental Center	1.00	Direct Training Technician I	12/1/2008	1	3/2/2009	Currently recruiting	$24,400	$48,790	$73,190
6439/2246	Developmental Center	1.00	Direct Training Technician I	10/21/2008	3	2/9/2009	Currently recruiting	$24,028	$48,029	$72,057
6600/2328	Developmental Center	1.00	Direct Training Technician I	1/1/2007	24	3/16/2009	Currently recruiting	$55,072	$88,029	$143,101
6692/2373	Developmental Center	1.00	Direct Training Technician I	10/23/2008	3	3/2/2009	Currently recruiting	$24,400	$48,790	$73,190
6744/2405	Developmental Center	1.00	Direct Training Technician I	11/8/2008	2	3/9/2009	Currently recruiting	$21,311	$50,746	$72,057
6409/2230	Developmental Center	1.00	Direct Training Technician I	12/11/2008	1	3/16/2009	Currently recruiting	$20,988	$48,949	$69,937
6622/2339	Developmental Center	1.00	Direct Training Technician I	10/13/2008	3	2/9/2009	Currently recruiting	$22,941	$53,627	$76,568
6673/2359	Developmental Center	1.00	Direct Training Technician I	12/31/2008	1	2/9/2009	Currently recruiting	$28,429	$66,447	$94,876
6797/2437	Developmental Center	1,00	Direct Training Technician I	10/21/2008	3	1/20/2009	Filled 1-20-09	$22,020	$51,424	$73,444
6828/2455	Developmental Center	1.00	Direct Training Technician I	12/10/2008	1	2/17/2009	Currently recruiting	$29,164	$46,618	$75,782
6830/2457	Developmental Center	1.00	Direct Training Technician I	11/1/2008	2	1/20/2009	Filled 1-20-09	$22,020	$51,424	$73,444
6529/2299	Developmental Center	1.00	Direct Training Technician I	12/8/2008	1	1/2/2009	Filled 1-2-09	$24,966	$52,852	$77,818
6421/2237	Developmental Center	1.00	Direct Training Technician I	12/31/2008	1	2/9/2009	Currently recruiting	$21,311	$50,746	$72,057
6794/2434	Developmental Center	1.00	Activity Assistant II	4/1/2008	9	1/5/2009	Filled 1-5-09	$17,498	$54,559	$72,057
6434/2243	Developmental Center	1.00	Direct Training Technician I	12/13/2008	1	3/23/2009	Currently recruiting	$20,667	$58,719	$79,386
6723/2392	Developmental Center	1.00	Direct Training Technician I	9/1/2008	4	3/9/2009	Currently recruiting	$23,836	$67,686	$91,522
6738/2401	Developmental Center	1.00	Assistant Residential Supervisor	6/1/2008	7	1/5/2009	Filled 1-5-09	$21,008	$59,702	$80,710
6771/2419	Developmental Center	1.00	Assistant Residential Supervisor	12/17/2008	1	3/9/2009	Currently recruiting	$26,375	$74,842	$101,217
6493/2283	Developmental Center	0.25	Direct Training Technician II	12/31/2008	1	2/9/2009	Filled 2-9-09	$5,492	$15,078	$20,570
6887/2486	Developmental Center	1.00	Activity Assistant II	2/20/2008	11	1/12/2009	Filled 1-12-09	$25,684	$54,420	$80,104
6087/2044	Developmental Center	0.40	Licensed Practical Nurse II	5/8/2007	20	N/A	Administrative hold	$19,567	$41,389	$60,956
6113/2064	Developmental Center	0.12	Registered Nurse III	8/24/2008	5	N/A	Administrative hold	$6,070	$12,149	$18,219
6038/2013	Developmental Center	1.00	Direct Training Technician I	9/1/2008	4	2/9/2009	Currently recruiting	$26,510	$73,701	$100,211
6724/2393	Developmental Center	1.00	Assistant Residential Supervisor	7/15/2008	6	3/16/2009	Currently recruiting	$27,500	$55,085	$82,585
6792/2433	Developmental Center	1.00	Direct Training Technician I	2/1/2007	23	3/16/2009	Currently recruiting	$55,072	$88,029	$143,101
6835/2461	Developmental Center	1.00	Direct Training Technician II	2/19/2008	11	3/16/2009	Currently recruiting	$21,612	$50,445	$72,057
6781/2426	Developmental Center	1.00	Direct Training Technician I	1/1/2007	24	3/16/2009	Currently recruiting	$18,790	$53,267	$72,057
6782/2427	Developmental Center	1.00	Direct Training Technician I	7/29/2008	6	3/23/2009	Currently recruiting	$25,005	$50,029	$75,034
6646/2350	Developmental Center	1.00	Direct Training Technician I	9/9/2008	4	3/23/2009	Currently recruiting	$24,028	$48,029	$72,057
Total		114.33						$6,107,722	$7,012,098	$13,119,820

NOTE: 40 Positions have been filled. The amount budgeted for those positions is $1,715,148 general fund; $2,243,844 federal fund; and $3,958,992 Total funds.
The Institutions Executive Budget recommendation already includes $1,356,774 of general fund salary underfunding.
The Child Support Division will need to manage salary dollars in order to fill the positions without funding.

B

Testimony
House Bill 1012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
January 12, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, I am Jennifer Witham, Director of Information Technology Services of the Department of Human Services. I am here today to provide you an overview of Information Technology Services Division for the Department of Human Services.

Programs

The Department's Information Technology Services Division staff is responsible for information technology strategic planning and budgeting, business analysis, project management, procurement, software development and maintenance, technology standards and policy enforcement, and data entry services.

Customer Base

The Department's Information Technology Services Division (ITS) provides technology services to support the business needs of the central office divisions, the eight Human Service Centers, the State Hospital, the Developmental Center, and the county social service boards across North Dakota.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / Decrease
Salary and Wages	4,215,801	5,043,855	828,054
Operating	82,308,602	41,567,463	(40,741,139)
Capital Payments	17,285	0	(17,285)
Total	86,541,688	46,611,318	(39,930,370)
General Funds	18,999,178	19,601,324	602,146
Federal Funds	63,199,145	25,404,513	(37,794,632)
Other Funds	4,343,365	1,605,481	(2,737,884)
Total	86,541,688	46,611,318	(39,930,370)
FTE	34.75	34.75	-

The Salary and Wages line item increased by $828,054 and can be attributed to the following:

- $426,737 in total funds of which $331,528 is general fund to fund the Governor's salary package for state employees.
- $101,725 in total funds of which $78,442 is general fund to fund the cost to continue raises from last biennium.
- $81,207 in total funds of which $59,189 is general fund to fund the salary underfunding from last legislative session.
- $42,850 in total funds of which $30,235 is general fund to fund a temporary administrative support position.
- $25,000 in total funds of which $17,640 is general fund to fund overtime for claims data entry staff.
- $13,958 in total funds of which $9,849 is general fund to provide for the annual and sick leave lump sum payouts for one FTE expected to retire.

- The remaining $136,577 in total funds of which ($18,033) is general fund represents a combination of increases and decreases needed to sustain the salary of the 34.75 FTE in this area of the budget.

The Operating line item decreased by ($40,741,139) and is a combination of increases and decreases expected next biennium. Major changes include:

- ($53,739,587) decrease in total funds of which ($3,643,133) is general fund provided in 2007-2009 to support the Medicaid Systems Project.
- $9,256,512 increase in total funds of which $2,295,133 is general fund to support vendor contracts for the ongoing operations of the new Medicaid Management Information System, the Pharmacy Point of Sale system and the Medicaid Decision Support system.
- $4,005,878 increase in total funds of which $1,320,881 is general fund to support Information Technology Department services as follows:
    - Increases in hardware and software hosting fees.
    - Increase in costs associated with moving from a device fee based on access points to a technology fee based on the number of FTEs.
    - Increase in rates for senior development and project management staff.
- ($299,722) decrease in total funds with a corresponding increase in general fund of $116,573 associated with increases in central

printing costs and other desktop hardware and software license fees and maintenance.

The general fund request increased by $602,146 with 55% of that increase ($331,528) related to the Governor's salary package for state employees. The remaining increase of $270,618 in general fund, as well as net decrease in federal and other funds, is associated with the changes described above.

This concludes my testimony on the 2009 – 2011 budget request for the Information Technology Services Division of the Department. I would be happy to answer any questions.

5

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
March 3, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, I am Jennifer Witham, Director of Information Technology Services of the Department of Human Services. I am here today to provide you an overview of Information Technology Services Division for the Department of Human Services.

Programs

The Department's Information Technology Services Division staff is responsible for information technology strategic planning and budgeting, business analysis, project management, procurement, software development and maintenance, technology standards and policy enforcement, and data entry services.

Customer Base

The Department's Information Technology Services Division (ITS) provides technology services to support the business needs of the central office divisions, the eight Human Service Centers, the State Hospital, the Developmental Center, and the county social service boards across North Dakota.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget	House Changes	To Senate
Salary and Wages	4,215,801	828,054	5,043,855	(83,211)	4,960,644
Operating	82,308,602	(40,741,139)	41,567,463	0	41,567,463
Capital Payments	17,285	(17,285)	0	0	0
Total	86,541,688	(39,930,370)	46,611,318	(83,211)	46,528,107
General Funds	18,999,178	602,146	19,601,324	(27,323)	19,574,001
Federal Funds	63,199,145	(37,794,632)	25,404,513	(55,565)	25,348,948
Other Funds	4,343,365	(2,737,884)	1,605,481	(323)	1,605,158
Total	86,541,688	(39,930,370)	46,611,318	(83,211)	46,528,107

FTE	34.75	-	34.75	-	34.75

Budget Changes from Current Budget to Executive Budget:

The Salary and Wages line item increased by $828,054 and can be attributed to the following:

- $426,737 in total funds of which $331,528 is general fund to fund the Governor's salary package for state employees.
- $101,725 in total funds of which $78,442 is general fund to fund the cost to continue raises from last biennium.
- $81,207 in total funds of which $59,189 is general fund to fund the salary underfunding from last legislative session.
- $42,850 in total funds of which $30,235 is general fund to fund a temporary administrative support position.

- $25,000 in total funds of which $17,640 is general fund to fund overtime for claims data entry staff.
- $13,958 in total funds of which $9,849 is general fund to provide for the annual and sick leave lump sum payouts for one FTE expected to retire.
- The remaining $136,577 in total funds of which ($18,033) is general fund represents a combination of increases and decreases needed to sustain the salary of the 34.75 FTE in this area of the budget.

The Operating line item decreased by ($40,741,139) and is a combination of increases and decreases expected next biennium. Major changes include:

- ($53,739,587) decrease in total funds of which ($3,643,133) is general fund provided in 2007-2009 to support the Medicaid Systems Project.
- $9,256,512 increase in total funds of which $2,295,133 is general fund to support vendor contracts for the ongoing operations of the new Medicaid Management Information System, the Pharmacy Point of Sale system and the Medicaid Decision Support system.
- $4,005,878 increase in total funds of which $1,320,881 is general fund to support Information Technology Department services as follows:
    - Increases in hardware and software hosting fees.
    - Increase in costs associated with moving from a device fee based on access points to a technology fee based on the number of FTEs.

    - Increase in rates for senior development and project management staff.
- ($299,722) decrease in total funds with a corresponding increase in general fund of $116,573 associated with increases in central printing costs and other desktop hardware and software license fees and maintenance.

The general fund request increased by $602,146 with 55% of that increase ($331,528) related to the Governor's salary package for state employees. The remaining increase of $270,618 in general fund, as well as net decrease in federal and other funds, is associated with the changes described above.

House Changes:

The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $27,323 - general fund, $55,565 - federal funds and - $323 other funds for a total of $83,211.

This concludes my testimony on the 2009 – 2011 budget request for the Information Technology Services Division of the Department. I would be happy to answer any questions.

A

Information Technology Services

2007 - 2009 Budget Account Code 603000 - IT Contractual Services and Repairs	$	40,757,206
Medicaid Systems Project:	$	(37,799,893)
IT Contracts:	$	9,256,512
IT Repairs:	$	(487)
IT Software:	$	14,209
IT Printers:	$	(3,790)
IT Software Maintenance:	$	26,781
IT Hardware Maintenance:	$	2,255
Net increases and decreases for 09-11	$	9,295,480
Total Budget Changes for ITD Services	$	(28,504,413)
2009 - 2011 Budget Account Code 603000 - IT Contractual Services and Repairs	$	12,252,793

General Fund	$	3,604,740
Federal Funds		8,619,679
Other Funds		28,374
Total	$	12,252,793

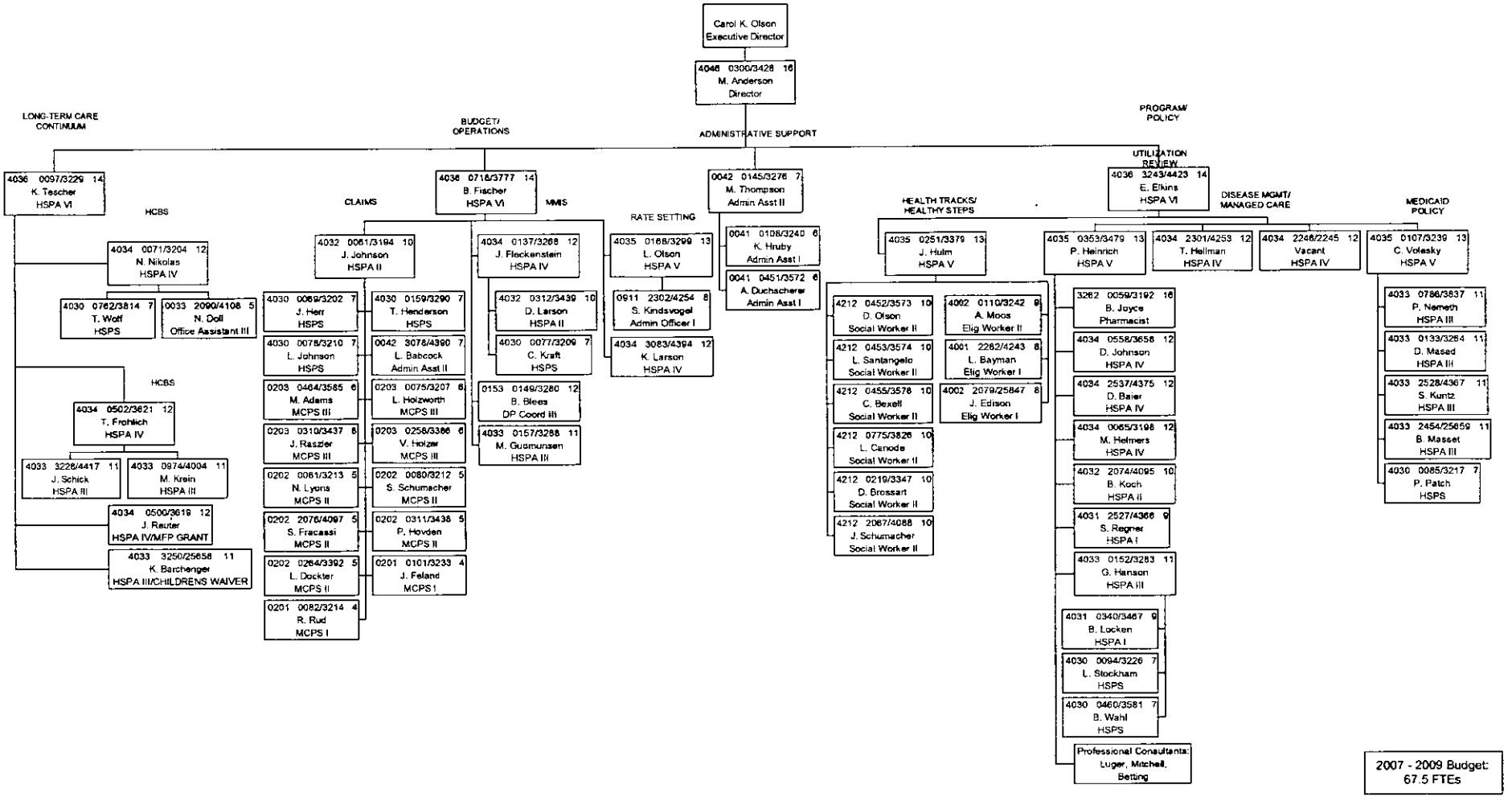
IT Contracts:		
Thompson Reuters Healthcare	$	2,187,355
Health Information Designs		417,488
ACS State Healthcare		8,106,860
Synergy Software Technologies		360,000
Child Support Enforcement Collaboration Grant		79,939
TANF Longitudinal Study		63,662
VERSA Management		40,000
IT Repairs		26,543
IT Software		26,737
IT Printers		14,710
IT Software/Hardware Maintenance		929,499
Total	$	12,252,793

Information Technology Services

2007 - 2009 Budget Account Code 601000 - IT Data Processing	$	33,074,400
Medicaid Systems Project:	$	(9,502,798)
Hosting Fee: Hosting fee for new MMIS system, additional systems administration labor costs, and increased CPU utilization on the mainframe for Economic Assistance (Vision) and Child Support (FASCES).	$	3,520,316
Technology Fee: $30.75/port to $43.50/ FTE	$	320,313
Labor Rates: Analyst $58/hr to $63/hr; Senior Analyst $63/hr to $75/hr	$	739,793
Master Client Index: '07-09 included start-up costs that will not be reoccurring in the '09-11 biennium	$	(693,440)
Other Service Categories:	$	118,895
Net increases and decreases for 09-11	$	4,005,878
Total Budget Changes for ITD Services	$	(5,496,920)
2009 - 2011 Budget Account Code 601000 - IT Data Processing	$	27,577,480

General Fund	$	11,312,297
Federal Funds		14,697,202
Other Funds		1,567,981
Total	$	27,577,480

North Dakota Department of Human Services
Medical Services Division



Revised 1/7/09

A

Testimony
House Bill 1012 – Department of Human Services
House Appropriations Committee – Human Resources Division
Representative Pollert, Chairman
January 12, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, I am Maggie Anderson, Director of Medical Services, for the Department of Human Services. I am here today to provide you with an overview of the Traditional Medicaid and the State Children's Health Insurance Programs, as well as the administrative costs of the Medical Services Division. The Long-Term Care Continuum overview will be provided separately.

Programs

The Medical Services Division currently administers two programs; they are Medicaid and the State Children's Health Insurance Program (Healthy Steps). This area of the budget for Medicaid and Healthy Steps provides health care coverage for families and children, pregnant women, the elderly, and the disabled citizens of North Dakota. Attachment A shows the Medicaid Mandatory and Optional Services, and Attachment B shows the current services that have a limit or a co-payment.

Caseload

Attachment C shows the Medicaid Enrollment (eligibles) and the unduplicated count of recipients for each month of the current biennium.

During the current biennium (effective October 1, 2008), the income level for Healthy Steps was increased to 150 percent (net). For the Executive

Budget, Healthy Steps was built on an average caseload of 6,021 children, which includes the growth expected as a result of increasing the income level to 200 percent (net). Attachment D shows the number of children enrolled each month in Healthy Steps since the beginning of the current biennium, and also provides the number of children enrolled in Medicaid for the same time period. Clearly, we are experiencing an enrollment trend change, which appears to be directly related to the implementation of 12-month continuous eligibility for Medicaid children. You can see from the chart that the Healthy Steps enrollment declined a bit between June and July. This decline has increased at a higher rate in the past two months. The chart also shows that enrollment of children in Medicaid, starting in June 2008, has significantly increased. The Department continues to explore the details of this trend change to ensure we can appropriately project expenditures for the current biennium and for 2009-2011.

The statute change needed (NDCC 50-29-04) to increase the income level for Healthy Steps is included in Section 7 of 2009 House Bill 1012. The Healthy Steps increase to 200 percent (net) is also contingent upon Congressional action regarding the reauthorization of, and increased appropriations for, the State Children's Health Insurance Program. In addition, any increase to the income level will require federal (Centers for Medicare and Medicaid) approval.

Program Trends / Program Changes

Federal Medical Assistance Percentage (FMAP)

The Federal Medical Assistance Percentage (FMAP) is calculated based on per capita income over a three-year period. The overall economy in

North Dakota continues to see improvement a bit faster than other states; therefore, the FMAP for North Dakota will continue to fall through Federal Fiscal Year 2010. The current FMAP (through September 2009) is 63.15 percent. The percentage will drop to 63.01 percent for Federal Fiscal Year 2010 (October 1, 2009 - September 30, 2010) and we estimated it to be 63.01 percent for Federal Fiscal Year 2011 (October 1, 2010 – September 30, 2011).

The estimated FMAP impact for this portion of the budget will be provided later in my testimony.

Medicaid Medical Advisory Committee

The Medicaid Medical Advisory Committee continues to meet quarterly to provide input, review and direction to the Department with regard to the Medicaid program. In addition, this committee has been exploring the "modernizing" of the Medicaid program. Three areas of specific focus have been identified; they are: Care Coordination, Dental Access, and Telehealth/Telemonitoring. The committee has been receiving and reviewing a variety of presentations and proposals regarding the identified areas. We expect to move forward with these efforts in 2009, following the Legislative Session. A list of the committee members during the current interim is included as Attachment E.

Medicare Savings Programs

The Medicare Improvements for Patients and Providers Act of 2008, which was signed into law on July 15, 2008, increases the federal asset allowance for individuals who apply for coverage under the Medicare Savings Programs (QMBs, SLMBs, and QIs), to be equal to the asset allowance for LIS (low income subsidy) recipients of Medicare Part D.

These new asset levels are effective January 1, 2010. We do not know the exact levels yet as they are increased each year by the Consumer Price Index (CPI). Based on the 2008 amounts, the asset allowance level for a one person household is anticipated to increase from $4,000 to $7,790 (+ CPI for 2009 and 2010); and from $6,000 for a couple to $12,440 (+ CPI for 2009 and 2010). This will allow current recipients to save more assets (the impact for current recipients would be minimal), and will allow additional individuals to qualify for coverage. The above act also prohibits estate recovery collections for Medicare Savings Programs costs paid by Medicaid. The estate recovery will have to end for all recipients who die after January 1, 2010, even for periods they were eligible prior to that date. This will reduce estate recovery cases; however, the impact is unknown at this time. To the extent possible, the affects of this federal legislation have been included in the Executive Budget request.

Critical Access Hospitals

2007 Senate Bill 2012 provided funding to increase the Medicaid reimbursement rate for Critical Access Hospitals to 100 percent of cost. This change was implemented July 1, 2007. During the interim, the Department has been very involved in meetings with the Centers for Medicare and Medicaid Services (CMS) and the North Dakota Healthcare Association about the limitations in federal statute and regulations regarding payment for Medicaid services at cost. Medicare and Medicaid are two different programs; and while there are many similarities, there are differences in the federal reimbursement rules that govern each program. For example, federal laws and regulations do not allow Medicaid to reimburse 100 percent of cost for lab services (Section 1903(i)(7) of the Social Security Act) or for the services of certified registered nurse

anesthetists (42 CFR 440.20 - Final Rule Published November 7, 2008 in Federal Register).

Medicaid Buy-In for Children with Disabilities

During the 2007 Legislative Assembly, Senate Bill 2326 authorized the Department of Human Services to develop and implement a Medicaid Buy-In for Children with Disabilities. This program is for families who have a child who is disabled (as defined by Social Security) and have a net income of 200 percent or less of the federal poverty level. This program became effective April 1, 2008 and as of December 1, 2008 has 10 children enrolled.

Twelve-month Continuous Eligibility for Children

Twelve-month continuous eligibility for Medicaid-eligible children was implemented June 1, 2008. This allows all Medicaid-eligible children 12-months of eligibility, during which there is no income reporting needed to retain benefits. As noted earlier, the preliminary enrollment numbers of children in Medicaid appear to indicate a significant trend change resulting from continuous eligibility. While the number of children in SCHIP has declined recently, when comparing enrollment numbers of both SCHIP and Medicaid from one year ago (November 2007 = 31,457) to current (November 2008 = 36,047) an additional **4,590** children are receiving health care coverage. The Executive Budget request retains continuous eligibility for 2009-2011.

Optometric Service Limits Changes

On January 1, 2004, the Medical Services Division implemented several new service limits and changed other, existing service limits (Reference: Attachment B). At that time, the limit imposed on eye exams and eye

glasses for individuals 21 years of age and older was changed from once every two years to once every three years. During the current interim, the North Dakota Optometric Association presented information to the Department on the Optometric Practice Guidelines (from the American Optometric Association). The Medicaid service limits conflict with the Optometric Practice Guidelines for eye care. Recognizing the importance of proper eye care, the Executive Budget contains funding to reduce the eye exam and eye glasses limit from once every three years to once every two years. The cost for changing the optometric service limits for adult eye exams and glasses is $128,987 of which $47,531 are general funds.

Funeral Set Aside

The current Funeral Set Aside for Medicaid-eligible individuals is $5,000 and was last increased on July 1, 2005. During the current interim, the North Dakota Funeral Directors Association provided information that demonstrates the average cost for a funeral is $9,314; they also requested the funeral set aside be increased to $7,000. The Executive Budget contains the funding ($566,000 in total funds, of which $209,297 are general funds) to increase the Funeral Set Aside from $5,000 to $7,000.

Section 6 of 2009 House Bill 1012 provides the language necessary to amend Section 50-24.1-02.3 of Century Code to authorize this change.

Durable Medical Equipment Reimbursement Changes

At the request of the Durable Medical Equipment Providers, the Executive Budget includes an increase to the fee schedule for certain wheelchair accessories, sit-to-standers and labor for repairs and adjustments to

wheelchairs. The funding to implement these changes ($69,726 total and $25,695 general) is included in the Executive Budget request.

Increase Medically Needy Income Levels

The medically needy income levels are intended to allow an individual, couple, or family enough money to meet their expenses for shelter, food, utilities, and clothing as well as other maintenance needs. Income above the "Medically Needy Income Level" is considered "recipient liability" and must be applied toward medical expenses before the individual becomes eligible for Medicaid. The current level for a one-person household is $500 per month and for two persons it is $516 per month. These levels have been frozen since 2003 and are lower than what is allowed for SSI recipients, who are Medicaid eligible with no recipient liability. The Executive Budget funds an increase in the medically needy income levels to 83 percent of poverty. According to the 2008 Poverty Levels, at 83 percent of poverty, the income levels would be $720 and $969 for one and two-person households, respectively. It is expected that this increase would benefit around 3,200 individuals. Please see Attachment F for a Fact Sheet on Medicaid Medically Needy Coverage.

Immunization Administration Fees for Children

The Executive Budget includes funding to increase the Medicaid fee schedule for immunization administrations for children. The increased funding is based on the number of Medicaid immunizations, as recorded by the North Dakota Department of Health. The fee schedule for immunizations would be increased to $13.90 for initial immunizations, which is the Regional Maximum set by the Federal Government for immunization administration. The fee schedule for subsequent

immunizations received during the same visit would be increased by $4.69 each.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / Decrease
Salary and Wages	7,111,808	8,372,238	1,260,430
Operating	23,778,877	23,803,330	24,453
Grants	417,381,648	519,779,299	102,397,651
Total	448,272,333	551,954,867	103,682,534
General Funds	140,880,119	170,852,118	29,971,999
Federal Funds	284,324,572	351,621,948	67,297,376
Other Funds	23,067,642	29,480,801	6,413,159
Total	448,272,333	551,954,867	103,682,534

FTE	67.50	70.00	2.50

The Salaries line item increased by $1,260,430 and can be attributed to the following changes:

- $776,828 in total funds, of which $348,586 are general funds, is due to the Governor's salary package for state employees.
- $116,184 in total funds, of which $62,170 are general funds, is needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- $117,476 in total funds, of which $30,402 are general funds, is related to the additional 1.5 FTE funded in the Executive Budget related to increasing Healthy Steps to 200 percent of net income.

Currently 33 percent of Healthy Steps applications are processed by the Healthy Steps eligibility staff in the Medical Services Division. If the income level for SCHIP is increased to 200 percent (net), we would expect a greater percentage of the applications to be processed in Medical Services. This is because, as the income threshold is increased, a lower number of applicants will also qualify for other economic assistance programs. The Medical Services Division will monitor the need to fill these positions, as we track Healthy Steps enrollment and program operations.

- $121,630 in total funds, of which $60,818 are general funds - related to the addition of one FTE funded in the Executive Budget related to the planning, development, implementation and management of a Medicaid Autism waiver. This work would not be able to be managed by the existing staff in the Medical Services or Developmental Disabilities Divisions.
- The remaining $128,312 is a combination of increases and decreases needed to sustain the salary of the 70 FTE in this area of the budget.

The Executive Budget for Operating Expenses is $23.8 million, which is a hold even budget for this area.

- The Medicare Part D Clawback payment is the most significant portion of this budget area. The Clawback is estimated at $19.4 million for 2009-2011. This is an increase of $.25 million over the current budget of $19.15 million, and was built based on an average of 9,450 individuals at $85.61 per month. The Clawback payment is funded with 95.9 percent general funds and 4.1 percent estate collections.
- Operating expenses also include contracts for services, such as: medical consultants; utilization review and prior authorization; drug

pricing; Medicaid Identification cards; nursing facility screenings; actuary services; and third party liability identification.

The Executive Budget for the Grants in this area reflects an increase of $102.4 million in total funds, of which $30.3 million are general funds, and $5.9 million are other funds. The $102.4 million increase is a combination of the following: cost changes $52.2 million increase; utilization changes $20.9 million decrease, funding to increase reimbursement for hospitals, physicians, chiropractors, ambulance services and dental providers ($40.1 million); the seven percent/seven percent inflationary increase* ($21.0 million); funding for the increase to the Medically Needy Income Levels ($5.5 million); funding to increase the Medicaid reimbursement for immunizations for children ($182,701); and funding to increase the income level for the Healthy Steps program to 200 percent (net) ($4.3 million).

*Inflationary increases are not provided for the first year of the Biennium for hospitals, physicians, chiropractors and ambulance service providers.

The impact to the Traditional Medicaid Grants as a result of the FMAP reductions is $3.2 million.

The Executive Budget includes funding for the following rebasing and other program/service changes:

- 2007 Senate Bill 2012 included funding and a directive for the Department of Human Services to hire a health care consultant to determine the cost of rebasing payment rates under the medical

assistance program for hospital, physician, dental, ambulance and chiropractic services to the actual cost of providing these services.

Service	Total	General	Federal/Other
Hospitals			
Rebase Funding	22,013,114	8,140,450	13,872,664
Inflation 0% / 7%	9,072,276	3,285,225	5,787,051
Total Rebase & Inflation	31,085,390	11,425,675	19,659,715
Physician			
Rebase @25%	13,250,000	4,899,850	8,350,150
Inflation 0% / 7%	2,430,643	882,558	1,548,085
Total Rebase & Inflation	15,680,643	5,782,408	9,898,235
Chiropractor			
Rebase Funding	416,000	153,836	262,164
Inflation 0% / 7%	32,886	12,140	20,746
Total Rebase & Inflation	448,886	165,976	282,910
Ambulance			
Rebase @ Medicare Rates	2,011,114	743,710	1,267,404
Inflation 0% / 7%	187,814	69,427	118,387
Total Rebase & Inflation	2,198,928	813,137	1,385,791
Dentists			
Rebase Fee Schedule @ a Minimum of 75% of Avg. Billed Charges	2,445,138	904,167	1,540,971
Inflation 7% / 7%	1,738,698	641,918	1,096,780
Total Rebase & Inflation	4,183,836	1,546,085	2,637,751

- The funding included for hospital services covers inpatient, outpatient, inpatient psychiatric, inpatient rehabilitation and long-term care hospitals. It does not include Critical Access Hospitals, Indian Health Services, or Out-of-State Hospitals. The per diem

rates for inpatient psychiatric and inpatient rehabilitative services are limited to one standard deviation from the mean.

- The funding included for physician services is twenty-five (25) percent of the results of the rebasing report.
- The funding provided for ambulance services is to increase the ambulance fee schedule to the Medicare rates on July 1, 2009.
- The funding provided for dental services would allow the Department to "rebase" the Medicaid dental fees (for both children and adults) to a minimum of 75 percent of the average billed charges. Medicaid dental fees that are currently above the 75 percent level would remain at their current level (plus inflation) and the dental fees that are below the 75 percent level would be raised to 75 percent of the average billed charges. Currently many of the children's Medicaid dental services are reimbursed more than 75 percent of the average billed charges.
- The Executive Budget includes $5.5 million ($2.0 million general funds) to increase the Medically Needy Income Levels to 83 percent of the federal poverty level.
- To implement the immunization administration fee change discussed under Program Changes, the Executive Budget request includes $182,701 of general funds; however, the federal funds available for this service were overlooked during the budget preparation process.
- The Executive Budget includes $566,000 ($209,297 general funds) to increase the funeral set aside to $7,000, effective July 1, 2009.
- The Executive Budget requests $142.3 million for Inpatient Hospital Services, of which $51.2 million are general funds. The current budget is $106.5 million. In addition to the utilization and cost trends, the increase includes funds for rebasing hospital services to

cost ($22 million) and seven percent inflation for year two of the biennium ($6.1million)

- The Executive Budget request for Outpatient Hospital Services is $63.4 million, of which $23.1 are general funds. The current 2007-2009 projected expenditures for Outpatient Hospital Services is $53.8 million. The increase requested includes the funding for the inflationary increase in year two of the biennium ($3 million) and to fund the expected cost and utilization changes.
- For Prescription Drugs, the Executive Budget requests $50.2 million, of which $.8 million are general funds, and $17.3 million are retained funds. The prescription drug inflation is estimated at four percent per year for brand name drugs and two percent per year for generics. The generic/brand split is estimated to be 68 percent/32 percent respectively. The Executive Budget reflects a $14.8 million decrease over the current appropriation. The current appropriation was estimated too high, which is primarily a result of (1) having very little "post Part D" data when the 2007-2009 Budget was prepared, (2) a different generic/brand split than was budgeted (60/40 - 2007-2009 budget) vs. (68/32 - 2007-2009 actual), and (3) increased rebates over what was budgeted for 2007-2009.
- The Executive Budget requests $74.3 million for Physician Services, of which $27 million are general funds. The request includes an increase toward the rebasing of the physician fee schedule ($13.3 million) and a seven percent inflationary increase for year two of the biennium ($2.4 million). The budget request for physicians would have been higher; however, the Department has implemented a clarification of category of service reporting on the Medicaid budget documents. This clarification is part of some

preliminary work done this interim to prepare for the implementation of the new MMIS. Previously some codes within several service categories (such as Health Tracks Screenings, Psychological Services, Physical Therapy, and Optometric Services) were reported under Physicians, when, more appropriately, they should have been reported in the categories noted below: These clarifications are a portion of the cost and utilization increases in the following service lines. These include Health Tracks ($2.7 million increase); Occupational Therapy ($.6 million increase); Optometric Services ($1.2 million increase); Physical Therapy ($1.1 million increase); and Psychological Services ($3.0 million increase).

- The Executive Budget Request for Psychiatric Residential Treatment Facilities is $25.9 million, of which $9.6 million are general funds. The increase in this area ($5.1 million) includes the cost and utilization increases as noted from the trends when preparing the budget and $1.8 million to fund a seven percent increase in both years of the biennium.
- The Healthy Steps request is based on increasing the income eligibility level to 200 percent (net). It is expected this increase to expand coverage to enroll an average of 6,021 children per month, at an average premium of $243.93 per child. This premium reflects an increase of 20.52 percent over the average premium paid for the current biennium. The total Healthy Steps request is $35.2 million of which $9.1 million are general funds.
- The Indian Health Services request is for $27.2 million, all of which are federal funds. The request in this area represents an $11.3 million increase. The increase results from cost and utilization changes and from the way the units of service and cost per unit are

presented, which are additional changes made as preliminary steps in implementing the new MMIS.

- The Executive Budget request for Dental Services is $18.1 million (of which $6.7 million are general funds). This is a $4.8 million increase over the 2007-2009 Budget. The increase includes $2.4 million for "rebasing" the Dental fee schedule to a minimum of an average of 75 percent of billed charges and $1.7 million for the seven percent inflation for both years of the biennium. The remaining $.7 million increase is to cover the utilization and cost trends used in preparing the budget.
- The Executive Budget Request for Premiums is $24.5 million, of which $8.7 million are general funds. This request represents a $.8 million increase over the 2007-2009 Budget. This area includes Premiums for cost-effective health insurance and the Medicare Savings Programs.
- The Executive Budget Request for Ambulance Services is $5.7 million of which $2.1 million are general funds. This increase includes $2 million for rebasing the Ambulance reimbursement rates to those paid by Medicare and a seven percent inflationary increase in year two of the biennium ($187,814).
- The request for Chiropractic Services is $987,572, of which $.4 million are general funds. This increase includes the rebasing of $416,000 and seven percent inflation ($32,886) for the second year of the biennium.
- The Executive Budget request for Durable Medical Equipment is $6.8 million (of which $2.5 million are general funds). This is a $1.5 million increase over the 2007-2009 Budget which includes the funding for the seven/seven percent inflationary increase ($.7

million) and the utilization and cost trends, including the reimbursement changes noted earlier ($69,726).

- The remaining changes are in the other services such as: Lab and Radiology Services ($.2 million increase), Speech and Hearing Services ($.2 million increase), Targeted Case Management – Pregnant Women and Division of Juvenile Services ($1.2 million decrease), Disease Management ($ 1.1 million increase), Federally Qualified Health Centers and Rural Health Clinics ($.6 million increase), Transportation Services ($.7 million increase), and Special Education Services ($.3 million decrease – all federal funds).

Attachment G shows each Traditional Medicaid Service comparing the 2007-2009 Budget, 2007-2009 Projected Need, and the 2009-2011 Executive Budget request.

Nurse Aide Registry and Nursing Facility Survey

The Medical Services Budget no longer contains the general funds for the Nurse Aide Registry and Nursing Facility Survey costs. The general funds are budgeted in the Department of Health's budget for 2009-2011. The federal funds are in Medical Services Budget; and are $2,170,377 for Nursing Facility Surveys and $137,034 for Nurse Aide Registry for 2009-2011.

I would be happy to address any questions that you may have.

Attachment A

North Dakota Department of Human Services
Medical Services Division

MEDICAID MANDATORY AND OPTIONAL SERVICES

MANDATORY	OPTIONAL	OPTIONAL
Inpatient Hospital	Chiropractic Services	Mental Health Rehab / Stabilization
Outpatient Hospital	Podiatrist Services	Inpatient Hospital / Nursing Facility / ICF Services 65 and older in IMD
Laboratory X-ray	Optometrists / Eyeglasses	Intermediate Care Facility Services for MR
Nursing Facility Services for beneficiaries age 21 and older	Psychologists	Inpatient Psychiatric Services Under Age 21
EPSDT for under age 21	Nurse Anesthetist	Personal Care Services
Family Planning Services & Supplies	Private Duty Nursing	Targeted Case Management
Physician Services	Clinic Services	Primary Care Case Management
Nurse Mid-wife Services	Home Health Therapy	Hospice Care
Pregnancy Related Services and services for other conditions that might complicate pregnancy	Dental & Dentures	Non-Emergency Transportation Services
60 Days Post Partum Pregnancy-Related Services	Physical Therapy & Occupational Therapy	Nursing Facility Services Under Age 21
Home Health Services (Nursing), including Durable Medical Equipment and Supplies	Speech, Hearing, Language Therapy	Emergency Hospital Services in Non-Medicare Participating
Medical and Surgical Services of a Dentist	Prescribed Drugs	Prosthetic Devices
Emergency Medical Transportation	Diagnostic/Screening/Preventative Services	
Federal Qualified Health Center (FQHC) / Rural Health Center (RHC)		

Note: ALL Optional services are available to children under the age of 21, if medically necessary (Required through EPSDT)

North Dakota Department of Human Services
Medical Services Division

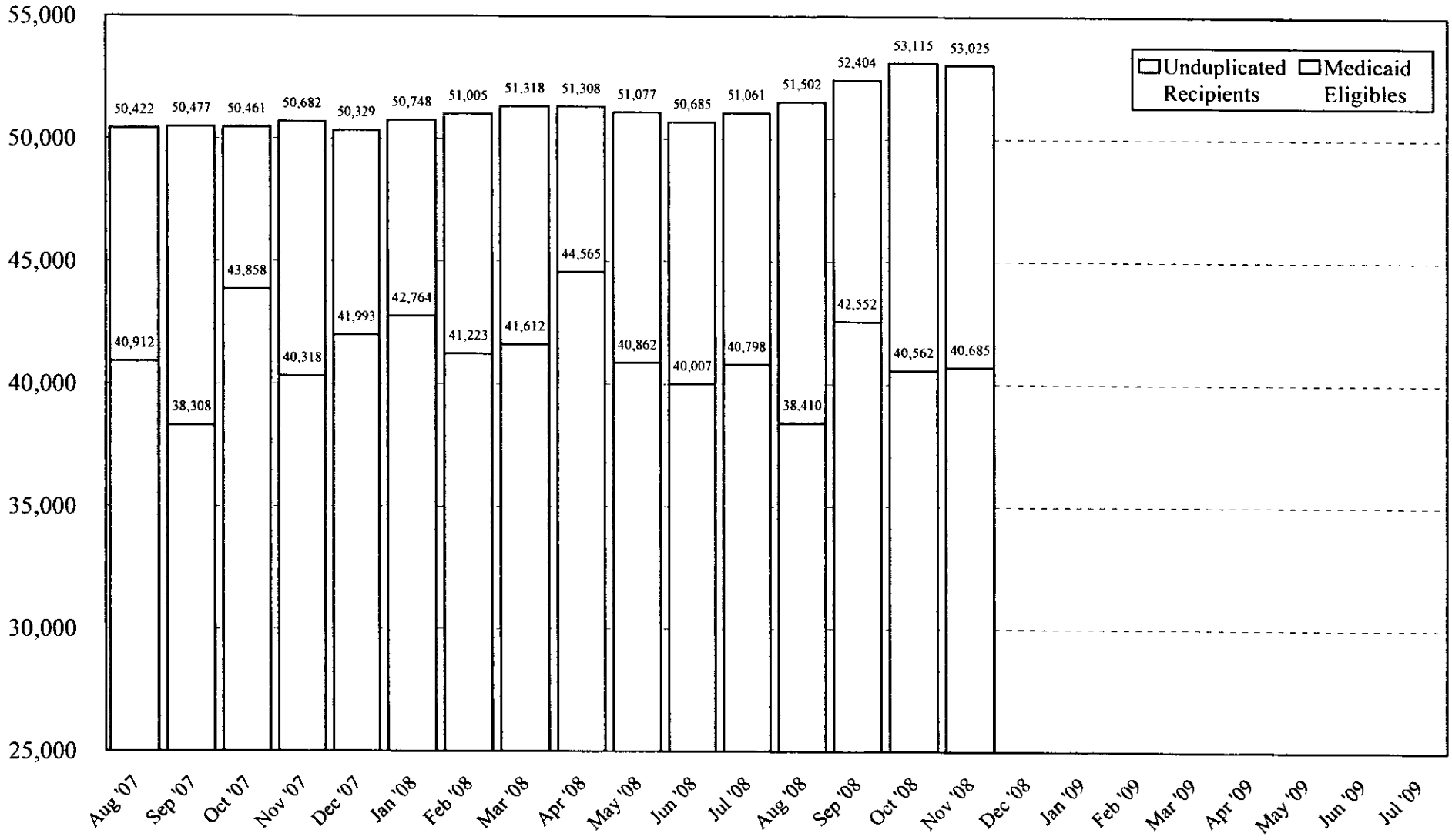
CURRENT MEDICAID SERVICE LIMITS AND COPAYMENTS

SERVICE LIMITS	COPAYMENTS
* Chiropractic Manipulations 12/year	$2 Occupational Therapy
Δ Chiropractic X-rays 2/year	$2 Optometry Service
* Physical / Occupational / Speech Therapy Evaluation 1/year	$2 Psychological Service
* Occupational Therapy 20 visits/year	$1 Speech Therapy
* Psychological Testing 4 hours/year	$2 Physical Therapy
* Psychological Therapy 40 visits/year	$3 Podiatry Service
* Speech Therapy 30 visits/year	$2 Hearing Test
* Physical Therapy 15 visits/year	$3 Hearing Aid
Δ Eyeglasses for Individuals 21 & Older once every 3 years	$75 Inpatient Hospital
Δ Eye exams for Individuals 21 & Older once every 3 years	$6 non-emergent use of Emergency Room
Ambulatory Behavioral Health – limited based on level of care	$2 Physician Visit
Inpatient Psychiatric – 21 days per admission, not to exceed 45 days per year	$3 Federally Qualified Health Center / Rural Health Center Visit
Inpatient Rehabilitation Services – 30 days per admission	$3 Brand Prescriptions
Nursing facilities – 15 days hospital leave; 24 therapeutic leave days per year	$1 Chiropractic Services
Wheelchairs – limited to once every 5 years	$2 Dental Services
Nebulizers limited to once every 5 years	
Dentures – limited to once every 5 years	
Dietitian – 4 visits per year	
Biofeedback – 6 visits per year	

Δ Changed January 1, 2004
* New Service Limit January 1, 2004

Attachment C

Comparison of Net Medicaid Eligibles (Less QMB's Only, SLMB's Only & QI's) and Unduplicated Recipients 2007 - 2009 Biennium (August '07 - July '09)



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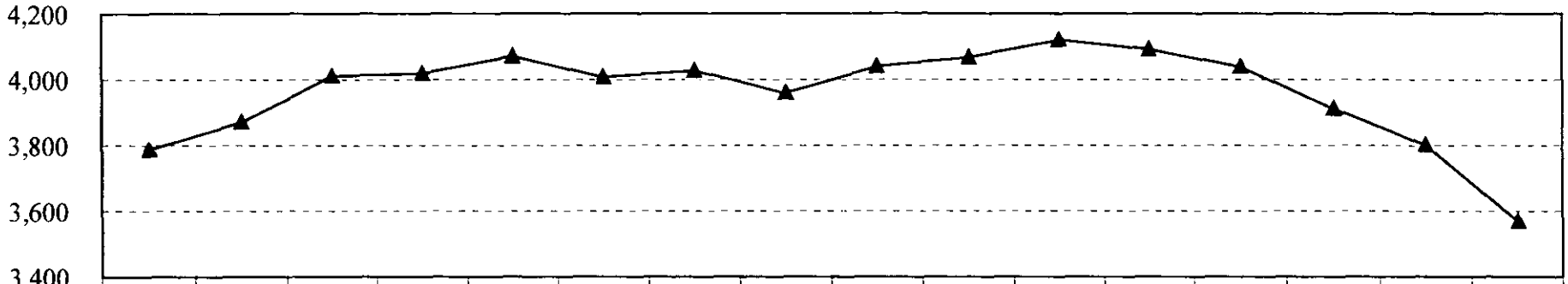
North Dakota Department of Human Services

Attachment D

Healthy Steps Enrollment by Month

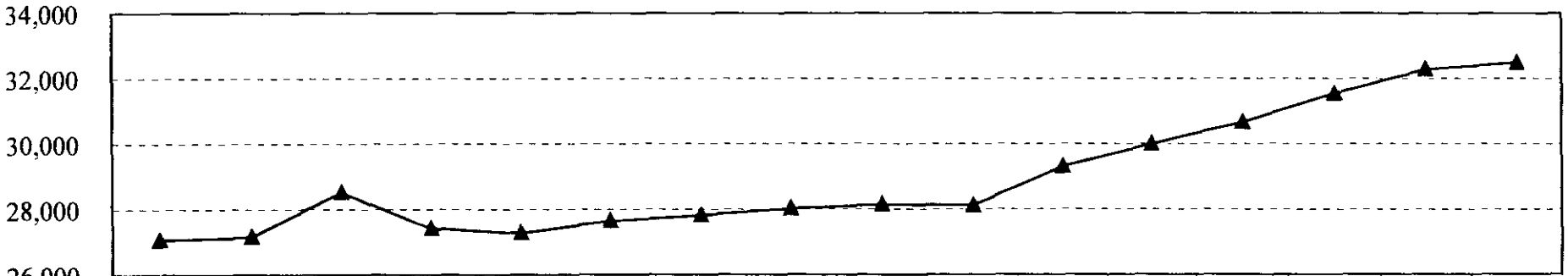
August 2007 - November 2008



Aug 07	Sep '07	Oct '07	Nov '07	Dec '07	Jan '08	Feb '08	Mar '08	Apr '08	May '08	Jun '08	Jul '08	Aug '08	Sep '08	Oct '08	Nov '08
3,787	3,871	4,011	4,019	4,071	4,008	4,027	3,959	4,039	4,067	4,119	4,091	4,038	3,911	3,800	3,568

Children Enrolled in Medicaid by Month

August 2007 - November 2008



Aug 07	Sep '07	Oct '07	Nov '07	Dec '07	Jan '08	Feb '08	Mar '08	Apr '08	May '08	Jun '08	Jul '08	Aug '08	Sep '08	Oct '08	Nov '08
27,084	27,174	28,532	27,438	27,291	27,654	27,819	28,030	28,142	28,113	29,306	29,984	30,652	31,523	32,274	32,479

Attachment E

North Dakota Department of Human Services
Medicaid Medical Advisory Committee

Salutation	First	Last	Organization
MS	KIMBER	WRAALSTAD	ND HEALTHCARE ASSOCIATION
DR	KIM	KROHN	ND MEDICAL ASSOCIATION
DR	TERRY	DWELLE	ND DEPT OF HEALTH
MR	ARNOLD "Chip"	THOMAS	ND HEALTHCARE ASSOCIATION
MR	BRUCE	LEVI	ND MEDICAL ASSOC
MR	MIKE	SCHWAB	ND PHARMACY ASSOC
MS	SHELLY	PETERSON	NORTH DAKOTA LONG TERM CARE ASSOCIATION
MS	NANCY	KOPP	ND OPTOMETRIC ASSOC
MR	JOE	CICHY	ND DENTAL ASSOC
MS	BEV	ADAMS	HEALTH POLICY CONSORTIUM
DR	GARY	BETTING	MEDICAL CONSULTANT - ND DEPT OF HUMAN SERVICES
MR	LARRY	BERNHARDT	ND COUNTY SOCIAL SERVICE DIRECTORS ASSOCATION
MS	TAMI	WAHL	GOVERNOR'S OFFICE - STATE OF NORTH DAKOTA
MS	TAMMY	THEURER	NORTH DAKOTA ASSOCIATION FOR HOME CARE
MS	BARBARA	MURRY	NORTH DAKOTA ASSOCIATION OF COMMUNITY FACILITIES
REPRESENTATIVE	MARY	EKSTROM	
REPRESENTATIVE	LOUISE	POTTER	
REPRESENTATIVE	CLARA SUE	PRICE	
REPRESENTATIVE	KEN	SVEDJAN	
SENATOR	AARON	KRAUTER	
SENATOR	JOHN	WARNER	
SENATOR	TOM	FISCHER	
SENATOR	RAY	HOLMBERG	
SENATOR	JUDY	LEE	
MR	RANDY	SORENSEN	OPTIONS RESOURCE CNTR FOR INDEPENDENT LIVING
MR	NATHAN	AALGAARD	FREEDOM RESOURCE CENTER
MR	JIM	MOENCH	ND DISABILITY ADVOCACY CONSORTIUM
MS	KAREN	LARSON	COMMUNITY HEALTHCARE OF THE DAKOTAS
MR	BRUCE	MURRY	ND PROTECTION AND ADVOCACY

Attachment E

North Dakota Department of Human Services
Medicaid Medical Advisory Committee

MS	CAROL	OLSON	DEPARTMENT OF HUMAN SERVICES
MS	TOVE	MANDIGO	DEPARTMENT OF HUMAN SERVICES
MS	BRENDA	WEISZ	DEPARTMENT OF HUMAN SERVICES
MS	JOANNE	HOESEL	DEPARTMENT OF HUMAN SERVICES
MS	BETH	STEFFAN	DEPARTMENT OF HUMAN SERVICES
MS	MAGGIE	ANDERSON	DEPARTMENT OF HUMAN SERVICES

north dakota department of human services

Fact Sheet

October 2008

North Dakota Department of Human Services
600 E Boulevard Avenue, Bismarck, ND 58505-0250 www.nd.gov/dhs

Medicaid Medically Needy Coverage

Medically needy coverage is available for Medicaid recipients whose incomes are too high to qualify for Supplemental Security Income (SSI) from Social Security, or Temporary Assistance for Needy Families (TANF), but who do not have enough income to meet their medical expenses. It is also available for recipients with lower incomes who do not meet technical requirements (such as age, or because they are not living with a caretaker, are not deprived of a parent's care, or if disabled – have a disability but have not applied for SSI).

Medically needy coverage requires recipients to spend down their excess income on medical expenses; then Medicaid pays the remainder of the recipient's medical costs for the future month. This spend down is known as "recipient liability." The amount of recipient liability that recipients are responsible to pay before they receive Medicaid assistance leaves these recipients with minimal income to meet their other needs. Concerns over this issue have been raised the past two interims during the Department of Human Services' Stakeholder meetings. In addition, providers have expressed concerns about the income levels, as clients are often unable to pay their recipient liability to the providers.

History

Medically needy coverage has been available in North Dakota for aged, blind, and disabled individuals, and families with deprived children since 1966. It was expanded to include children (under age 21) from intact families in January 1978.

The medically needy income level was last changed effective January 2003.

Medically Needy Income Levels

The medically needy income levels are intended to allow an individual, couple, or family enough money to meet their expenses for shelter, food, utilities, and clothing, as well as other maintenance needs (such as gas, auto maintenance, auto or property insurance, etc.). Some recipients may also receive Supplemental Nutrition Assistance (formally known as Food Stamps) or Low-Income Home Energy assistance benefits to help with these costs.

Aged and disabled individuals who have worked and paid enough into Social Security to receive retirement or disability benefits are currently allowed a medically needy income level of $500 per month for a single person, and $516 per month for a couple. Any income above these amounts becomes recipient liability that must be applied toward medical expenses before the individual or couple can become eligible for Medicaid coverage.

Aged and disabled individuals who have not paid enough into Social Security to receive retirement or disability benefits can qualify for SSI. Single recipients of SSI receive $637 (2008) per month and couples receive $956 (2008) per month to meet their maintenance needs. SSI recipients are allowed an income level equal to their SSI payment and receive full Medicaid benefits with no recipient liability.

The following scenarios identify the discrepancies between medically needy and SSI recipients, and indicate the extreme financial limitations in which medically needy recipients are placed. The last column shows the results if increased to 83% of the Federal Poverty Level.

Scenario 1	**Single SSI recipient**	**Single medically needy recipient at current level**	**Single medically needy recipient at 83% of poverty**
Monthly Income	SSI benefits $637**	Social Security benefits $728**	Social Security benefits $728**
Rent	$300	$300	$300
Telephone	$ 45	$ 45	$ 45
Recipient Liability	$ 0	$208 *	$ 0
Remaining income for food, clothing, and other expenses	$292	$175	$383

* Recipient liability amount after allowing $20 income disregard.
** Income is low enough to qualify for coverage of Medicare premium by Medicaid.

Scenario 2	**SSI couple**	**Medically needy couple at current level**	**Medically needy couple at 83% of poverty**
Monthly Income	SSI benefits $956	Social Security benefits $725 + $700 = $1425**	Social Security benefits $725 + $700 = $1425**
Rent	$300	$300	$300
Telephone	$ 45	$ 45	$ 45
Medicare Premium(s)	Covered by Medicaid	$ 96.40 $ 96.40	$ 96.40 $ 96.40
Recipient Liability	$ 0	$696.20*	$ 243.20*
Remaining income for food, clothing, and other expenses	$611	$191	$ 624

* Recipient liability amount after allowing $20 income disregard.
** Income is over the limit to qualify for payment of Medicare premium by Medicaid.

North Dakota Department of Human Services

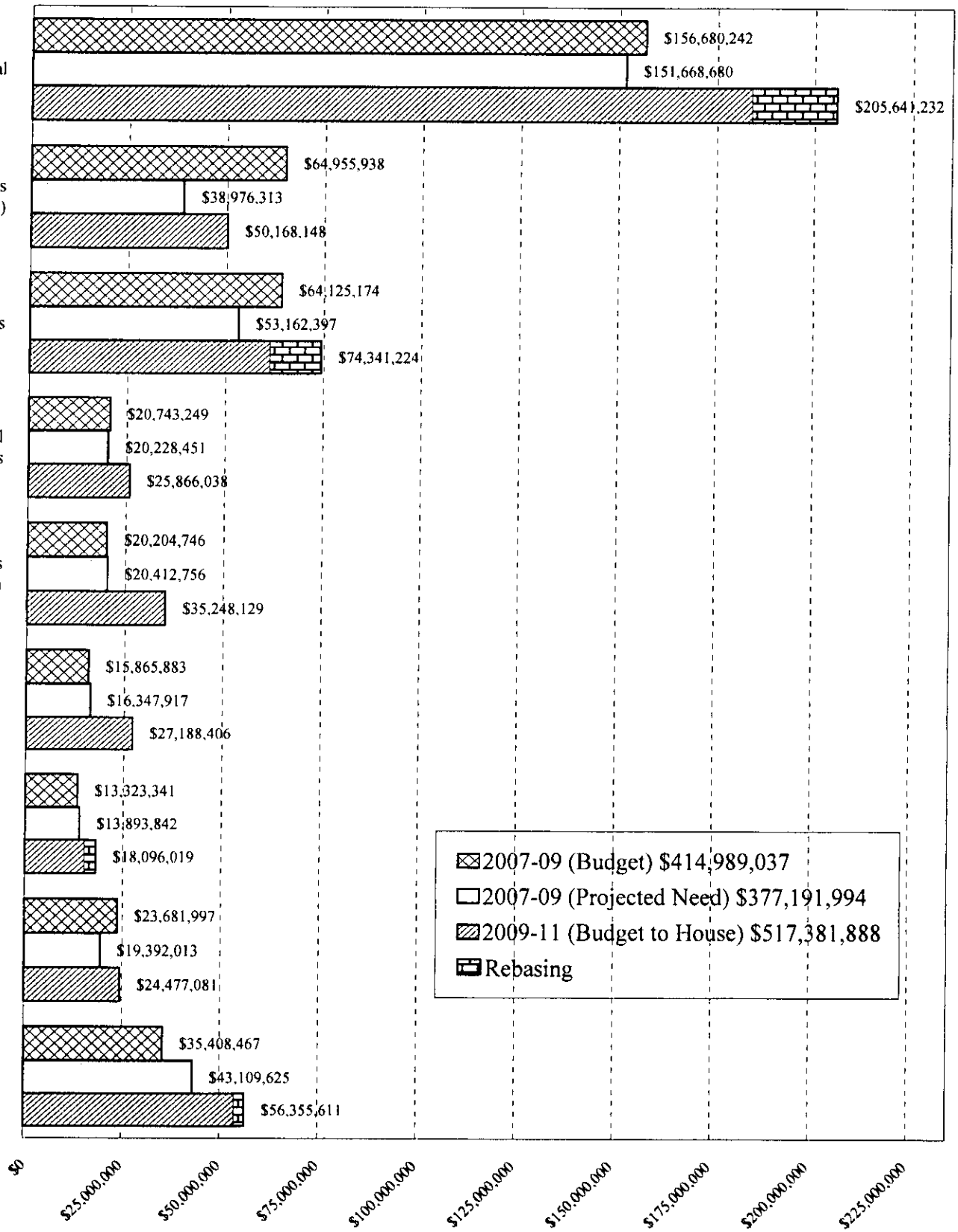
Attachment G

Medical Services

2007-09 and 2009-11 Biennium Comparisons

House Bill 1012

2009 - 2011 Biennium



Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations Committee
Senator Holmberg, Chairman
March 3, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, I am Maggie Anderson, Director of Medical Services, for the Department of Human Services. I am here today to provide you with an overview of the Traditional Medicaid and the State Children's Health Insurance Programs, as well as the administrative costs of the Medical Services Division. The Long-Term Care Continuum overview will be provided separately.

Programs

The Medical Services Division currently administers two programs; they are Medicaid and the State Children's Health Insurance Program (Healthy Steps). This area of the budget for Medicaid and Healthy Steps provides health care coverage for families and children, pregnant women, the elderly, and the disabled citizens of North Dakota. Attachment A shows the Medicaid Mandatory and Optional Services, and Attachment B shows the current services that have a limit or a co-payment.

Caseload

Attachment C shows the Medicaid Enrollment (eligibles) and the unduplicated count of recipients for each month of the current biennium.

During the current biennium (effective October 1, 2008), the income level for Healthy Steps was increased to 150 percent (net). For the Executive Budget, Healthy Steps was built on an average caseload of 6,021

children, which includes the growth expected as a result of increasing the income level to 200 percent (net). Attachment D shows the number of children enrolled each month in Healthy Steps since the beginning of the current biennium, and also provides the number of children enrolled in Medicaid for the same time period. Clearly, we are experiencing an enrollment trend change, which appears to be related to the implementation of 12-month continuous eligibility for Medicaid children. The Department continues to explore the details of this trend change to ensure we can appropriately project expenditures for the current biennium and for 2009-2011.

The statute change needed (NDCC 50-29-04) to increase the income level for Healthy Steps was removed from House Bill 1012 and was placed in House Bill 1478. As amended, House Bill 1478 would increase Healthy Steps to 160 percent (net) of the federal poverty level. The Department continues to support the Executive Budget request to increase the income level to 200% of the poverty level. Later in my testimony as I review the grants I will provide details about the reprojected cost of increasing the income level to 200%.

Any increase to the Healthy Steps income level will require federal (Centers for Medicare and Medicaid) approval.

Program Trends / Program Changes

Federal Medical Assistance Percentage (FMAP)

The Federal Medical Assistance Percentage (FMAP) is calculated based on per capita income over a three-year period. The overall economy in North Dakota continues to see improvement a bit faster than other

states; therefore, the FMAP for North Dakota will continue to fall through Federal Fiscal Year 2010. The current FMAP (through September 2009) is 63.15 percent. The percentage will drop to 63.01 percent for Federal Fiscal Year 2010 (October 1, 2009 - September 30, 2010) and we estimated it to be 63.01 percent for Federal Fiscal Year 2011 (October 1, 2010 – September 30, 2011).

The estimated FMAP impact for this portion of the budget will be provided later in my testimony.

Medicaid Medical Advisory Committee

The Medicaid Medical Advisory Committee continues to meet quarterly to provide input, review and direction to the Department with regard to the Medicaid program. In addition, this committee has been exploring the "modernizing" of the Medicaid program. Three areas of specific focus have been identified; they are: Care Coordination, Dental Access, and Telehealth/Telemonitoring. The committee has been receiving and reviewing a variety of presentations and proposals regarding the identified areas. We expect to move forward with these efforts in 2009, following the Legislative Session. A list of the committee members during the current interim is included as Attachment E.

Medicare Savings Programs

The Medicare Improvements for Patients and Providers Act of 2008, which was signed into law on July 15, 2008, increases the federal asset allowance for individuals who apply for coverage under the Medicare Savings Programs (QMBs, SLMBs, and QIs), to be equal to the asset allowance for LIS (low income subsidy) recipients of Medicare Part D. These new asset levels are effective January 1, 2010. We do not know

the exact levels yet as they are increased each year by the Consumer Price Index (CPI). Based on the 2008 amounts, the asset allowance level for a one person household is anticipated to increase from $4,000 to $7,790 (+ CPI for 2009 and 2010); and from $6,000 for a couple to $12,440 (+ CPI for 2009 and 2010). This will allow current recipients to save more assets (the impact for current recipients would be minimal), and will allow additional individuals to qualify for coverage. The above act also prohibits estate recovery collections for Medicare Savings Programs costs paid by Medicaid. The estate recovery will have to end for all recipients who die after January 1, 2010, even for periods they were eligible prior to that date. This will reduce estate recovery cases; however, the impact is unknown at this time. To the extent possible, the affects of this federal legislation have been included in the Executive Budget request.

Critical Access Hospitals

2007 Senate Bill 2012 provided funding to increase the Medicaid reimbursement rate for Critical Access Hospitals to 100 percent of cost. This change was implemented July 1, 2007. During the interim, the Department has been very involved in meetings with the Centers for Medicare and Medicaid Services (CMS) and the North Dakota Healthcare Association about the limitations in federal statute and regulations regarding payment for Medicaid services at cost. Medicare and Medicaid are two different programs; and while there are many similarities, there are differences in the federal reimbursement rules that govern each program. For example, federal laws and regulations do not allow Medicaid to reimburse 100 percent of cost for lab services (Section 1903(i)(7) of the Social Security Act) or for the services of certified registered nurse anesthetists (42 CFR 440.20 - Final Rule Published November 7, 2008 in

Federal Register). Note: As part of The American Recovery and Reinvestment Act, the November 7, 2008 Final Rule was placed on moratorium until June 30, 2009.

Medicaid Buy-In for Children with Disabilities

During the 2007 Legislative Assembly, Senate Bill 2326 authorized the Department of Human Services to develop and implement a Medicaid Buy-In for Children with Disabilities. This program is for families who have a child who is disabled (as defined by Social Security) and have a net income of 200 percent or less of the federal poverty level. This program became effective April 1, 2008 and as of December 1, 2008 has 10 children enrolled.

Twelve-month Continuous Eligibility for Children

Twelve-month continuous eligibility for Medicaid-eligible children was implemented June 1, 2008. This allows all Medicaid-eligible children 12-months of eligibility, during which there is no income reporting needed to retain benefits. As noted earlier, the preliminary enrollment numbers of children in Medicaid appear to indicate a trend change resulting from continuous eligibility. While the number of children in SCHIP has declined recently, when comparing enrollment numbers of both SCHIP and Medicaid from one year ago (January 2008 = 32,985) to current (January 2009 = 37,194) an additional **4,209** children are receiving health care coverage. The Executive Budget request retains continuous eligibility for 2009-2011.

Optometric Service Limits Changes

On January 1, 2004, the Medical Services Division implemented several new service limits and changed other, existing service limits (Reference:

Attachment B). At that time, the limit imposed on eye exams and eye glasses for individuals 21 years of age and older was changed from once every two years to once every three years. During the current interim, the North Dakota Optometric Association presented information to the Department on the Optometric Practice Guidelines (from the American Optometric Association). The Medicaid service limits conflict with the Optometric Practice Guidelines for eye care. Recognizing the importance of proper eye care, the Executive Budget contains funding to reduce the eye exam and eye glasses limit from once every three years to once every two years. The cost for changing the optometric service limits for adult eye exams and glasses is $128,987 of which $47,531 are general funds.

Funeral Set Aside

The current Funeral Set Aside for Medicaid-eligible individuals is $5,000 and was last increased on July 1, 2005. During the current interim, the North Dakota Funeral Directors Association provided information that demonstrates the average cost for a funeral is $9,314; they also requested the funeral set aside be increased to $7,000. The Executive Budget contained the funding ($566,000 in total funds, of which $209,297 are general funds) to increase the Funeral Set Aside from $5,000 to $7,000.

The language needed for this change was removed from House Bill 1012 and placed in House Bill 1477. The House amended House Bill 1477 to increase the Funeral Set Aside to $6,000, rather than $7,000.

Durable Medical Equipment Reimbursement Changes

At the request of the Durable Medical Equipment Providers, the Executive Budget includes an increase to the fee schedule for certain wheelchair accessories, sit-to-standers and labor for repairs and adjustments to wheelchairs. The funding to implement these changes ($69,726 total and $25,695 general) is included in the Executive Budget request.

Increase Medically Needy Income Levels

The medically needy income levels are intended to allow an individual, couple, or family enough money to meet their expenses for shelter, food, utilities, and clothing as well as other maintenance needs. Income above the "Medically Needy Income Level" is considered "recipient liability" and must be applied toward medical expenses before the individual becomes eligible for Medicaid. The current level for a one-person household is $500 per month and for two persons it is $516 per month. These levels have been frozen since 2003 and are lower than what is allowed for SSI recipients, who are Medicaid eligible with no recipient liability. The Executive Budget funds an increase in the medically needy income levels to 83 percent of poverty. According to the 2008 Poverty Levels, at 83 percent of poverty, the income levels would be $720 and $969 for one and two-person households, respectively. It is expected that this increase would benefit around 3,200 individuals. Please see Attachment F for a Fact Sheet on Medicaid Medically Needy Coverage.

The House amended the Medically Needy Coverage to 75 percent of poverty.

Immunization Administration Fees for Children

The Executive Budget includes funding to increase the Medicaid fee schedule for immunization administrations for children. The increased funding is based on the number of Medicaid immunizations, as recorded by the North Dakota Department of Health. The fee schedule for immunizations would be increased to $13.90 for initial immunizations, which is the Regional Maximum set by the Federal Government for immunization administration. The fee schedule for subsequent immunizations received during the same visit would be increased by $4.69 each.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget	House Changes	To Senate
Salary and Wages	7,111,808	1,260,430	8,372,238	(403,721)	7,968,517
Operating	23,778,877	24,453	23,803,330	(39,136)	23,764,194
Grants	417,381,648	102,397,651	519,779,299	(38,003,451)	481,775,848
Total	448,272,333	103,682,534	551,954,867	(38,446,308)	513,508,559
General Funds	140,880,119	29,971,999	170,852,118	(13,771,977)	157,080,141
Federal Funds	284,324,572	67,297,376	351,621,948	(24,661,997)	326,959,951
Other Funds	23,067,642	6,413,159	29,480,801	(12,334)	29,468,467
Total	448,272,333	103,682,534	551,954,867	(38,446,308)	513,508,559

FTE	67.50	2.50	70.00	(2.50)	67.50

Budget Changes from Current Budget to Executive Budget:

The Salaries line item increased by $1,260,430 and can be attributed to the following changes:

- $776,828 in total funds, of which $348,586 are general funds, is due to the Governor's salary package for state employees.
- $116,184 in total funds, of which $62,170 are general funds, is needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- $117,476 in total funds, of which $30,402 are general funds, is related to the additional 1.5 FTE funded in the Executive Budget related to increasing Healthy Steps to 200 percent of net income. Currently 33 percent of Healthy Steps applications are processed by the Healthy Steps eligibility staff in the Medical Services Division. If the income level for SCHIP is increased to 200 percent (net), we would expect a greater percentage of the applications to be processed in Medical Services. This is because, as the income threshold is increased, a lower number of applicants will also qualify for other economic assistance programs. The Medical Services Division will monitor the need to fill these positions, as we track Healthy Steps enrollment and program operations. The House removed the 1.5 FTE and changed the income level to 160 percent.
- $121,630 in total funds, of which $60,818 are general funds - related to the addition of one FTE funded in the Executive Budget related to the planning, development, implementation and management of a Medicaid Autism waiver. This work would not be able to be managed by the existing staff in the Medical Services or Developmental Disabilities Divisions. The House removed the FTE.

- The remaining $128,312 is a combination of increases and decreases needed to sustain the salary of the 70 FTE in this area of the budget.

The Executive Budget for Operating Expenses is $23.8 million, which is a hold even budget for this area.

- The Medicare Part D Clawback payment is the most significant portion of this budget area. The Clawback is estimated at $19.4 million for 2009-2011. This is an increase of $.25 million over the current budget of $19.15 million, and was built based on an average of 9,450 individuals at $85.61 per month. The Clawback payment is funded with 95.9 percent general funds and 4.1 percent estate collections.
- Operating expenses also include contracts for services, such as: medical consultants; utilization review and prior authorization; drug pricing; Medicaid Identification cards; nursing facility screenings; actuary services; and third party liability identification.

The Executive Budget for the Grants in this area reflects an increase of $102.4 million in total funds, of which $30.3 million are general funds, and $5.9 million are other funds. The $102.4 million increase is a combination of the following: cost changes $52.2 million increase; utilization changes $20.9 million decrease, funding to increase reimbursement for hospitals, physicians, chiropractors, ambulance services and dental providers ($40.1 million); the seven percent/seven percent inflationary increase* ($21.0 million); funding for the increase to the Medically Needy Income Levels ($5.5 million); funding to increase the Medicaid reimbursement for immunizations for children ($182,701); and funding to increase the income level for the Healthy Steps program to 200 percent (net) ($4.3 million).

*Inflationary increases are not provided for the first year of the Biennium for hospitals, physicians, chiropractors and ambulance service providers.

The impact to the Traditional Medicaid Grants as a result of the FMAP reductions is $3.2 million.

The Executive Budget includes funding for the following rebasing changes:

- 2007 Senate Bill 2012 included funding and a directive for the Department of Human Services to hire a health care consultant to determine the cost of rebasing payment rates under the medical assistance program for hospital, physician, dental, ambulance and chiropractic services to the actual cost of providing these services.

Service	Total	General	Federal/Other
Hospitals			
Rebase Funding @ 100%	22,013,114	8,140,450	13,872,664
Inflation 0% / 7%	9,072,276	3,285,225	5,787,051
Total Rebase & Inflation	31,085,390	11,425,675	19,659,715
Physician			
Rebase @25%	13,250,000	4,899,850	8,350,150
Inflation 0% / 7%	2,430,643	882,558	1,548,085
Total Rebase & Inflation	15,680,643	5,782,408	9,898,235
Chiropractor			
Rebase Funding @ 100%	416,000	153,836	262,164
Inflation 0% / 7%	32,886	12,140	20,746
Total Rebase & Inflation	448,886	165,976	282,910
Ambulance			
Rebase @ Medicare Rates	2,011,114	743,710	1,267,404
Inflation 0% / 7%	187,814	69,427	118,387
Total Rebase & Inflation	2,198,928	813,137	1,385,791
Dentists			
Rebase Fee Schedule @ a Minimum of 75% of Avg. Billed Charges	2,445,138	904,167	1,540,971
Inflation 7% / 7%	1,738,698	641,918	1,096,780
Total Rebase & Inflation	4,183,836	1,546,085	2,637,751

- The funding included for hospital services covers inpatient, outpatient, inpatient psychiatric, inpatient rehabilitation and long-term care hospitals. It does not include Critical Access Hospitals, Indian Health Services, or Out-of-State Hospitals. The per diem rates for inpatient psychiatric and inpatient rehabilitative services are limited to one standard deviation from the mean.

- The funding included for physician services is twenty-five (25) percent of the results of the rebasing report.
- The funding provided for ambulance services is to increase the ambulance fee schedule to the Medicare rates on July 1, 2009.
- The funding provided for dental services would allow the Department to "rebase" the Medicaid dental fees (for both children and adults) to a minimum of 75 percent of the average billed charges. Medicaid dental fees that are currently above the 75 percent level would remain at their current level (plus inflation) and the dental fees that are below the 75 percent level would be raised to 75 percent of the average billed charges. Currently many of the children's Medicaid dental services are reimbursed more than 75 percent of the average billed charges.
- The House modified the rebasing for all provider groups, except hospitals.

The Executive Budget contains funding for the following program and service changes:

- The Executive Budget includes $5.5 million ($2.0 million general funds) to increase the Medically Needy Income Levels to 83 percent of the federal poverty level.
- To implement the immunization administration fee change discussed under Program Changes, the Executive Budget request includes $182,701 of general funds; however, the federal funds available for this service were overlooked during the budget preparation process.
- The Executive Budget includes $566,000 ($209,297 general funds) to increase the funeral set aside to $7,000, effective July 1, 2009.

- The Executive Budget requests $142.3 million for Inpatient Hospital Services, of which $51.2 million are general funds. The current budget is $106.5 million. In addition to the utilization and cost trends, the increase includes funds for rebasing hospital services to cost ($22 million) and seven percent inflation for year two of the biennium ($6.1million)
- The Executive Budget request for Outpatient Hospital Services is $63.4 million, of which $23.1 are general funds. The current 2007-2009 projected expenditures for Outpatient Hospital Services is $53.8 million. The increase requested includes the funding for the inflationary increase in year two of the biennium ($3 million) and to fund the expected cost and utilization changes.
- For Prescription Drugs, the Executive Budget requests $50.2 million, of which $.8 million are general funds, and $17.3 million are retained funds. The prescription drug inflation is estimated at four percent per year for brand name drugs and two percent per year for generics. The generic/brand split is estimated to be 68 percent/32 percent respectively. The Executive Budget reflects a $14.8 million decrease over the current appropriation. The current appropriation was estimated too high, which is primarily a result of (1) having very little "post Part D" data when the 2007-2009 Budget was prepared, (2) a different generic/brand split than was budgeted (60/40 - 2007-2009 budget) vs. (68/32 - 2007-2009 actual), and (3) increased rebates over what was budgeted for 2007-2009.
- The Executive Budget requests $74.3 million for Physician Services, of which $27 million are general funds. The request includes an increase toward the rebasing of the physician fee schedule ($13.3 million) and a seven percent inflationary increase for year two of

the biennium ($2.4 million). The budget request for physicians would have been higher; however, the Department has implemented a clarification of category of service reporting on the Medicaid budget documents. This clarification is part of some preliminary work done this interim to prepare for the implementation of the new MMIS. Previously some codes within several service categories (such as Health Tracks Screenings, Psychological Services, Physical Therapy, and Optometric Services) were reported under Physicians, when, more appropriately, they should have been reported in the categories noted below: These clarifications are a portion of the cost and utilization increases in the following service lines. These include Health Tracks ($2.7 million increase); Occupational Therapy ($.6 million increase); Optometric Services ($1.2 million increase); Physical Therapy ($1.1 million increase); and Psychological Services ($3.0 million increase).

- The Executive Budget Request for Psychiatric Residential Treatment Facilities is $25.9 million, of which $9.6 million are general funds. The increase in this area ($5.1 million) includes the cost and utilization increases as noted from the trends when preparing the budget and $1.8 million to fund a seven percent increase in both years of the biennium.
- The Healthy Steps request is based on increasing the income eligibility level to 200 percent (net). It is expected this increase to expand coverage to enroll an average of 6,021 children per month, at an average premium of $243.93 per child. This premium reflects an increase of 20.52 percent over the average premium paid for the current biennium. The total Healthy Steps request is $35.2 million of which $9.1 million are general funds.

- The Indian Health Services request is for $27.2 million, all of which are federal funds. The request in this area represents an $11.3 million increase. The increase results from cost and utilization changes and from the way the units of service and cost per unit are presented, which are additional changes made as preliminary steps in implementing the new MMIS.
- The Executive Budget request for Dental Services is $18.1 million (of which $6.7 million are general funds). This is a $4.8 million increase over the 2007-2009 Budget. The increase includes $2.4 million for "rebasing" the Dental fee schedule to a minimum of an average of 75 percent of billed charges and $1.7 million for the seven percent inflation for both years of the biennium. The remaining $.7 million increase is to cover the utilization and cost trends used in preparing the budget.
- The Executive Budget Request for Premiums is $24.5 million, of which $8.7 million are general funds. This request represents a $.8 million increase over the 2007-2009 Budget. This area includes Premiums for cost-effective health insurance and the Medicare Savings Programs.
- The Executive Budget Request for Ambulance Services is $5.7 million of which $2.1 million are general funds. This increase includes $2 million for rebasing the Ambulance reimbursement rates to those paid by Medicare and a seven percent inflationary increase in year two of the biennium ($187,814).
- The request for Chiropractic Services is $987,572, of which $.4 million are general funds. This increase includes the rebasing of $416,000 and seven percent inflation ($32,886) for the second year of the biennium.

- The Executive Budget request for Durable Medical Equipment is $6.8 million (of which $2.5 million are general funds). This is a $1.5 million increase over the 2007-2009 Budget which includes the funding for the seven/seven percent inflationary increase ($.7 million) and the utilization and cost trends, including the reimbursement changes noted earlier ($69,726).
- The remaining changes are in the other services such as: Lab and Radiology Services ($.2 million increase), Speech and Hearing Services ($.2 million increase), Targeted Case Management – Pregnant Women and Division of Juvenile Services ($1.2 million decrease), Disease Management ($1.1 million increase), Federally Qualified Health Centers and Rural Health Clinics ($.6 million increase), Transportation Services ($.7 million increase), and Special Education Services ($.3 million decrease – all federal funds).

Attachment G shows each Traditional Medicaid Service comparing the 2007-2009 Budget, 2007-2009 Projected Need, and the 2009-2011 Executive Budget request.

Nurse Aide Registry and Nursing Facility Survey

The Medical Services Budget no longer contains the general funds for the Nurse Aide Registry and Nursing Facility Survey costs. The general funds are budgeted in the Department of Health's budget for 2009-2011. The federal funds are in Medical Services Budget; and are $2,170,377 for Nursing Facility Surveys and $137,034 for Nurse Aide Registry for 2009-2011.

House Changes

- The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $44,010 - general fund and $90,020 - federal funds for at total of $134,030.

- $133,743 in total funds, of which $66,873 are general funds - related to the addition of one FTE to develop, implement and manage the Medicaid Autism waiver were removed by the House.

- Removed $135,948 in total funds, of which $35,183 are general funds, for the additional 1.5 FTE funded in the Executive Budget related to increasing Healthy Steps to 200 percent of net income.

- The House reduced 50% of the department-wide travel increase. Medical Services' share of this decrease is $39,136 total funds; $21,830 – general fund.

- The House amended the Medically Needy Income Levels from 83 percent of the poverty level in the Executive Budget to 75 percent of the poverty level. This is a reduction from the Executive Budget of $1 million in total funds of which $.4 million are general funds, and $.6 million are federal funds. Attachment H provides a comparison of the Medically Needy levels at 75 percent compared to 85 percent in the Executive Budget.

- As noted on page 6 of my testimony, the House reduced the funding for the Funeral Set Aside by $.3 million, of which $.1 million are general funds. The funding level in the Engrossed version of

House Bill 1012 would allow an increase from $5,000 to $6,000, rather than the $7,000 contained in the Executive Budget.

The House reduced the funding for the increase in Healthy Steps income level. This reduction correlated to the decision made on House Bill 1478 to increase the income level to 160%, rather than 200% of the federal poverty level. The Department continues to support the Executive Budget request to increase the income level to 200% of the poverty level. As part of the Department's monitoring of the trend change noted earlier in my testimony, we have reprojected the SCHIP enrollment expectations for 2009-2011. Because of the decline in SCHIP enrollment that we are experiencing, our estimates now indicate:

Executive Budget (with SCHIP at 200%)	$35.2 million
Reprojected Cost to increase SCHIP to 200%	$25.7 million
Funds currently in HB 1012 to increase to 160%	$32.6 million

Summary: Increasing SCHIP to 200%, based on the reprojected enrollment, compared to the current funding in HB 1012 to increase SCHIP to 160% will be a decrease of $6.9 million, of which $1.7 million are general funds.

The Department respectively requests that the 200% income threshold for Healthy Steps, requested in the Executive Budget, be restored at the reprojected amounts.

The House made the following changes related to Medicaid provider rebasing:

- Physicians – Funded at 25% of rebasing report in the Executive Budget. The House amendment reduced this to 20%. This reduction is $2.7 million of total funds of which $1 million are general funds.

- Chiropractors – Funded at 100% of the rebasing results in the Executive Budget. The House amended this to 75%, which is a reduction of $104,000 in total funds and $38,459 are general funds.
- Ambulance Services – Funded to rebase to the Medicare rates in the Executive Budget. The House amendment provided 75% of the funding in the Executive Budget. This is a reduction of $.5 million in total funds, and $.2 million in general funds.
- Dental Services – Funded at a minimum of 75 percent of the average billed charges in the Executive Budget. The House amendment dropped this to a minimum of 70 percent of the average billed charges. This is a reduction of $.8 million in total funds, and $.3 million in general funds.
- Inflationary Increases – The Executive Budget provided a 7 percent inflationary increase each year of the biennium, for all providers (including dentists), except: hospitals, physicians, chiropractors and ambulance services. The House amended the inflationary increase to 6 percent each year; except for the hospitals, physicians, chiropractors, ambulance services, and dentists, which would be zero for year one and 6 percent for year two. This is a reduction of $4.1 million of which $1.3 million are general funds.
- The House also removed $9.6 million in general funds, related to caseload and utilization. This reduction also removed $16.4 million in federal funds; totaling $26 million.

I would be happy to address any questions that you may have.

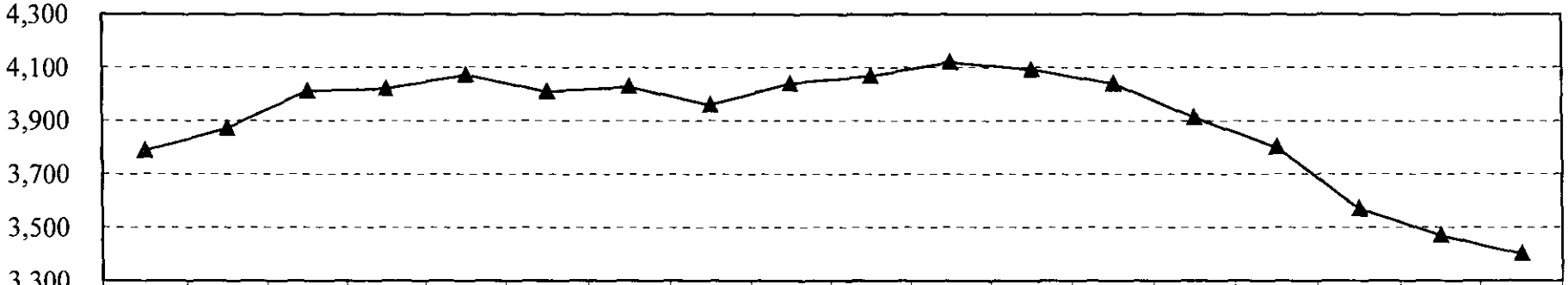
With following exceptions Some attachments Sent to House on 1-12-09

North Dakota Department of Human Services

Attachment D

Healthy Steps Enrollment by Month

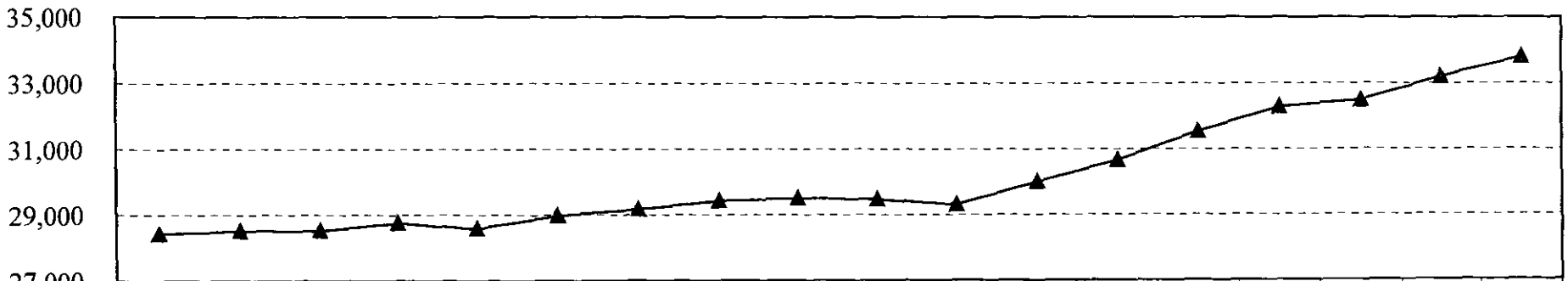
August 2007 - January 2009



Aug 07	Sep '07	Oct '07	Nov '07	Dec '07	Jan '08	Feb '08	Mar '08	Apr '08	May '08	Jun '08	Jul '08	Aug '08	Sep '08	Oct '08	Nov '08	Dec '08	Jan '09
3,787	3,871	4,011	4,019	4,071	4,008	4,027	3,959	4,039	4,067	4,119	4,091	4,038	3,911	3,800	3,568	3,468	3,399

Children Enrolled in Medicaid by Month

August 2007 - January 2009



Aug 07	Sep '07	Oct '07	Nov '07	Dec '07	Jan '08	Feb '08	Mar '08	Apr '08	May '08	Jun '08	Jul '08	Aug '08	Sep '08	Oct '08	Nov '08	Dec '08	Jan '09
28,435	28,522	28,531	28,758	28,590	28,977	29,173	29,420	29,508	29,462	29,306	29,984	30,652	31,532	32,274	32,479	33,184	33,795

North Dakota Department of Human Services

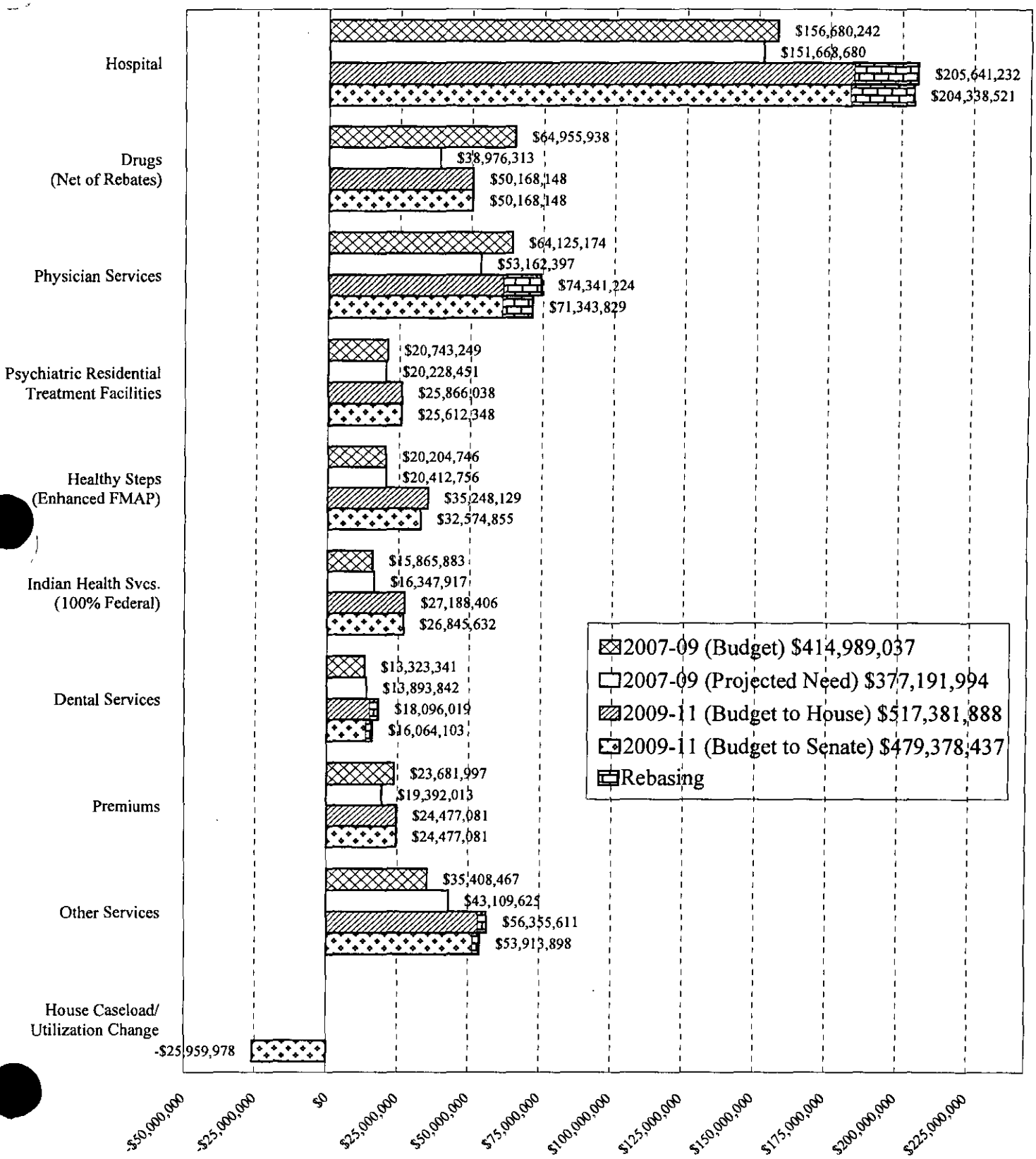
Attachment G

Medical Services

2007-09 and 2009-11 Biennium Comparisons

House Bill 1012 to Senate

2009 - 2011 Biennium



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Attachment H

north dakota department of human services

Fact Sheet
Supplement
February 2009

North Dakota Department of Human Services
600 E Boulevard Avenue, Bismarck, ND 58505-0250 www.nd.gov/dhs

Medically Needy Income Levels (As amended by House at 75% of poverty)

The medically needy income levels are the amount of income an individual, couple, or family are allowed to keep to meet their expenses for shelter, food, utilities, and clothing, as well as other maintenance needs (such as gas, auto maintenance, auto or property insurance, etc.). Some recipients may also receive Supplemental Nutrition Assistance (formally known as Food Stamps) or Low-Income Home Energy assistance benefits to help with these costs.

The following chart compares the current medically needy income levels; and the proposed medically needy income level as amended by the House (75% of poverty), with the levels for SSI, the Supplemental Nutrition Assistance, and the Low-Income Home Energy Assistance programs. The income levels identify the amounts each program allows to meet basic maintenance needs.

INCOME LEVELS (Monthly)
Effective April 2008 through March 2009

Family Size	Current Medically Needy	Medically Needy at 75% of PL	SSI	Food Assistance (SNAP) *	Fuel Assistance (LIHEAP) **
1	$500	$650	$637	$ 867	$1,757
2	$516	$875	$956	$1,167	$2,297
3	$666	$1,100		$1,467	$2,838
4	$800	$1,325		$1,767	$3,378

*The Supplemental Nutrition Assistance program has a gross and a net income test. This is the net income level.
** The Fuel Assistance Income Levels are in effect from October 1, 2008 thru September 30, 2009.

A July 1, 2009 increase in the medically needy income level to 75% of poverty (as amended by the House), and the corresponding decrease in recipient liability, is estimated to increase Medicaid expenditures by $4.5 million, of which $1.7 million would be state general funds for the 2009 -2011 biennium.

The following chart compares the medically needy income level at 75% of the poverty level to 83% of the poverty level (from the Executive Budget), and to the SSI income levels.

Family Size	75% of Poverty*	83% of Poverty*	SSI
1	$650	$ 720	$637
2	$875	$ 969	$956
3	$1,100	$1,218	
4	$1,325	$1,467	

*Based on 2008 Federal Poverty Level

Impacts on Recipients

The requirement to spend down to the current medically needy income levels makes medically needy recipients the very poorest to qualify for Medicaid, and affects approximately 3,500 recipients. Many of these recipients cannot afford to pay their full recipient liability each month, which results in medical providers not being able to collect for services they provide, or recipients not receiving the services they need. These losses to providers also affect access to services.

The following scenarios identify the discrepancies between medically needy and SSI recipients, and indicate the extreme financial limitations in which medically needy recipients are placed. The last column shows the results if increased to 75% of the Federal Poverty Level.

Scenario 1	**Single SSI recipient**	**Single medically needy recipient at current level**	**Single medically needy recipient at 75% of poverty**
Monthly Income	SSI benefits $637**	Social Security benefits $728**	Social Security benefits $728**
Rent	$300	$300	$300
Telephone	$ 45	$ 45	$ 45
Recipient Liability	$ 0	$208 *	$ 58
Remaining income for food, clothing, and other expenses	$292	$175	$325

* Recipient liability amount after allowing $20 income disregard.
** Income is low enough to qualify for coverage of Medicare premium by Medicaid.

Scenario 2	**SSI couple**	**Medically needy couple at current level**	**Medically needy couple at 75% of poverty**
Monthly Income	SSI benefits $956	Social Security benefits $725 + $700 = $1425**	Social Security benefits $725 + $700 = $1425**
Rent	$300	$300	$300
Telephone	$ 45	$ 45	$ 45
Medicare Premium(s)	Covered by Medicaid	$ 96.40 $ 96.40	$ 96.40 $ 96.40
Recipient Liability	$ 0	$696.20*	$ 337.20*
Remaining income for food, clothing, and other expenses	$611	$191	$ 550

* Recipient liability amount after allowing $20 income disregard.
** Income is over the limit to qualify for payment of Medicare premium by Medicaid.

Medical Services

Detail of Budget Account Code 621000 - Operating Fees & Services

Operating Fees & Services	Total	General	Federal/Other
Professional Consultants	$ 226,080	$ 56,520	$ 169,560
North Dakota Healthcare Review	625,445	156,361	469,084
NPI Database	112,500	28,125	84,375
Prior Authorization	50,000	12,500	37,500
Health Information Design, Inc.	223,704	55,926	167,778
Prescription Drug Monitoring Program	40,000	7,500	32,500
Emergency Room Diversion	200,000	-	200,000
First Data Bank	100,000	26,990	73,010
Noridian (cost settlement)	20,000	10,000	10,000
Medicaid ID Cards	33,400	16,700	16,700
MAC Program	128,170	64,085	64,085
Annual DSH Audit	40,000	20,000	20,000
Actuary Services	110,000	55,000	55,000
Public Consulting Group	75,000	37,500	37,500
Acumen (Fiscal Agent)	15,840	7,920	7,920
Transition Coordinator Services	195,000	97,500	97,500
SCHIP Outreach	453,000	117,236	335,764
PASAR - Dual Diagnosis	1,275,283	318,821	956,462
Medicare Clawback*	19,174,944	18,382,944	792,000
Other Miscellaneous Fees & Services	15,493	7,678	7,815
Total Operating Fees & Services Budget Account Code	$ 23,113,859	$ 19,479,306	$ 3,634,553
*Executive Budget Recommendation for additional clawback contained in account 699000 - Operating Budget Adjustment	$ 241,318	$ 241,318	$ -
Total Clawback	$ 19,416,262	$ 18,624,262	$ 792,000

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code		Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-03 MEDICAL SERVICES									
		S101 FULL-TIME EQUIVALENTS (FTEs)		64.000	67.500	0.000	2.500	0.000	70.000
32510	B	511000 Salaries - Permanent		3,996,750	4,966,032	2,433,599	419,856	(4)	5,385,884
32510	B	513000 Temporary Salaries		68,470	107,733	21,650	11,907	3	119,643
32510	B	514000 Overtime		27,441	87,457	45,146	(31,189)	0	56,268
32510	B	516000 Fringe Benefits		1,422,978	1,950,586	885,911	83,028	279,412	2,313,026
32510	B	599110 Salary Increase		0	0	0	0	426,170	426;170
32510	B	599160 Benefit Increase		0	0	0	0	71,247	71,247
			Subtotal:	5,515,639	7,111,808	3,386,306	483,602	776,828	8,372,238
32510	F	F_1991 Salary - General Fund		2,220,218	3,498,134	1,419,747	(254,712)	348,586	3,592,008
32510	F	F_1992 Salary - Federal Funds		3,275,176	3,613,674	1,966,559	738,314	428,242	4,780,230
32510	F	F_1993 Salary - Other Funds		20,245	0	0	0	0	0
			Subtotal:	5,515,639	7,111,808	3,386,306	483,602	776,828	8,372,238
32530	B	521000 Travel		55,246	106,470	59,789	78,494	0	184,964
32530	B	531000 Supplies - IT Software		19,703	12,850	12,088	11,102	0	23,952
32530	B	532000 Supply/Material-Professional		26,106	19,285	13,554	3,948	0	23,233
32530	B	535000 Miscellaneous Supplies		6,910	2,635	315	13,753	0	16,388
32530	B	536000 Office Supplies		21,681	21,526	16,448	(808)	0	20,718
32530	B	541000 Postage		5,701	1,367	513	(615)	0	752
32530	B	542000 Printing		90,523	66,212	47,743	(11,036)	0	55,176
32530	B	553000 Office Equip & Furniture-Under		10,900	1,000	868	1,500	0	2,500
32530	B	582000 Rentals/Leases - Bldg/Land		36,839	44,985	27,099	21,271	0	66,256
32530	B	591000 Repairs		909	1,306	1,227	1,218	0	2,524
32530	B	601000 IT - Data Processing		29,940	25,529	20,358	(10,529)	0	15,000
32530	B	602000 IT-Communications		3,088	3,324	1,431	(651)	0	2,673
32530	B	603000 IT Contractual Services and Re		742	304	235	8	0	312
32530	B	611000 Professional Development		28,974	30,505	15,865	3,200	0	33,705
32530	B	621000 Operating Fees and Services		2,801,085	23,441,579	10,317,174	(327,720)	0	23,113,859
32530	B	623000 Fees - Professional Services		2,908	0	0	0	0	0
32530	B	699000 Operating Budget Adjustment		0	0	0	241,318	0	241,318

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-03 MEDICAL SERVICES								
		Subtotal:	3,141,255	23,778,877	10,534,707	24,453	0	23,803,330
32530	F	F_3991 Operating - General Fund	1,003,382	20,318,215	8,936,790	(388,170)	0	19,930,045
32530	F	F_3992 Operating - Federal Funds	2,100,859	3,160,662	1,330,108	(79,377)	0	3,081,285
32530	F	F_3993 Operating - Other Funds	3,374	300,000	267,809	492,000	0	792,000
32530	F	F_3994 Operating - Swap Funds	33,640	0	0	0	0	0
		Subtotal:	3,141,255	23,778,877	10,534,707	24,453	0	23,803,330
32573	B	712000 Grants, Benefits & Claims	382,707,873	417,381,648	199,241,268	102,397,651	0	519,779,299
		Subtotal:	382,707,873	417,381,648	199,241,268	102,397,651	0	519,779,299
32573	F	F_7391 MA Grants - General Fund	113,340,646	117,063,770	60,819,450	30,266,295	0	147,330,065
32573	F	F_7392 MA Grants - Federal Funds	250,867,432	277,550,236	130,744,231	66,210,197	0	343,760,433
32573	F	F_7393 MA Grants - Other Funds	11,270,235	11,008,360	1,877,578	305,105	0	11,313,465
32573	F	F_7394 MA Grants - Swap Funds	6,382,848	11,759,282	5,800,009	5,616,054	0	17,375,336
32573	F	F_7396 MA Grants - IGT Funds	846,712	0	0	0	0	0
		Subtotal:	382,707,873	417,381,648	199,241,268	102,397,651	0	519,779,299
		Subdivision Budget Total:	391,364,767	448,272,333	213,162,281	102,905,706	776,828	551,954,867
300-03 MEDICAL SERVICES		**General Funds:**	116,564,246	140,880,119	71,175,987	29,623,413	348,586	170,852,118
		Federal Funds:	256,243,467	284,324,572	134,040,898	66,869,134	428,242	351,621,948
		Other Funds:	11,293,854	11,308,360	2,145,387	797,105	0	12,105,465
		SWAP Funds:	6,416,488	11,759,282	5,800,009	5,616,054	0	17,375,336
		County Funds:	0	0	0	0	0	0
		IGT Funds:	846,712	0	0	0	0	0
		Subdivision Funding Total:	391,364,767	448,272,333	213,162,281	102,905,706	776,828	551,954,867

North Dakota Department of Human Services
Medical Assistance
Changes in Medical Assistance Services from 2007-2009 Appropriation to 2009-2011 Budget to House

Description	2007-2009 Appropriation	Cost Changes	Caseload/ Utilization Changes	FMAP Changes	Rebased Services *	Inflation - 7/7 (0/7 on Rebased Services ^)	Medically Needy Income Levels	Immunizations for Children	Healthy Steps @ 200% Net of Poverty Level	Total Changes	2009-2011 Budget To House
Hospitals	156,680,242	57,794,705	(39,919,105)		22,013,114	9,072,276				48,960,990	205,641,232
Drugs - NET (Includes Rebates)	64,955,938	(2,981,057)	(11,806,733)		0	0				(14,787,790)	50,168,148
Physician Services	64,125,174	4,704,373	(10,168,966)		13,250,000	2,430,643				10,216,050	74,341,224
Psychiatric Residential Treatment Fac.	20,743,249	1,757,819	1,614,464		0	1,750,506				5,122,789	25,866,038
Indian Health Services	15,865,883	1,104,883	7,856,162		0	2,361,478				11,322,523	27,188,406
Dental Services	13,323,341	(1,526,186)	2,115,028		2,445,138	1,738,698				4,772,678	18,096,019
Premiums	23,681,997	(3,648,801)	4,443,885		0	0				795,084	24,477,081
Other Services	35,408,467	(8,579,095)	17,713,496	0	2,427,114	3,682,069	5,520,859	182,701	0	20,947,144	56,355,611
Durable Medical Equipment	5,301,290	(3,352,065)	4,225,730		0	668,403				1,542,068	6,843,358
Ambulance Services	2,964,019	(1,714,875)	2,226,791		2,011,114	187,814				2,710,844	5,674,863
Federally Qualified Health Centers	2,237,118	(482,077)	1,184,268		0	0				702,191	2,939,309
Rural Health Clinics	4,070,405	(449,223)	368,938		0	0				(80,285)	3,990,120
Home Health Services	3,170,190	(400,958)	76,265		0	303,731				(20,962)	3,149,228
Laboratory & Radiology	1,680,354	(270,289)	245,437		0	176,974				152,122	1,832,476
Chiropractic Services	455,167	(53,512)	137,031		416,000	32,886				532,405	987,572
Disease Management	1,836,000	629,280	182,592		0	284,580				1,096,452	2,932,452
Foster Care Family Support	784,520	(184,369)	54,194		0	69,931				(60,244)	724,276
Hospice Services	721,512	(161,269)	186,748		0	0				25,479	746,991
ND Health Tracks - EPSDT Screenings	2,322,471	(593,774)	2,833,566		0	486,906				2,726,698	5,049,169
Occupational Therapy	179,107	585,941	(81,569)		0	72,727				577,099	756,206
Optometry Services	2,201,863	323,801	567,177		0	329,889				1,220,867	3,422,730
Physical Therapy	118,290	33,342	944,944		0	116,814				1,095,100	1,213,390
Psychological Services	803,439	8,489	2,666,432		0	371,266				3,046,187	3,849,626
Special Education	2,370,749	(2,370,221)	1,886,592		0	202,416				(281,213)	2,089,536
Speech & Hearing Services	897,184	(191,175)	256,048		0	102,620				167,493	1,064,677
Targeted Case Mgt - Pregnant Women	403,712	(388,592)	59,736		0	8,076				(320,780)	82,932
Transportaion Services	2,047,669	729,859	(307,424)		0	267,036				689,471	2,737,140
Targeted Case Mgt - DJS Alt Care	843,408	(843,408)	0		0	0				(843,408)	0
Funeral Set Aside	0	566,000	0		0	0				566,000	566,000
Medically Needy Income Levels	0	0	0		0	0	5,520,859			5,520,859	5,520,859
Immunizations For Children	0	0	0		0	0		182,701		182,701	182,701
Total (Excluding Healthy Steps)	**394,784,291**	**48,626,641**	**(28,151,769)**	**0**	**40,135,366**	**21,035,670**	**5,520,859**	**182,701**	**0**	**87,349,468**	**482,133,759**
Healthy Steps	20,204,746	3,568,422	7,197,648	0	0	0			4,277,313	15,043,383	35,248,129
Total Medical Assistance	**414,989,037**	**52,195,063**	**(20,954,121)**	**0**	**40,135,366**	**21,035,670**	**5,520,859**	**182,701**	**4,277,313**	**102,392,851**	**517,381,888**
		0								0	0
General Funds	**117,052,873**	**12,522,540**	**(10,395,297)**	**3,197,129**	**14,842,013**	**6,734,524**	**2,041,614**	**182,701**	**1,106,968**	**30,232,192**	**147,285,065**

* Hospital and Chiroprator @100%, Physicians @ 25%, Ambulance @ Medicare rates, Dental services at minimum of 75% of average billed charges.

^ Hospitals and Chiropractors, Physicians and Ambulance Services are inflated at 0/7, Dental services are inflated at 7/7.

North Dakota Department of Human Services
Medical Assistance Grants

	2007-2009 Appropriation				
	Total	General	Federal	Other	SWAP
Grants by Services (Attached Page)	414,989,037	117,052,873	275,806,554	11,008,360	11,121,250
Other Grants: (Nursing Home Surveys, Nurse Aid Registry & Remedial Blind:	2,392,611	10,897	1,743,682		638,032
Total (Agrees to BARS Report)	417,381,648	117,063,770	277,550,236	11,008,360	11,759,282

	2009-2011 Budget To House				
	Total	General	Federal	Other	SWAP
Grants by Services (Attached Page)	517,381,888	147,285,065	341,408,022	11,313,465	17,375,336
Other Grants: (Nursing Home Surveys, Nurse Aid Registry & Remedial Blind:	2,397,411	45,000	2,352,411		
Total (Agrees to BARS Report)	519,779,299	147,330,065	343,760,433	11,313,465	17,375,336

GRANT SUMMARY
2009-2011 Biennium
To House

Description	2007-2009 Appropriation				2009-2011 Budget To House				Increase / (Decrease)				
	Average Monthly Caseload / Recipient	Average Monthly Cost	Total Expenditures	General Fund Expenditures	Average Monthly Caseload / Recipient	Average Monthly Cost	Total Expenditures	General Fund Expenditures	Average Monthly Caseload / Recipient	Average Monthly Cost	Total Expenditures	General Fund Expenditures	Unit Description
Traditional Medicaid			**414,989,037**	**117,052,873**			**517,381,888**	**147,285,065**			**102,392,851**	**30,232,192**	
Selected Services:													
Inpatient Hospital	8,058	553.24	106,466,089	38,154,265	6,682	887.70	142,254,927	51,177,998	(1,376)	334.46	35,788,838	13,023,733	Average cost per discharge.
Outpatient Hospital	183,404	11.41	50,214,153	17,863,268	137,401	19.24	63,386,305	23,142,010	(46,003)	7.83	13,172,152	5,278,742	Average cost per visit.
Physician	207,432	12.89	64,125,174	22,606,206	176,059	17.61	74,341,224	26,992,026	(31,373)	4.72	10,216,050	4,385,820	Average cost per visit.
Net Drugs (Includes Rebates)	50,001	53.91	64,955,938	10,307,414	46,800	44.69	50,168,148	771,111	(3,201)	(9.22)	(14,787,790)	(9,536,303)	Average cost per prescription.
Healthy Steps	4,061	207.31	20,204,746	4,669,885	6,021	243.93	35,248,129	9,122,897	1,960	36.62	15,043,383	4,453,012	Average cost per premium per month.
Indian Health Services	337	1,963.91	15,865,883	-	1,690	670.33	27,188,406	-	1,353	(1,293.58)	11,322,523	-	Average cost per encounter.
Premiums	7,419	133.00	23,681,997	8,283,916	9,134	111.51	24,477,081	8,663,236	1,715	(21.49)	795,084	379,320	Average cost per premium per month.
PRTF	87	326.67	20,743,249	7,474,104	93	381.18	25,866,038	9,565,113	6	54.51	5,122,789	2,091,009	Average cost per child per day.
Dental	9,772	56.84	13,323,341	4,789,686	11,691	64.53	18,096,019	6,680,538	1,919	7.69	4,772,678	1,890,852	Average cost per visit.
Durable Medical Equipment	45,386	4.86	5,301,290	1,905,344	146,640	1.94	6,843,358	2,498,301	101,254	(2.92)	1,542,068	592,957	Average cost per item.

Norh Dakota Department of Human Services
2009-2011
Changes in Medical Services Caseload and Cost from 2007-2009 Appropriation to 2009-2011 Budget To House

	2007-2009 Appropriation		Changes before Rebasing & Inflation		Rebasing Changes		Inflation Changes		2009-2011 To House	
Description	Average Monthly Caseload / Recipient	Average Monthly Cost	Average Monthly Caseload / Recipient	Average Monthly Cost	Average Monthly Caseload / Recipient	Average Monthly Cost	Average Monthly Caseload / Recipient	Average Monthly Cost	Average Monthly Caseload / Recipient	Average Monthly Cost
Traditional Medicaid										
Selected Services:										
Inpatient Hospital	8,058	553.24	(1,376)	158.56		137.31		38.59	6,682	887.70
Outpatient Hospital	183,404	11.41	(46,003)	6.91				0.92	137,401	19.24
Physician	207,432	12.89	(31,373)	1.09		3.04		0.59	176,059	17.61
Net Drugs (Includes Rebates)	50,001	53.91	(3,201)	(9.22)					46,800	44.69
Healthy Steps	4,061	207.31	1,960	36.62					6,021	243.93
Indian Health Services	337	1,963.91	1,353	(1,351.81)				58.23	1,690	670.33
Premiums	7,419	133.00	1,715	(21.49)					9,134	111.51
PRTF	87	326.67	6	28.61				25.90	93	381.18
Dental	9,772	56.84	1,919	(7.26)		8.72		6.23	11,691	64.53
Durable Medical Equipment	45,386	4.86	101,254	(3.11)				0.19	146,640	1.94
Ambulance Services	6,045	20.45	10,764	(11.83)		4.98		0.48	16,809	14.08
Chiropractor Services	1,059	17.94	366	(2.19)		12.14		0.98	1,425	28.87

A

Department of Human Services
HB 1012
House Appropriations - Human Resources Subcommittee

Medical Services traditional grants **		12,600,000
SCHIP		(563,000)
Medical Services clawback		1,600,000
LTC - primarily Nursing Facilities		4,000,000
HSCs		
NWHSC	100,000	
NCHSC	-	
LRHSC	385,000	
NEHSC	175,000	
SEHSC	-	
SCHSC	1,000,000	
WCHSC	230,000	
BLHSC	111,000	
		2,001,000
Institutions		2,700,000
Net of all other areas		26,000
Total turnback		22,364,000

**** - if major changes occur in the claims being submitted in Medicaid, this number will be updated**

Department of Human Services
HB1012
Travel Increase - Medical Services

Department Wide Travel Rates used in Budget Preparation

Budgeted Travel Rates				
In-State Travel	07-09 Biennium	09-11 Biennium	Difference	% Difference
Meals	25	25	0	
IRS Meals Taxable	10	10	0	
Lodging (Includes Taxes)	55	61	6	9.84%
Mileage (Non-State Employee or Personal Vehicle)	0.375	0.45	0.075	16.67%
Motor Pool Mileage	0.37	0.40	0.03	7.50%
Out of State Travel				
Meals	64	64	0	
Lodging (Includes Taxes)	140	140	0	
Mileage	0.375	0.45	0.075	16.67%
Airfare	600	800	200	25.00%
Other Transportation (Taxi, parking, etc.)	60	60	0	

	07-09		09-11		Breakdown of Rate Increases			Rate	Utilization	Total
	Trips	Budget	Trips	Budget	Lodging	Mileage	Airfare	Increase	Increase*	
Total Non-Employee Trips	-	$ -	80	$ 10,732				$ -	$ 10,732	$ 10,732
Total In-State Trips	402	$ 31,590	684	$ 64,204	$ 2,412			$ 2,412	$ 30,202	$ 32,614
Total Out-of-State Trips	53	$ 74,880	74	$ 110,028			$ 10,600	$ 10,600	$ 24,548	$ 35,148
Total		$ 106,470		$ 184,964	$ 2,412	$ -	$ 10,600	$ 13,012	$ 65,482	$ 78,494

*Explanation of usage increases:
Non-Employee travel consists of Money Follows the Person Stakeholder Committee and Medicaid Advisory Board, which was not budgeted for in 2007-2009.

In-State Trips increased due to Money Follows the Person grant and MMIS training.

Out of state trips increased due to extra trips to CMS Regional Office on policy issues and additional training needed to manage the increasing complexity of the Medicaid and SCHIP Programs.

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2009-2011 Budget to House

	Budget	% of Budget
Traditional Medical Services		
Selected Services		
Inpatient Hospital	142,254,927	27.50%
Outpatient Hospital	63,386,305	12.25%
Physician Services	74,341,224	14.37%
Drugs (net of rebates)	50,168,148	9.70%
Healthy Steps (SCHIP)	35,248,129	5.25%
Indian Health Services (100% Federal Funds)	27,188,406	4.73%
Premiums	24,477,081	5.00%
Psychiatric Residential Treatment Facilities	25,866,038	3.50%
Dental	18,096,019	3.50%
Durable Medical Equipment	6,843,358	1.32%
Total of Selected Services	**467,869,635**	**90.43%**
Remaining Services	**49,512,253**	**9.57%**
Total 2009-2011 Budget	**517,381,888**	**100.00%**

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2007-2009 Actual

Inpatient Hospital

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	1,291	$ 1,006.99	6,412	$ 202.75	$ 1,300,018
September-07	493	19,862.04	2,354	4,159.72	9,791,985
October-07	1,306	8,110.76	6,339	1,671.03	10,592,649
November-07	1,759	2,808.45	9,296	531.42	4,940,062
December-07	1,429	3,924.33	7,611	736.81	5,607,861
January-08	1,303	3,586.34	6,210	752.50	4,673,003
February-08	838	3,527.24	3,701	798.66	2,955,824
March-08	1,160	3,536.54	5,498	746.16	4,102,384
April-08	1,466	2,653.18	7,094	548.29	3,889,564
May-08	1,093	2,905.19	5,882	539.84	3,175,368
June-08	1,349	2,693.57	6,509	558.25	3,633,630
July-08	1,244	1,435.38	5,705	312.99	1,785,615
August-08	904	3,523.06	4,608	691.16	3,184,848
September-08	1,189	2,344.94	5,669	491.82	2,788,129
October-08	941	2,010.91	3,823	494.97	1,892,268
November-08	915	3,146.17	4,360	660.26	2,878,742
Monthly Averages	1,168	$4,192.19	5,692	$ 868.54	$ 4,199,497

November 07-June 08	6,871	$651.49	Exclude February 08 for units.
5% Inflationary Increase		$32.57	
Rebasing		$137.71	
7/7 Inflationary Increase		$38.59	
See Footnote below	-189	$27.34	
2009-2011 To House	**6,682**	**$887.70**	

This area is affected by the payouts and offsets, resulting from the claims backlog. This impacts both the units and cost per unit (See earlier handout). In addition, with the new reporting system discussed in the Medical Services overview (Pages 13-14), this area contains different payment methodologies and units that are used to calculate the overall Inpatient Hospital estimates.

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2007-2009 Actual

Outpatient Hospital

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	5,529	$ 321.57	99,639	$ 17.84	$ 1,777,977
September-07	6,944	303.27	191,968	10.97	2,105,897
October-07	8,828	272.55	213,304	11.28	2,406,069
November-07	8,298	266.17	158,771	13.91	2,208,719
December-07	8,065	262.62	158,602	13.35	2,118,044
January-08	8,513	322.04	206,797	13.26	2,741,485
February-08	7,893	252.19	137,688	14.46	1,990,559
March-08	7,387	315.81	117,746	19.81	2,332,894
April-08	10,111	243.63	190,587	12.92	2,463,314
May-08	7,070	301.74	231,371	9.22	2,133,277
June-08	7,585	321.40	143,790	16.95	2,437,790
July-08	7,670	278.13	97,862	21.80	2,133,256
August-08	5,978	263.71	79,783	19.76	1,576,468
September-08	7,757	284.11	91,640	24.05	2,203,814
October-08	6,889	276.30	79,193	24.04	1,903,429
November-08	7,176	266.78	87,941	21.77	1,914,381
Monthly Averages	7,606	$284.50	142,918	$16.59	$2,152,960.81

Avg Nov 07 through Sept 08	138,327	$17.03	Remove May 08
5% Inflation & cost increase for CAHs		$1.29	See Note
7/7 Inflation		$0.92	
2009-2001 To House	**137,401**	**$19.24**	See Note

The $1.29 of inflation will not exactly total a 5% increase. This is because this area contains a variety of Outpatient hospital reimbursement methodologies.

Outpatient includes Non-Critical Access, Critical Access, and Out of State Facilities. The average utlization for the Biennium to date in September 2008 was 127,670 for Non-Critical Access and 22,205 for Critical Access. The utliziation for Non-Critical Access was not increased; however, the utliziation for Critical Access was increased because of the expected switch of Jamestown and Williston to Critical Access. The 22,205 was increased by 6% to total an average monthly utlization of 23,348 for Critical Access. When these utilizations are weighted in the overall Outpatient tables, which includes the expected out of state Outpatient Services (average of 3,406 units per month), the average monthly utilization is 137,401.

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2007-2009 Actual

Physician

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	19,234	$ 63.49	150,805	$ 8.10	$ 1,221,097
September-07	15,884	291.89	117,710	39.39	4,636,395
October-07	22,055	147.88	221,836	14.70	3,261,502
November-07	19,529	117.22	173,066	13.23	2,289,230
December-07	22,310	106.25	187,195	12.66	2,370,343
January-08	22,128	118.61	226,290	11.60	2,624,547
February-08	19,889	119.73	153,073	15.56	2,381,228
March-08	20,857	117.19	155,938	15.67	2,444,264
April-08	23,497	90.08	187,969	11.26	2,116,545
May-08	19,349	114.97	151,292	14.70	2,224,613
June-08	17,784	86.04	134,764	11.35	1,530,047
July-08	19,536	103.18	178,370	11.30	2,015,699
August-08	17,987	105.80	133,159	14.29	1,903,001
September-08	20,758	78.57	172,684	9.44	1,630,955
October-08	19,343	109.57	159,567	13.28	2,119,494
November-08	19,017	94.23	156,784	11.43	1,791,953
Monthly Averages	19,947	$116.54	166,281	$14.25	$2,285,057

Avg Oct 07 - July 08	176,979	$13.20
5% inflation		$0.66
Rebasing		$3.04
7/7 Inflation		$0.59
See Footnote Below	-920	$0.12
2009-2011 to the House	**176,059**	**$17.61**

This area is affected by the payouts and offsets, resulting from the claims backlog. This impacts both the units and cost per unit (See earlier handout). In addition, with the new reporting system discussed in the Medical Services overview (Pages 13-14), the services in this area have been clarified.

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2007-2009 Actual

Drugs (Net of Rebates)

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures (EMAR)	Actual Rebates (EMAR)
August-07	16,542	$ 160.19	51,746	$ 39.42	$2,649,829	$ (609,965)
September-07	15,291	140.87	42,646	47.85	2,154,052	(113,639)
October-07	17,759	155.34	55,183	18.07	2,758,759	(1,761,508)
November-07	15,603	139.19	41,999	35.62	2,171,786	(675,681)
December-07	16,217	148.90	45,960	51.75	2,414,653	(36,391)
January-08	17,700	159.94	51,892	48.64	2,830,912	(306,818)
February-08	17,077	141.33	46,502	17.18	2,413,484	(1,614,655)
March-08	16,972	143.08	46,210	42.68	2,428,377	(455,905)
April-08	18,476	163.48	56,698	33.98	3,020,453	(1,093,806)
May-08	15,627	160.61	43,836	29.06	2,509,915	(1,236,180)
June-08	14,458	152.25	40,538	50.05	2,201,299	(172,393)
July-08	15,515	174.19	47,195	5.75	2,702,587	(2,431,133)
August-08	14,382	156.98	40,213	44.44	2,257,622	(470,666)
September-08	17,935	162.79	55,046	49.41	2,919,698	(199,900)
October-08	15,985	141.34	43,725	(4.52)	2,259,278	(2,457,062)
November-08	15,923	151.22	43,824	53.56	2,407,832	(60,698)
Monthly Averages	16,341	$153.23	47,076	$35.18	$2,506,284	(856,025)

Avg Aug 07 through April 08		$37.24
Inflation to the end of the biennium and loss of pre-2008 J-Code Rebates		$4.08
4% Inflation		$1.65
4% Inflation		$1.72
2009-2011 To House	**46,800**	**$44.69**

Inflation is not 7/7 for drugs, as this service is impacted by the actual cost of prescriptions. As noted on page 13 of the overview testimony, we used 4/4 inflation for brand and 2/2 for generic. Even though the generic/brand split is 68/32, the average cost of brand name is $149.13 vs. $22.23 for generics. Therefore, we used the 4% inflation to project the increased expenditures.

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2007-2009 Actual

Healthy Steps (SCHIP)

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Number of Premiums	Actual Cost Per Unit	Actual Expenditures
August-07	-	-	3,787	$ 202.45	$ 766,690
September-07	-	-	3,871	202.38	783,405
October-07	-	-	4,011	202.37	811,689
November-07	-	-	4,019	202.39	813,408
December-07	-	-	4,071	202.38	823,904
January-08	-	-	4,008	202.40	811,222
February-08	-	-	4,027	202.39	815,042
March-08	-	-	3,959	202.39	801,264
April-08	-	-	4,039	202.34	817,238
May-08	-	-	4,067	202.38	823,064
June-08	-	-	4,119	201.71	830,860
July-08	-	-	4,091	202.24	827,363
August-08	-	-	4,038	201.18	812,357
September-08	-	-	3,911	202.27	791,075
October-08	-	-	3,800	202.38	769,031
November-08	-	-	3,568	202.33	721,907
Monthly Averages	-	-	3,962	$202.25	$801,220

Sept 08 Actual	3,911	See Note
07-09 Growth for expanding to 150% and for regular expected growth	984	
09-11 Growth for expanding to 150% and for regular expected growth	395	
Growth for expanding to 200%	731	
2009-2011 To House	**6,021**	**$243.93**

$243.93 is the premium from Blue Cross/Blue Shield of North Dakota.

September 08 was used as a starting point, as we knew we were going to 150% (net) for SCHIP on October 1, 2008 and we were beginning to see the decline in SCHIP enrollment (See page 2 of the overview testimony)

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2007-2009 Actual

Premiums

Month	Actual Number of Premiums	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	-	$ -	8,919	$ 85.03	$ 758,364
September-07	-	-	9,323	83.83	781,573
October-07	-	-	9,018	85.47	770,742
November-07	-	-	9,125	83.73	764,023
December-07	-	-	8,894	89.03	791,799
January-08	-	-	8,447	89.52	756,167
February-08	-	-	8,661	92.66	802,520
March-08	-	-	8,620	91.85	791,719
April-08	-	-	8,692	93.23	810,326
May-08	-	-	8,705	91.31	794,884
June-08	-	-	8,737	90.76	792,969
July-08	-	-	8,649	90.72	784,607
August-08	-	-	8,858	90.11	798,236
September-08	-	-	8,823	87.40	771,161
October-08	-	-	8,738	93.07	813,270
November-08	-	-	8,806	91.60	806,645
Monthly Averages	-	-	8,813	$89.33	$786,813

Avg. Aug 07 - April 08	8,855	$88.25	
Inflation in premium costs effective January 1, 2009		$1.80	
Inflation for remainder CY 2009 and 1/2 CY 2010.		$10.15	11.5% increase
Inflation for remainder of CY 2010 and 1/2 CY 20111)		$11.32	11.5% increase
2009 -2011 Growth*	279		
2009-2011 To House	**9,134**	**$111.51**	

* Growth in QMB of 8 per month through November 2009, then 9 per month. Growth in SLMB of 1 per month through November 2009, then 5 per month. Growth for QI1 of 1 per month through November 2009, then 2 per month. Growth of 9 per month for SSA for entire biennium.

Premiums paid for the groups noted above are set by the Federal Government. Premiums for AIDs and other Group Health Insurance are cost-effective programs under Medicaid. This area does not receive the 7/7 inflation adjustment.

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2007-2009 Actual

Psychiatric Residential Treatment Facilities (PRTF)

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	62	$ 9,750.97	1,999	$ 302.43	$ 604,560
September-07	58	10,025.36	1,776	327.40	581,471
October-07	85	8,113.25	2,369	291.10	689,626
November-07	90	9,950.21	2,850	314.22	895,519
December-07	101	8,477.69	4,280	200.06	856,247
January-08	94	8,716.64	3,146	260.45	819,364
February-08	89	10,570.67	4,395	214.06	940,790
March-08	76	11,746.79	3,720	239.99	892,756
April-08	61	11,327.43	2,065	334.61	690,973
May-08	58	10,288.45	1,803	330.97	596,730
June-08	63	8,409.35	1,776	298.30	529,789
July-08	87	14,456.26	4,466	281.62	1,257,695
August-08	76	11,072.59	2,716	309.84	841,517
September-08	86	10,230.71	2,629	334.67	879,841
October-08	91	11,636.03	3,652	289.94	1,058,879
November-08	75	9,749.85	2,117	345.41	731,239
Monthly Averages	78	$10,282.64	2,860	$292.19	$804,187

Avg - Aug 07 thru April 08	80	$295.74	without Dec 07 and Feb 08
5% increase		$14.79	
Annual Cost Report Increases		$44.75	Weighted increases expected for in and out of state PRTFs, based on cost reports (in-state) and actual rate charged by out of state facility.
7/7 Inflation		$25.90	
Estimated growth of 1 child per month	13		
2009-2011 To House	**93**	**$381.18**	

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2007-2009 Actual

Dental Services

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	2,882	$ 189.89	11,748	$ 46.58	$ 547,272
September-07	1,501	168.11	5,595	45.10	252,332
October-07	3,929	173.40	14,691	46.37	681,295
November-07	2,099	173.18	7,553	48.13	363,512
December-07	3,492	184.77	13,843	46.61	645,222
January-08	3,894	199.92	15,622	49.83	778,495
February-08	2,382	192.02	9,165	49.91	457,402
March-08	2,539	177.80	9,613	46.96	451,428
April-08	4,253	209.17	17,386	51.17	889,615
May-08	3,088	195.74	12,040	50.20	604,436
June-08	2,869	210.09	11,424	52.76	602,746
July-08	2,788	180.67	10,641	47.34	503,702
August-08	2,584	192.45	9,892	50.27	497,287
September-08	3,487	197.08	13,931	49.33	687,230
October-08	2,998	201.59	11,556	52.30	604,374
November-08	2,220	206.07	8,611	53.13	457,466
Monthly Averages	2,938	$190.75	11,457	$49.12	$563,988

Avg Aug 07 - April 08	11,691	$47.85	
5% Increase		$2.39	
Rebasing		$8.72	
7/7 Inflation		$6.23	
		$65.19	Total of above
2009-2001 To House	**11,691**	**$64.53**	

The above total is $.66 higher than the 09-11 budget because we budget for children and adult dental and then the overall costs are weighted in a roll-up dental services summary.

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2007-2009 Actual

Durable Medical Equipment

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	1,582	$ 122.86	150,215	$ 1.29	$ 194,362
September-07	1,157	112.12	113,405	1.14	129,724
October-07	1,517	126.44	134,459	1.43	191,814
November-07	1,318	109.32	124,424	1.16	144,087
December-07	1,815	189.59	166,995	2.06	344,103
January-08	1,694	161.32	140,253	1.95	273,282
February-08	1,721	161.56	144,513	1.92	278,053
March-08	1,589	173.43	142,672	1.93	275,588
April-08	1,949	167.27	162,726	2.00	326,010
May-08	1,480	150.12	125,963	1.76	222,177
June-08	1,323	158.43	121,447	1.73	209,597
July-08	1,436	168.42	155,940	1.55	241,852
August-08	1,341	184.73	122,449	2.02	247,728
September-08	1,338	170.95	137,095	1.67	228,737
October-08	1,574	138.40	150,751	1.45	217,844
November-08	1,457	160.70	123,308	1.90	234,134
Monthly Averages	1,518	$153.48	138,538	$1.69	$234,943

Avg Aug 07 through April 08	145,708	$1.65	Remove September 2007 Units
Expected Caseload growth for 07-09 (approximately 62 UNITS per month)	932		
5% Inflation		$0.08	
7 & 7 Inflation		$0.19	
09-11 Averages	**146,640**	**$1.92**	

NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

Testimony on House Bill 1012
House Appropriations
Human Resources Division
January 30, 2009

Chairman Pollert, Members of the House Appropriations Sub-Committee on Health and Human Services. I am Terry Hoff, President of Trinity Health, Minot, North Dakota. I am here today speaking on behalf of my own organization as well as on behalf the North Dakota Healthcare Association.

I am here today in support of the Governors Medical Services budget recommendation. Adoption of the Governors budget for Medical services will complete the rebasing initiative you begun last session. The amount requested, 8.1million in general funds, is the result of a study commissioned by the Department of Human Services to identify the general funds needed to complete rebasing of hospital payments.

Among our reasons for requesting your support of the Governors budget recommendations:

- The hospital Medicaid fee schedule has not been rebased for at least seventeen years.
- The study shows that the current fee schedule for hospitals is approximately 30% less than the hospital cost to deliver the services.
- The current Medicaid payment schedule does not cover hospital uncontrollable costs such supplies, utilities, insurance, equipment, and drugs, and is inadequate to manpower recruitment and retention challenges.
- Hospitals never recovered the lost ground created by a Medicaid hospital payment freeze in 2002, even though there were federal funds available to the state for relief.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

- On measures of efficiency and effectiveness, ND hospitals rank among the top five states in the nation with respect to quality of medical care (effectiveness) and low cost (efficiency). (Figure 1)

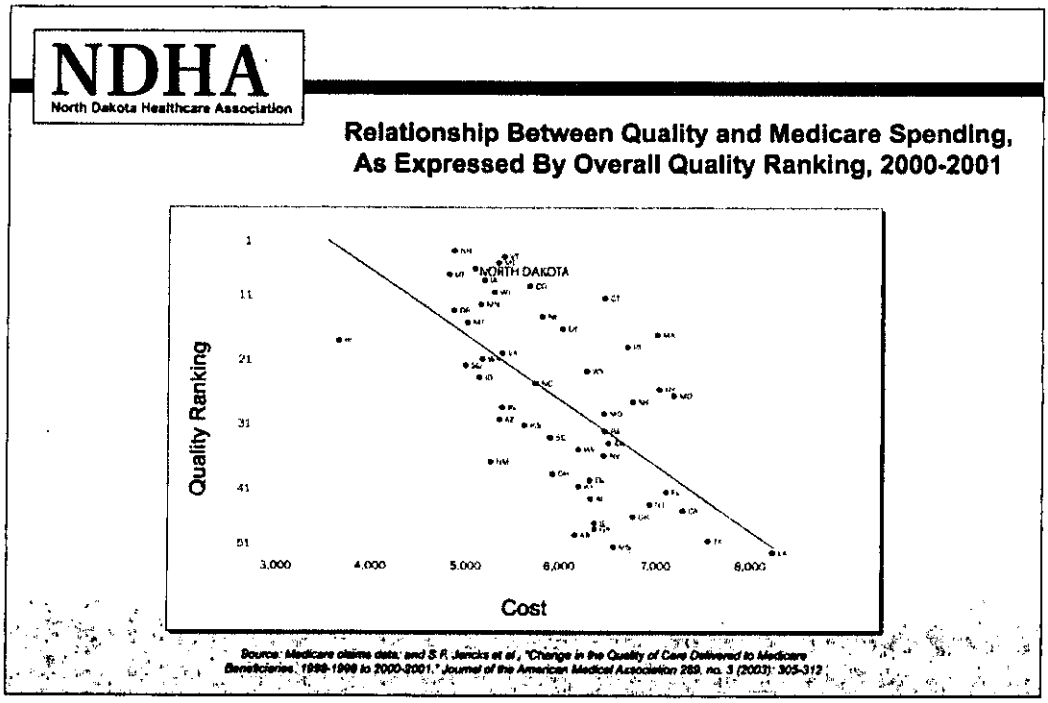


Figure 1

- Compared to other states, ND ranks lowest among all states in terms of percentage of dollars spent on acute care services. (Figure 2)

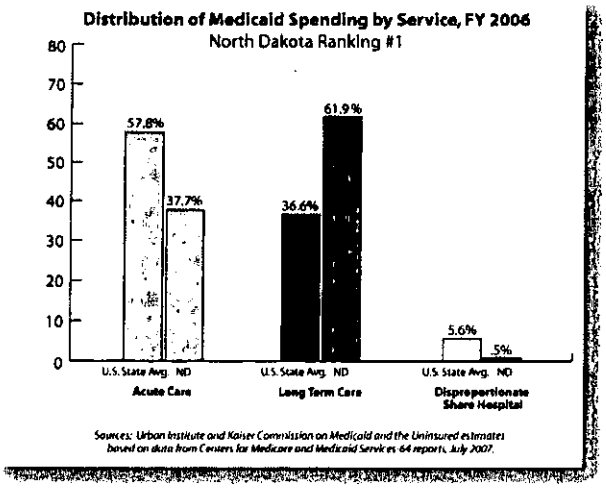


Figure 2

- ND ranks 37th among the states in percentage of general funds spent on Medicaid. (Figure 3)

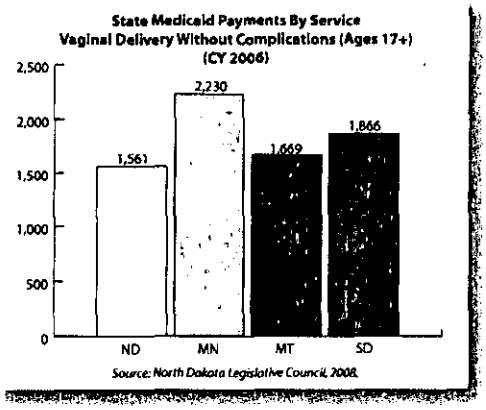


Figure 3

- ND Medicaid payments to hospitals are generally the lowest in the region. (Figure 4a, 4b, 4c)

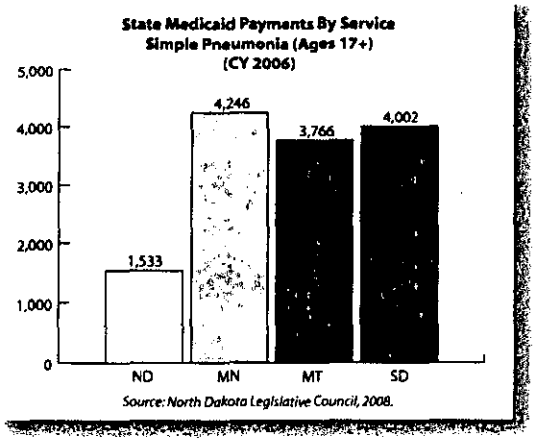


Figure 4a

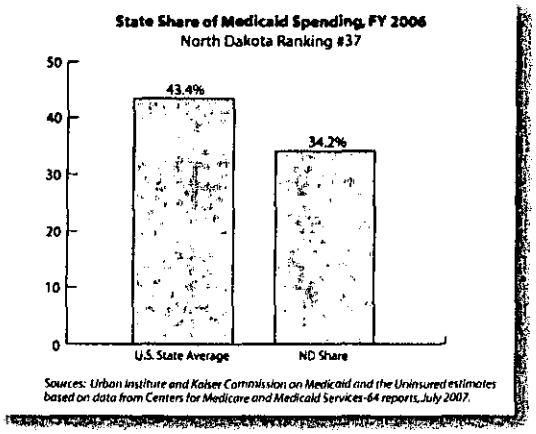


Figure 4b

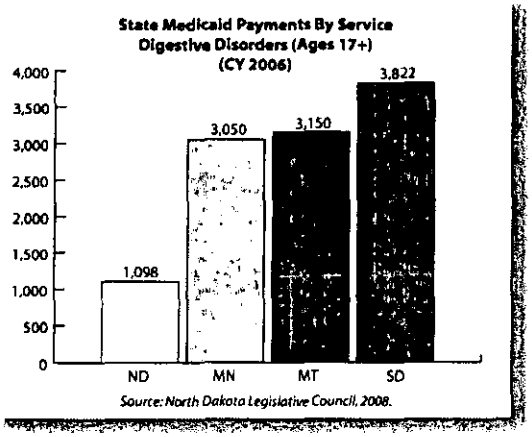


Figure 4c

- With an average age of 11.1 years in 2007, compared to Standard and Poors recommendation of 9.5 years, hospitals in ND are among the oldest in the nation.
- ND hospital margins—whether total (1.8 % in 2007) or operating (-.3 % in 2007)—are among the lowest in the nation and insufficient to meet operating and capital needs.

Chairman Pollert, members of the Appropriations Sub Committee, rebasing hospitals fee schedule is long overdue. The Governors budget addresses this long over remedy. We ask you to support the Governors budget for hospital rebasing.

I would be pleased to respond to questions you or the committee may have.

A

Testimony for HB 1012

Chairman Pollert and Members of the Appropriations Health and Human Services Sub-Committee:

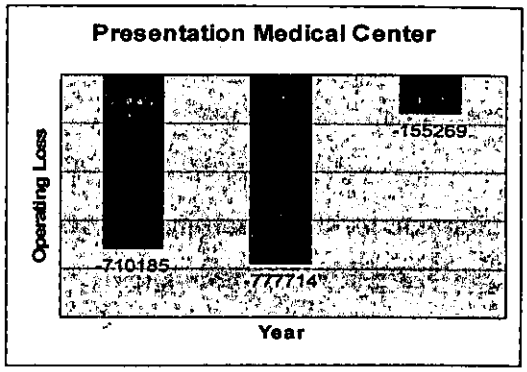
Thank you for the opportunity to speak with you today in support of the Medicaid budget. I am Kimber Wraalstad, Administrator of Presentation Medical Center, located in Rolla. I am here today speaking on behalf of the North Dakota Healthcare Association in support of the Medical Services budget recommended by the Governor.

Presentation Medical Center is a 25-bed Critical Access Hospital providing medical services to the citizens in Rolette and Towner Counties. As you may recall from my testimony last session, Presentation Medical Center provides medical services to a very high percentage of Medicaid beneficiaries. During 2008, 49.53% of the patients who came through our front door had Medicaid as their primary insurance. Our ability to continue meeting the medical needs of the people in my area is contingent upon Medicaid payments covering the costs of services provided.

In 2007, I described to you the impact Medicaid reimbursement had on Presentation Medical Center and supported the Associations recommendation that hospitals be reimbursed in a manner that covered our costs. **Thank you** for your positive actions to this request last session. You provided funding that allowed North Dakota's Critical Access Hospitals to be reimbursed on a cost basis. I would like to note, however, there is still work to be done on reimbursement for anesthesia and outpatient laboratory services. These conversations are ongoing. Because estimates for bringing the remaining hospitals to a rebased cost rate were not readily available, you deferred completion of rebasing for these hospitals, pending the completion of an analysis by an outside consultant and their projection of the dollars needed to complete the rebasing effort.

The proposed budget includes the funds to continue to pay Critical Access Hospitals at cost. Equally important, the budget includes funds to provide rebasing to costs for those hospitals not included in the actions of the 2007 session.

How important was the action you took last session? Let me tell you what it has meant to Presentation Medical Center. In our 2006 fiscal year, Presentation Medical Center had an operating loss of $710,185. In our 2007 fiscal year, Presentation Medical Center had an operating loss of $777,714 and in our recently completed 2008 fiscal year, our operating loss was $155,269. What was the difference? The 2008 fiscal year was the first full year that Presentation Medical Center's Medicaid payments were cost based. I believe we would have not had an operating loss had our costs been recognized for anesthesia and outpatient lab services.



You are aware of the many ways in which North Dakota hospitals are disadvantaged in reimbursements when compared to surrounding states. No hospital, large or small, can continue to provide services to meet the medical needs of our communities if the reimbursements we receive do not cover the cost of care provided. I am very privileged to be part of a faith based mission focused health care organization. Presentation Medical Center is a primary point of access for medical care in our region. To continue to fulfill our important mission, we need reimbursement that covers our costs. HB 1012 meets this objective, not only for Presentation Medical Center, but for all hospitals.

I appreciate your attention and I would be happy to address your questions. Thank you.

North Dakota Department of Human Services
2009-2011 Biennium
HB 1012
Comparison of Dental Services Budget with Rebasing to Minimum of 75% of Average Billed Charges VS. No Rebasing

	2007-2009 Appropriation*	Cost/Caseload Changes	Rebasing of Dental Services Fee Schedule to a Minimum of 75% of Average Billed Charges	7/7 Inflation	Total
2009-2011 Executive Budget	13,323,341	588,842	2,445,138	1,738,698	18,096,019
No Rebasing with 7/7	13,323,341	588,842	-	1,484,315	15,396,498
Difference	-	-	2,445,138	254,383	2,699,521

* Includes $444,198 from 2007 HB 1246, which provided funds to increase the Medicaid dental fee schedule for children.

NDHA
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Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

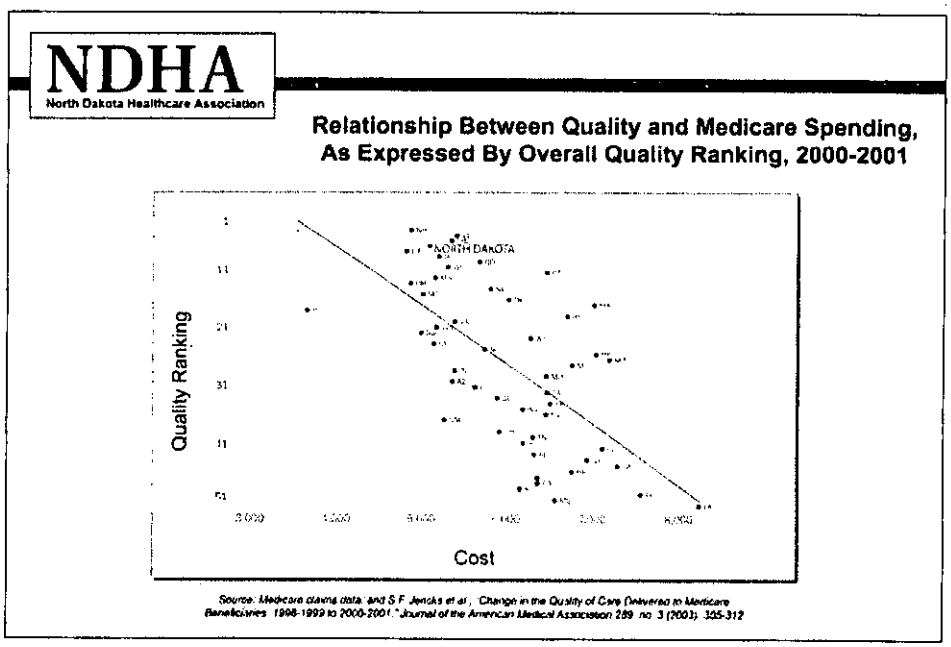
Testimony on House Bill 1012
Senate Appropriations
March 3, 2009

Chairman Holmberg, Members of the Senate Appropriations Committee. I am Arnold Thomas, President of the North Dakota Healthcare Association. I am here today asking your support for the Governors Medical Services budget recommendation. Adoption of the Governors recommendation for Medical services will complete the hospital rebasing initiative you began last session. The amount requested in the Governors budget to complete hospital rebasing is 8.1 million in general funds. This figure is based on the study funded by the Legislature and commissioned by the Department of Human Services to identify the general funds needed to complete last sessions hospital payment rebasing initiative.

Among our reasons for requesting your support:

- The hospital Medicaid fee schedule has not been rebased for at least seventeen years.
- The study shows that the current fee schedule for hospitals is approximately 30% less than the hospital cost to deliver the services.
- The current Medicaid payment schedule does not cover hospital uncontrollable costs such as supplies, utilities, insurance, equipment, and drugs, and is inadequate for address of manpower recruitment and retention challenges.
- Hospitals never recovered the lost ground created by a Medicaid hospital payment freeze in 2002, even though there were federal funds available to the state for relief.
- On measures of efficiency and effectiveness, ND hospitals rank among the top five states in the nation with respect to quality of medical care (effectiveness) and low cost (efficiency). (Figure 1)

Figure 1



- Compared to other states, ND ranks lowest among all states in terms of percentage of dollars spent on acute care services. (Figure 2)

Figure 2

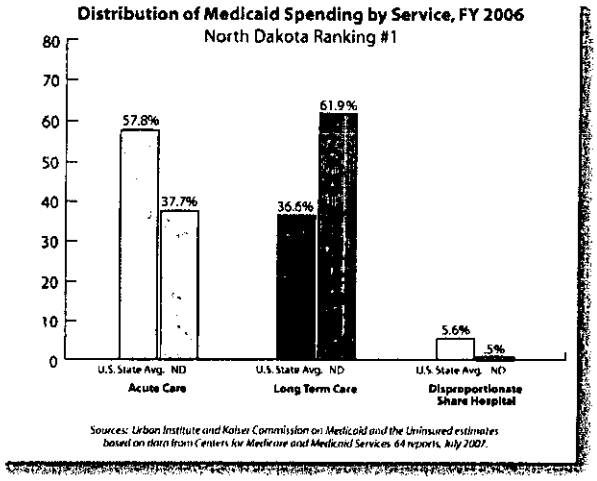


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Figure 3

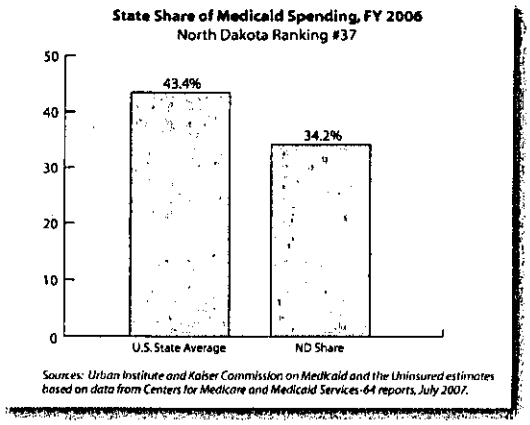

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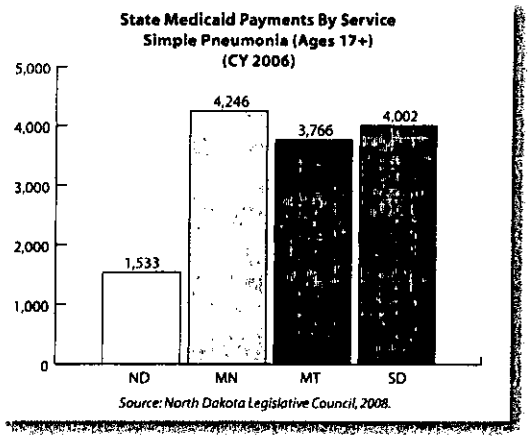
Figure 4a



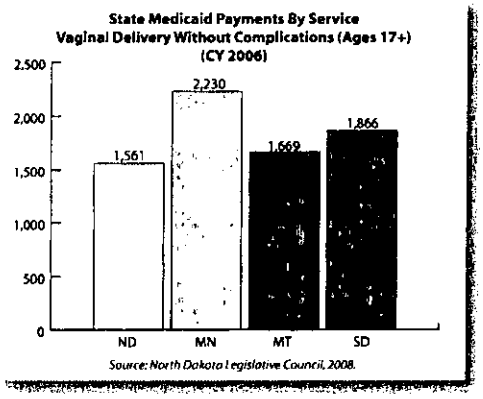


Figure 4b

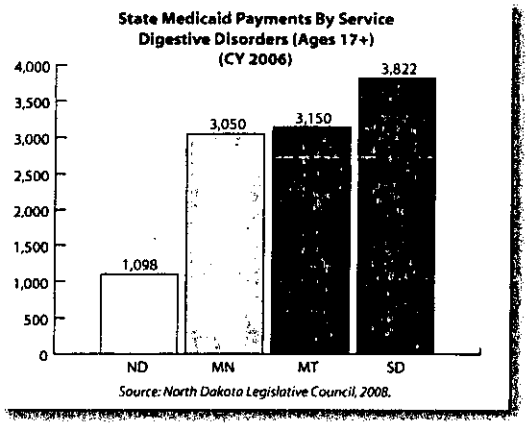


Figure 4c

- With an average age of facility of 11.1 years in 2007, compared to Standard and Poor's recommendation of 9.5 years, hospitals in ND are among the oldest in the nation.
- ND hospital margins—whether total (1.8 % in 2007) or operating (-.3 % in 2007) - are among the lowest in the nation and insufficient to meet operating and capital needs.

Chairman Holmberg, members of the Appropriations Committee, rebasing hospitals fee schedule is long overdue. The Governors budget addresses this long over remedy. We ask you to appropriate the general funds necessary to complete hospital rebasing for all of the state's hospitals.

I would be pleased to respond to questions you or the Committee may have.

F

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North Dakota 2009 Legislative Session

House Appropriations - Human Services Division Committee

Testimony on House Bill 1012

January 26, 2009

Chairman Pollert and Members of the House Appropriations Subcommittee - Human Resources Division:

My name is Beverley Adams and I am the Executive Administrator for the Health Policy Consortium (HPC). The Health Policy Consortium is comprised of Altru Health System in Grand Forks, MedCenter One Health System in Bismarck, MeritCare Health System in Fargo and Trinity Health System in Minot.

The four health systems that I represent, are integrated health systems they are not simply hospitals. They are hospitals, clinics, labs, physicians, all working under one system. This means that the physicians are employees of the hospital. Traditionally physicians owned their own businesses and had privileges to practice in the hospitals. The four health systems that comprise the HPC realized that having a healthcare system where the physicians are employed by the hospitals provides a more cost efficient and patient focused model of care, despite the reimbursement systems not rewarding quality and efficiency. As a result of the hospitals employing the physicians, these organizations are

affected by both the rebasing of Medicaid on the hospital side and the rebasing on the physician side. The integrated systems are affected by the Medicaid reimbursement on the hospital and the physician side.

These organizations provide specialty and sub-specialty care as well as a significant amount of high quality primary care in the most rural of communities, such as New Town, Cavalier and Wahpeton. In 2007/2008 the HPC health systems provided over $120 million of uncompensated care in either the form of bad debt and charity care services for the patients we serve. This is reflective of the substantial amount of care provided to the more than 80,000 under-insured and uninsured North Dakotans. These numbers will be rising significantly as the economy declines.

Your decisions relating to appropriations for reimbursement for Medicaid recipients has a profound impact on our ability to provide care to North Dakotans and the future viability of health care services within the State of North Dakota.

We would like to discuss the current reimbursement status from all payers in order to explain in detail the delicate healthcare reimbursement ecosystem in North Dakota. The current system is not sustainable and threatens the future viability of healthcare in North Dakota including MeritCare, Altru, MedCenter and Trinity. These healthcare systems are a safety net to the healthcare providers in rural North Dakota. As a safety net, these facilities provide specialty health care services to more than 80% of the citizens of North

Dakota. As a safety net these facilities provide specialized services in areas such as cardiology, children's specialty services, trauma, orthopedics, etc.

Altru, MedCenter, MeritCare and Trinity have gone from showing a small profit margin in 2004 to negative margins in 2007. **Exhibit 1** is a slide showing the total operating margin for Trinity, MeritCare, MedCenter and Altru from 2004 to 2007. They also are losing ground with regard to their debt service coverage. **Exhibit 2**. Their average age of plant is also increasing. **Exhibit 3**. Also, in comparison to surrounding States, Missouri, Kansas, Minnesota, Iowa, Montana, Nebraska and South Dakota, the average operating margin was 6.9%, while North Dakota's state wide average is 1.8% in 2007. **Exhibit 4**.

The current financial crises is caused by the healthcare systems having no control over reimbursement rates and no control over rising costs. We are told what we are going to get paid and little if any consideration is given to the actual cost of providing the care. The current fee schedule for Medicaid for hospitals is approximately 30% less than cost to deliver the service. Commercial private payers are 37% below surrounding states and Medicare reimbursement is 30 to 40% below cost and Medicare consists of approximately 38% of the revenue generated by MeritCare alone.

The Medicare system also has built-in mechanisms to geographically adjust the payments in each area of the country. Significant portions of hospital payments are adjusted for the healthcare provider's relative wage index to the national average. The wage index for

North Dakota is 82%, resulting in payments of $17 Million (for MeritCare alone) annually below the national average for the same services. Likewise, physician payments are geographically adjusted and in North Dakota are 91% of the national average. For MeritCare alone, this equates to an additional $8 Million annually below the national average.

Nationally, Medicare payments are insufficient to cover hospital costs for Medicare patients. As a result, those losses must be covered through higher payment from commercial payers. In North Dakota, the BCBSND premiums are approximately 15% below surrounding states, such as Kansas, Missouri, Iowa, Nebraska, Minnesota and South Dakota. **Exhibit 5.** This results in lower reimbursement payments from commercial payers to healthcare providers. This results in North Dakota being unable to cover the losses and offset the inadequate government payers from the higher private commercial payers like the rest of the nation. However, the cost of providing care is not cheaper in North Dakota than surrounding States.

I want to briefly talk about the different payer sources and provide you with some detail on reimbursement in North Dakota, so we can better explain the financial difficulties that the healthcare systems in North Dakota are experiencing.

Medicaid has not been rebased to cost for approximately 17 years. Additionally, since the 1980's the amount of the annual increase in payments to hospitals and physicians has consistently been less than the increase in inflationary costs experienced by hospitals and

physicians. In 2007 the legislature had the foresight to commission a study to determine what the actual cost of care is compared to reimbursement rates in order to determine fair and equitable reimbursement rates for hospitals in North Dakota in the 2009 legislative session. The study showed that to get the inpatient, psych, rehab, outpatient and physician components to cost, it would require $29 Million of State General Funds for the biennium. **Exhibit 6.**

Based on this information it is clear that Medicaid has been historically under funded. The physician component of the rebasing study had the most significant adjustment as historically, it has been the most underpaid. This has caused the healthcare systems to provide services to Medicaid patients at a loss for the past 17 years.

The second payer I would like to discuss is Medicare. The Medicare Trust Fund is predicted to go bankrupt in the near future. Therefore, Medicare is taking significant steps to cut payments and is actively looking at payment system reform. Based on a Milliman Study prepared for Altru, Trinity, MedCenter One, MeritCare and Innovis analyzing Medicare reimbursement for North Dakota compared to surrounding states, North Dakota's reimbursement is 91% less than Kansas, Iowa, South Dakota, Montana, Missouri, Nebraska and Minnesota. **Exhibit 7.** Therefore, Medicare reimbursement to healthcare facilities in North Dakota is 9% lower than surrounding states. Although 9% does not appear significant, if MeritCare alone was reimbursed at the average of the surrounding States, this would equate to an additional $25 Million annually.

The last groups of payers we are going to discuss is the commercial payer. As you know, BCBS has over 84% of the market share of the commercial healthcare coverage in North Dakota. As a result, there has not been equal bargaining footing between the parties when reimbursement contracts are negotiated. As a result, BCBS has set reimbursement rates and terms and they do not negotiate provider contracts. The choices for hospitals are either to accept the unilateral terms which are subject to change with little notice throughout the year or go without a contract. If the hospitals do not have a contract this means that patients will be billed directly for hospital services and they would be financially responsible to the hospitals for the cost of care and would have to negotiate with BCBS what portion of their bill would be covered by insurance. Since there is no free market system in North Dakota with commercial insurance carriers, North Dakota is reimbursed approximately 37% less than surrounding States including Kansas, Missouri, Iowa, Minnesota, Montana, South Dakota and Nebraska by commercial payers in North Dakota for the same level of care. **Exhibit 8.** If MeritCare was paid the average of the surrounding States on private commercial payers alone, this would mean an additional $30 Million dollars per year.

The information on the comparisons for Medicare and the private commercial payers was obtained through two separate studies completed by Milliman. Milliman is among the world's largest independent actuarial and consulting firms. They are similar to the consultants hired to complete the rebasing study for Medicaid. These studies provide credibility to the data contained in this testimony.

With North Dakota receiving lower reimbursement rates from all payers in comparison to surrounding States and lower rates in comparison to costs, it sheds light on the current financial crises North Dakota healthcare systems are facing. It is important to note that the surrounding States are not the highest paid States relating to Medicare and private payer reimbursement, in the United States. We are not comparing ourselves with the highest reimbursed States in the Nation; we are comparing ourselves with States that are similarly situated to ourselves.

Throughout the nation, healthcare systems in other States, are compensated by higher private reimbursement when the government payers are paying less than cost. This is clearly demonstrated by **Exhibit 9** which is a graph which shows the national average comparison of cost to reimbursement by Medicare, Medicaid and private payers. As you can see when the government payers lower reimbursement, the private payer reimbursement increases and the converse of that statement is also true. When government payers increase reimbursement, private payers' reimbursement lowers. However this has not happened in North Dakota. Over the years, the government payers are reimbursing below cost and BCBS which has 84% of the market for private insurers has not increased their reimbursement to cover the losses on the government payer side. North Dakota has continued to keep premiums to individuals low and this has caused lower reimbursement rates on the private commercial payer side to the healthcare providers, while the costs of providing the care have continued to rise.

The current reimbursement system in North Dakota undermines our ability to invest in modern technology and to make needed improvements and repairs to facilities. It also reduces our ability to subsidize charity care. If the situation continues, North Dakota providers will become unattractive to physicians and to patients and out migration to other states for health care will snowball, causing the State's healthcare system to collapse.

North Dakota hospitals have been recognized nationally for providing high quality and cost-effective healthcare. **Exhibit 10**. North Dakota is not wasting medical resources which cause the cost of care to rise. In fact in North Dakota it is just the opposite. Therefore the rising costs and current financial instability of the healthcare facilities in North Dakota is not attributable to financial mismanagement and wasting of resources.

A major contributor to rising costs in health care in North Dakota is the cost of recruiting physicians to North Dakota when they can live in other areas of the country that pay significantly more. North Dakota hospitals have to pay these physicians more money in order to recruit them to North Dakota than they would receive if they worked in New York, Florida, California and Texas. The government payers and the private payers do not take this into consideration when deciding what reimbursement rates will be to hospitals. In addition, technology and the cost of supplies continue to rise which creates additional contributors to rising health care costs, while reimbursement declines.

The current payment policy of increasing payments for hospital and physician services at an amount that is **consistently less than actual inflationary costs**, coupled with an inability to shift this un-funded cost of Medicaid services to other third party payers like Blue Cross Blue Shield of North Dakota, will ultimately **jeopardize the hospital system and the delivery of care in North Dakota. Healthcare systems will be unable to provide the high quality, efficient healthcare services that patients in North Dakota have become accustom to.**

The financial crises for healthcare facilities will have a broad impact to the citizens of North Dakota and will affect the economy, and jobs in addition to the inability to attract individuals to North Dakota. It is essential that North Dakota continue to be recognized for its high quality and efficient manner that it provides healthcare. It is essential to have a viable healthcare system as it contributes to North Dakota's economy.

In 2002 a study was completed by NDHA to evaluate the healthcare industries' contribution to the economy in North Dakota. In 2002 Health services represented one of the State's largest employment sectors. In 2002 roughly 10.5% of all workers in North Dakota were employed by a healthcare organization and about 5.5% were employed by community hospitals. In 2002 - 8 of the top 12 largest employers in the state were health care providers. In 2002 hospitals generated over a billion dollars in total revenue each year, and much of the revenue represents new wealth to the State. In 2000 hospitals spent $1 Billion, 21 million, with the largest expense being payroll which on average was 43% of each hospital's total annual expense budget. The 43% only included salaries and not

other employee benefits. A large majority of the hospitals expenses are spent in North Dakota. On average 83.6% of the dollars remain in the State. Of the 16.4% of the dollars going out of state the majority is spent on supplies. Clearly, it is important to the economic stability of North Dakota for the healthcare systems to continue as strong economic engines.

In summary, it is imperative that the healthcare reimbursement ecosystem is balanced. Hospitals cannot survive under the current reimbursement system and each payer needs to evaluate and reimburse the hospitals equitably for their use of the valuable healthcare resources in this community. Hospitals are large economic drivers in the State with many North Dakotans relying on jobs in healthcare systems. In order to keep young people and business from migrating from the State and attract them to the State of North Dakota, we need to have financially viable, stable and comprehensive healthcare systems.

MeritCare, Altru, MedCenter and Trinity, are very appreciative and support the Governor's Budget and the proposed increase that brings payment for physician services closer to cost (64% of cost) as well as the positions of NDHA and NDMA. However to rebase physicians at less than cost, simply perpetuates the inequitable payment system that contributes to the overall financial strains on healthcare systems. We respectfully request that this committee accept the Governor's proposed budget with respect to Medicaid funding for both the hospital and the physician component in addition to considering rebasing the physician component to cost. This would require an additional $14,699,550.00 in general funds for the

biennium, in addition to the $4,899,850 for the physician component which has already budgeted. At this level, physician payments would rebase from 51% to about 100% of cost.

Mr. Chairman and members of the Committee, thank you for the opportunity to address you this morning. I am willing to respond to your questions.

Exhibit 1

12

Health Care Policy Consortium

Ratio Trends on Consolidated Basis

Total Operating Margin
FY2004 - FY2007 and as of Apr 30, 2008

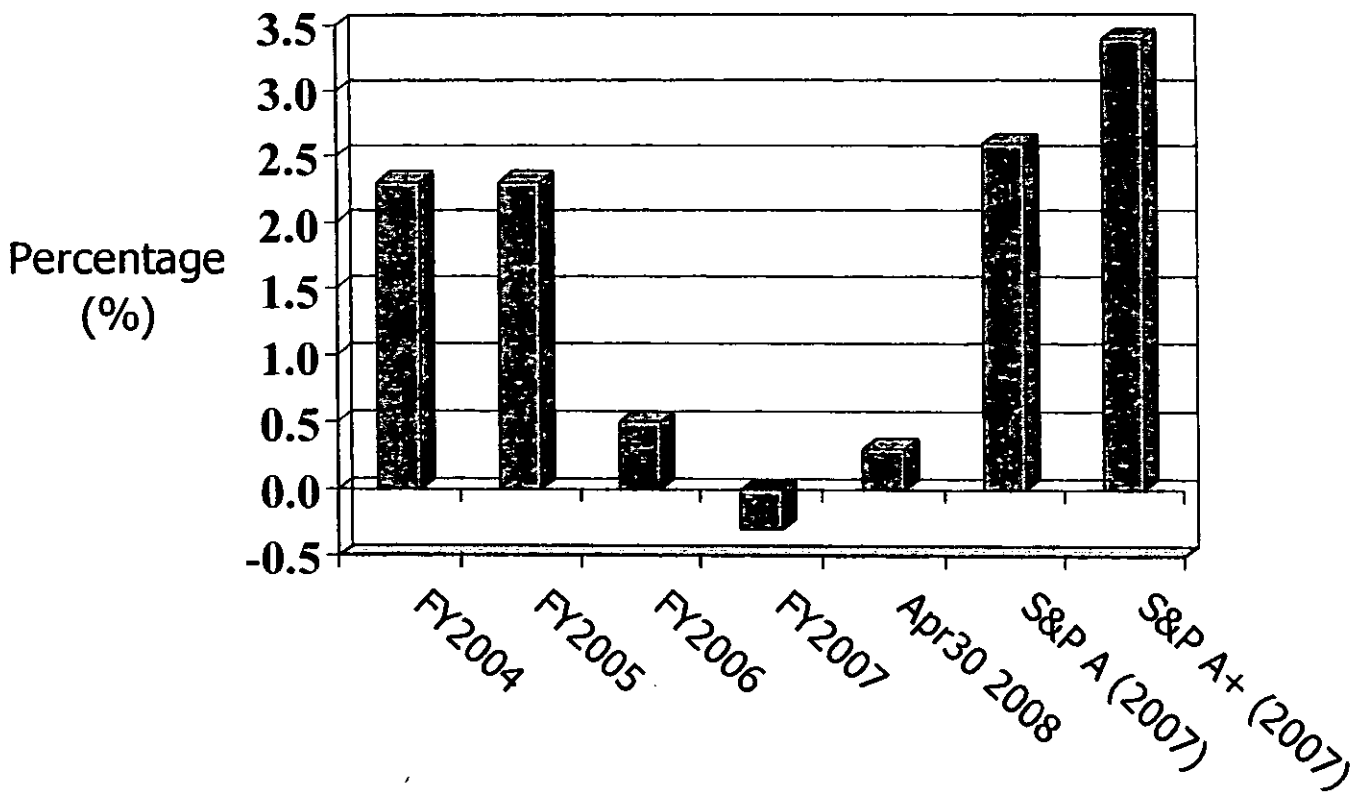


Exhibit 2

13

Health Care Policy Consortium

Ratio Trends on Consolidated Basis

Debt Service Coverage
FY2004 - FY2007 and as of Apr 30, 2008

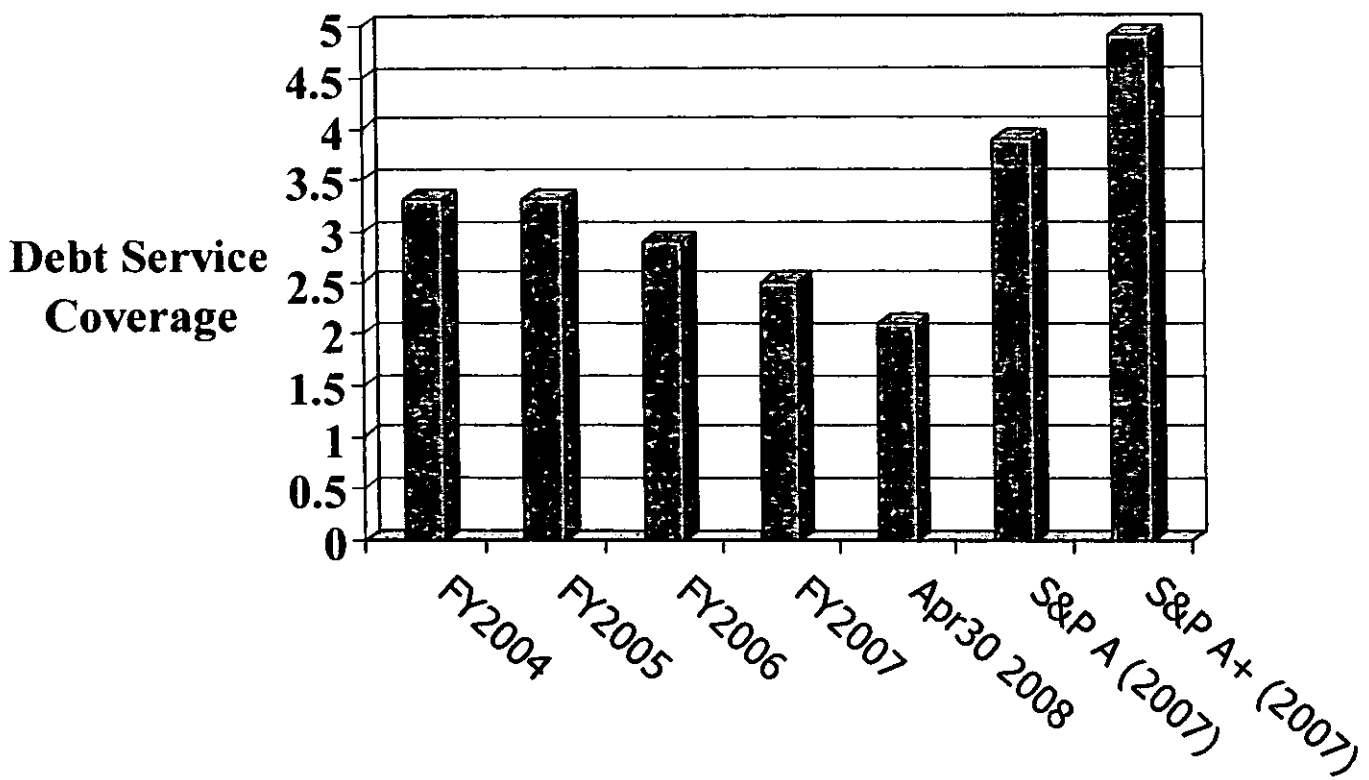


Exhibit 3

Health Care Policy Consortium

Ratio Trends on Consolidated Basis

Average Age of Plant
FY2004 - FY2007 and as of Apr 30, 2008

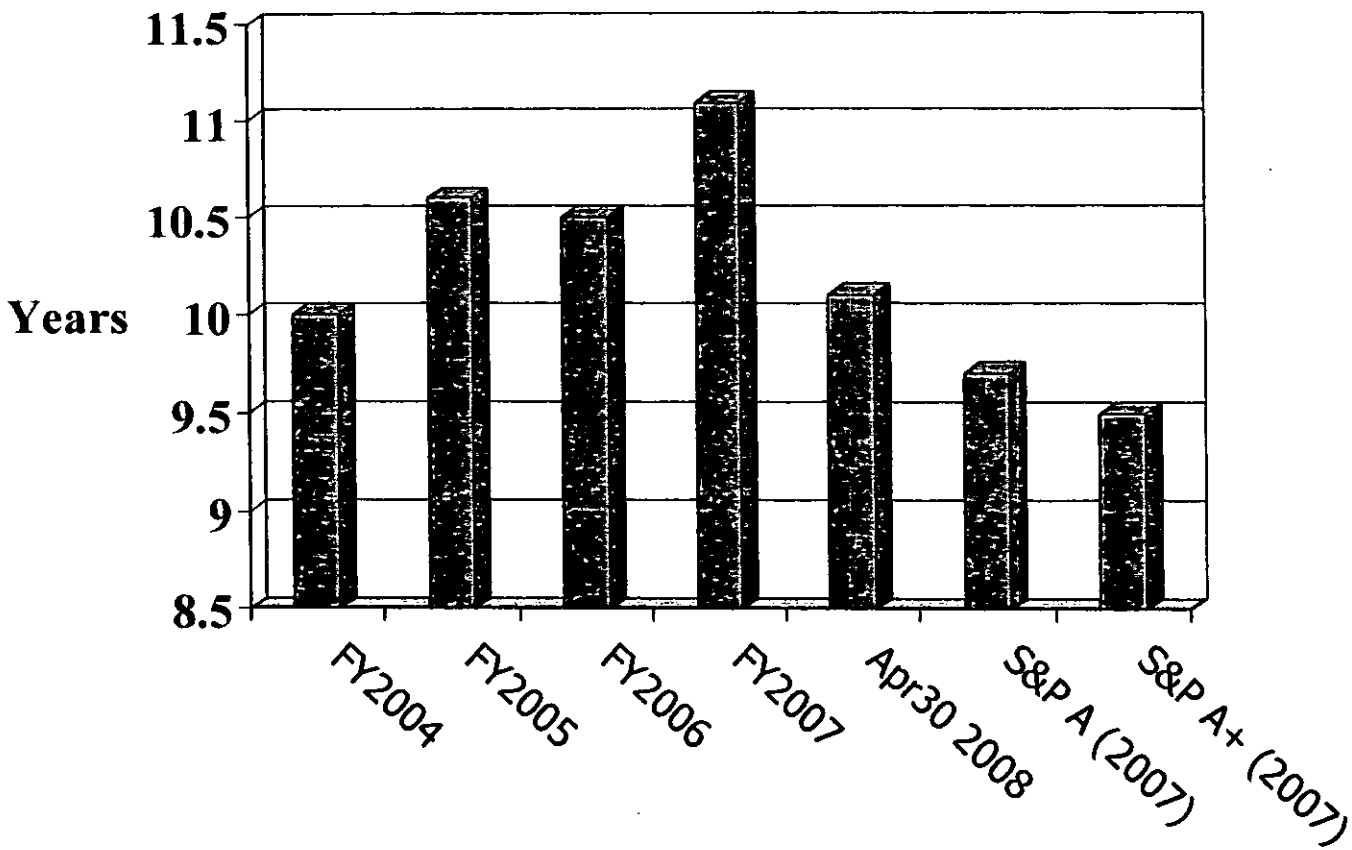
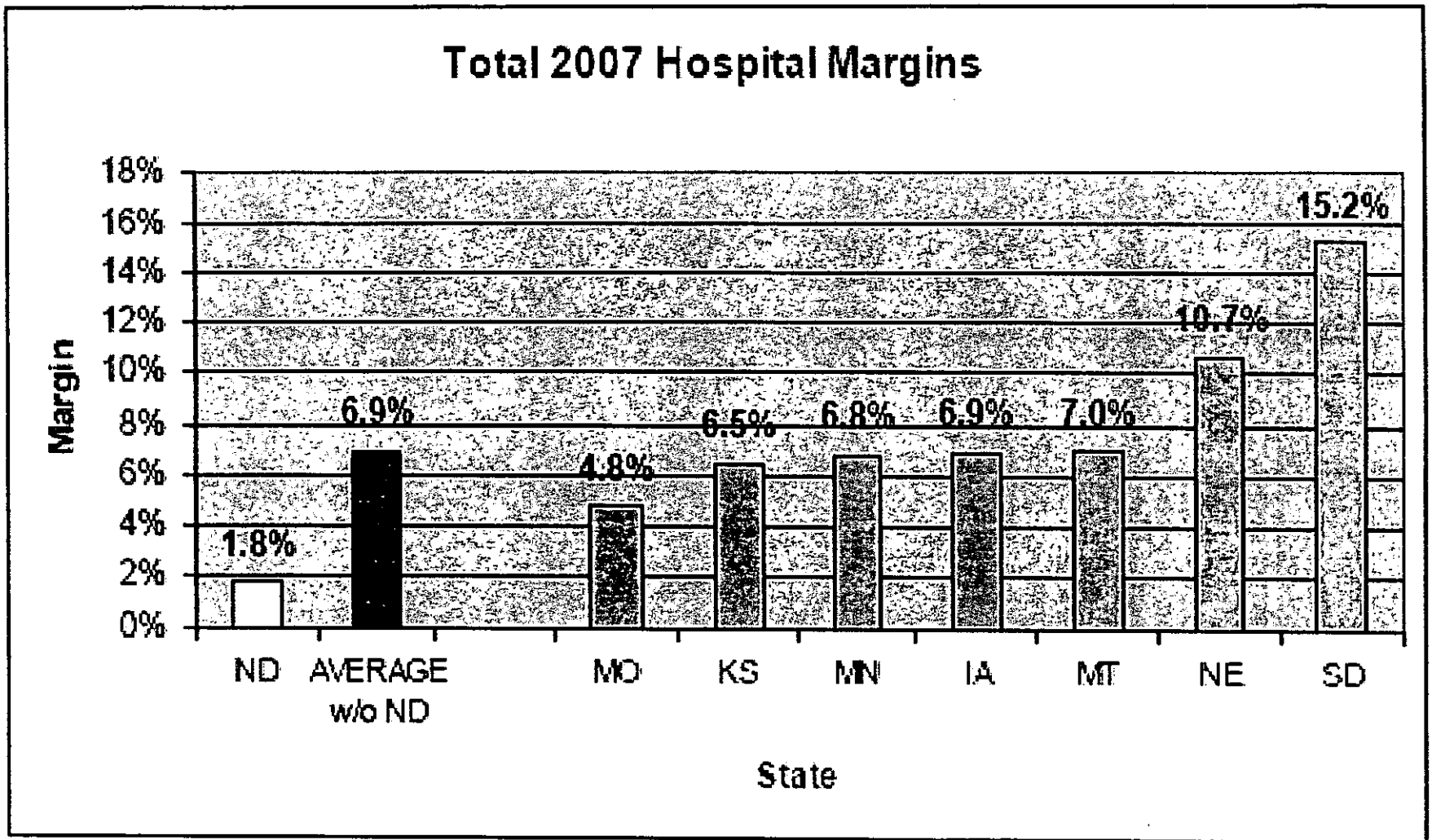


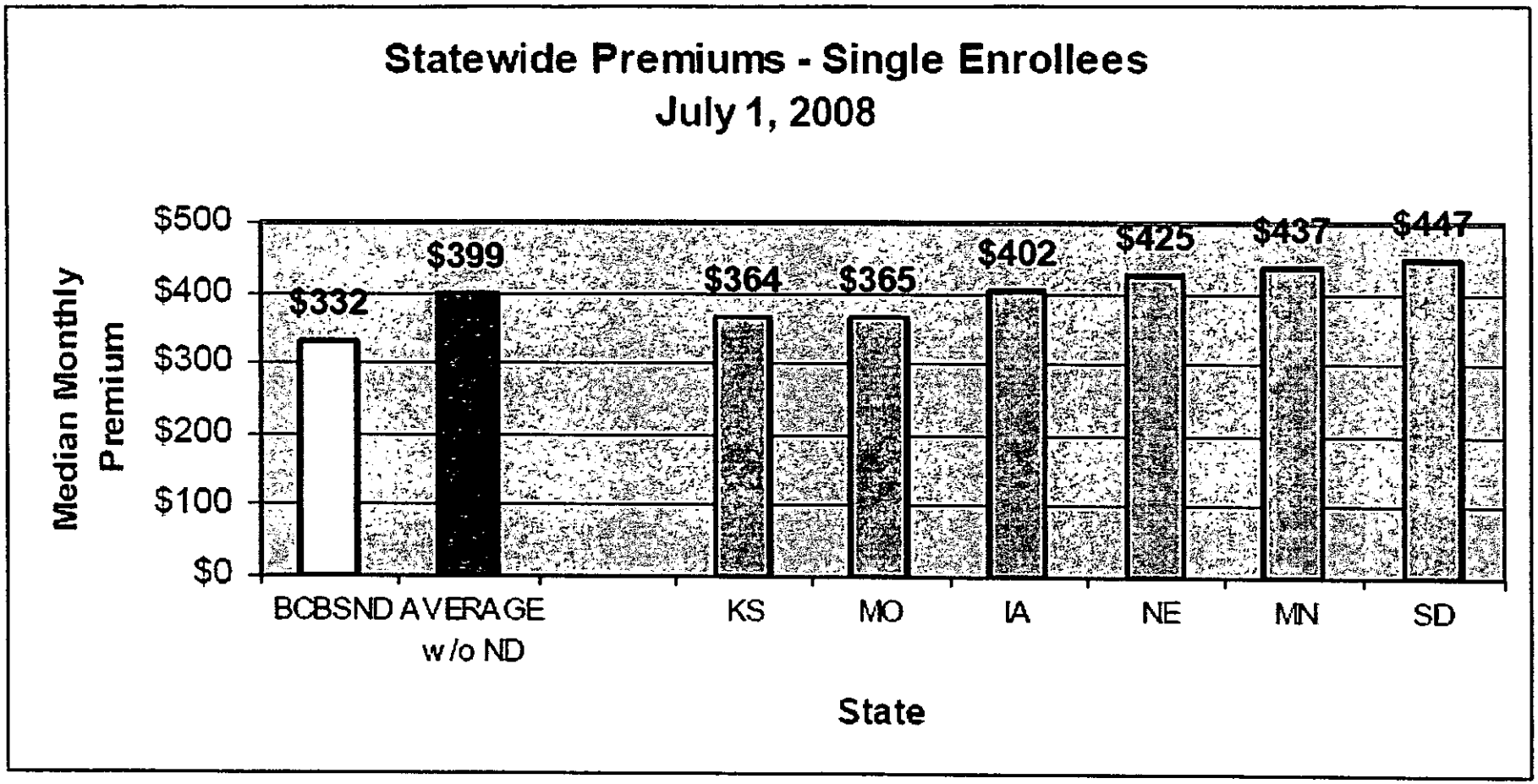
Exhibit 4



Milliman Private Insurer Study

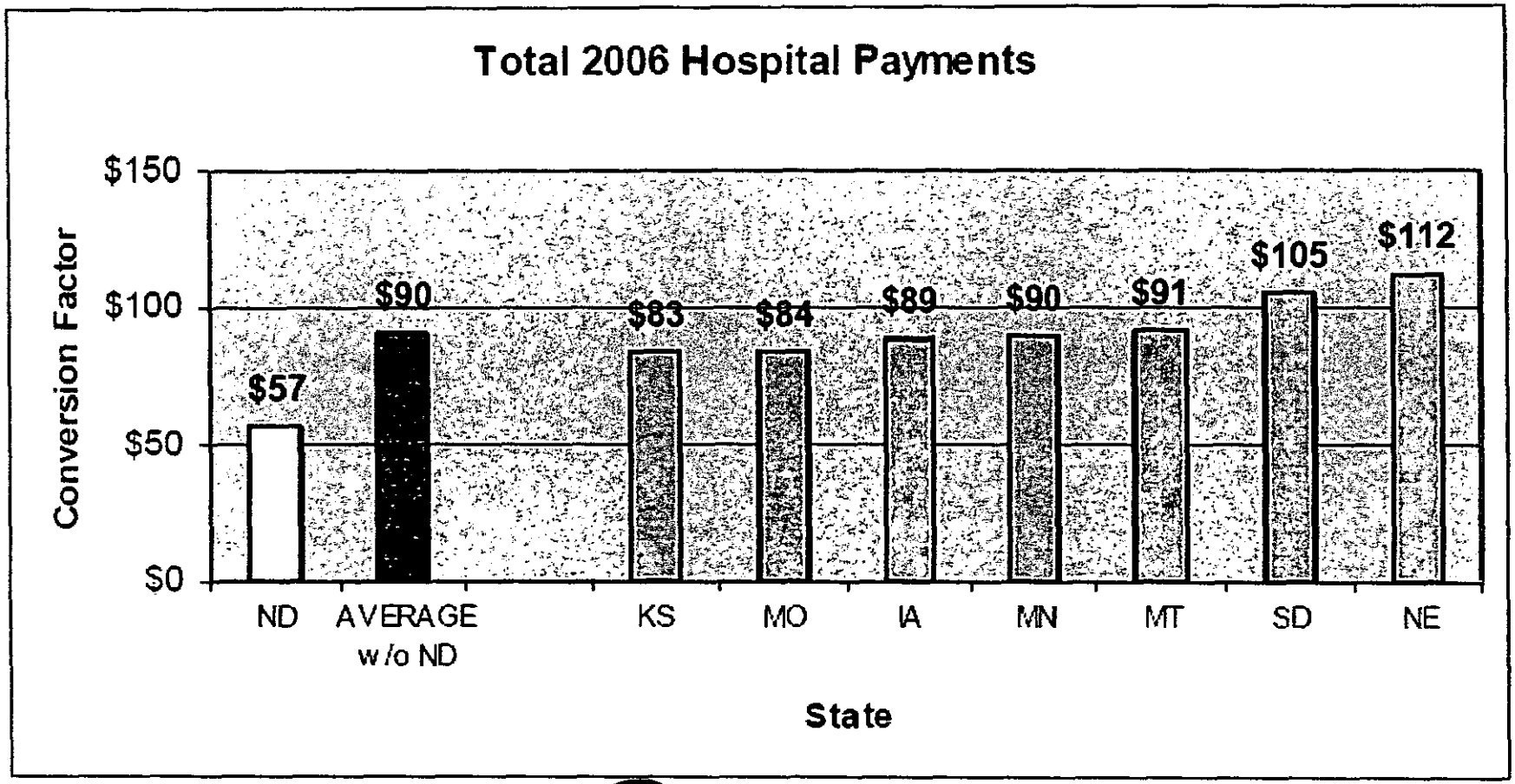
Exhibit 5

16



Milliman Private Insurer Study

Exhibit 8



Milliman Private Insurer Study

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North Dakota 2009 Legislative Session

Senate Appropriations Committee – Chairman Ray Holmberg

Testimony on House Bill 1012

March 2, 2009

Chairman Holmberg and Members of the Senate Appropriations Subcommittee:

My name is Beverley Adams and I am the Executive Administrator for the Health Policy Consortium (HPC). The Health Policy Consortium is comprised of Altru Health System in Grand Forks, MedCenter One Health System in Bismarck, MeritCare Health System in Fargo and Trinity Health System in Minot.

The four health systems that I represent, are integrated health systems they are not simply hospitals. They are hospitals, clinics, labs, physicians, all working under one system. This means that the physicians are employees of the hospital. Traditionally physicians owned their own businesses and had privileges to practice in the hospitals. The four health systems that comprise the HPC realized that having a healthcare system where the physicians are employed by the hospitals provides a more cost efficient and patient focused model of care, despite the reimbursement systems not rewarding quality and efficiency. As a result of the hospitals employing the physicians, these organizations are affected by both the rebasing of Medicaid on the hospital side and the rebasing on the

physician side. The integrated systems are affected by the Medicaid reimbursement on the hospital and the physician side.

These organizations provide specialty and sub-specialty care as well as a significant amount of high quality primary care in the most rural of communities, such as New Town, Cavalier and Wahpeton. In 2007/2008 the HPC health systems provided over $120 million of uncompensated care in either the form of bad debt and charity care services for the patients we serve. This is reflective of the substantial amount of care provided to the more than 80,000 under-insured and uninsured North Dakotans. These numbers will be rising significantly as the economy declines.

Your decisions relating to appropriations for reimbursement for Medicaid recipients has a profound impact on our ability to provide care to North Dakotans and the future viability of health care services within the State of North Dakota.

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Altru, MedCenter, MeritCare and Trinity have gone from showing a small profit margin in 2004 to negative margins in 2007. **Exhibit 1** is a slide showing the total operating margin for Trinity, MeritCare, MedCenter and Altru from 2004 to 2007. They also are losing ground with regard to their debt service coverage. **Exhibit 2.** Their average age of plant is also increasing. **Exhibit 3.** Also, in comparison to surrounding States, Missouri, Kansas, Minnesota, Iowa, Montana, Nebraska and South Dakota, the average operating margin was 6.9%, while North Dakota's state wide average is 1.8% in 2007. **Exhibit 4.**

The current financial crises is caused by the healthcare systems having no control over reimbursement rates and no control over rising costs. We are told what we are going to get paid and little if any consideration is given to the actual cost of providing the care. The current fee schedule for Medicaid for hospitals is approximately 30% less than cost to deliver the service. Commercial private payers are 19% below surrounding states and Medicare reimbursement is 30% to 40% below cost and Medicare consists of approximately 38% of the revenue generated by MeritCare alone.

The Medicare system also has built-in mechanisms to geographically adjust the payments in each area of the country. Significant portions of hospital payments are adjusted for the healthcare provider's relative wage index to the national average. The wage index for North Dakota is 82%, resulting in payments of $17 Million (for MeritCare alone) annually below the national average for the same services. Likewise, physician payments

are geographically adjusted and in North Dakota are 91% of the national average. For MeritCare alone, this equates to an additional $8 Million annually below the national average.

Nationally, Medicare payments are insufficient to cover hospital costs for Medicare patients. As a result, those losses must be covered through higher payment from commercial payers. In North Dakota, the BCBSND premiums are approximately 17% below surrounding states, such as Kansas, Missouri, Iowa, Nebraska, Minnesota and South Dakota. **Exhibit 5**. This results in lower reimbursement payments from commercial payers to healthcare providers. This results in North Dakota being unable to cover the losses and offset the inadequate government payers from the higher private commercial payers like the rest of the nation. However, the cost of providing care is not cheaper in North Dakota than surrounding States.

I want to briefly talk about the different payer sources and provide you with some detail on reimbursement in North Dakota, so we can better explain the financial difficulties that the healthcare systems in North Dakota are experiencing.

Medicaid has not been rebased to cost for approximately 17 years. Additionally, since the 1980's the amount of the annual increase in payments to hospitals and physicians has consistently been less than the increase in inflationary costs experienced by hospitals and physicians. In 2007 the legislature had the foresight to commission a study to determine what the actual cost of care is compared to reimbursement rates in order to determine fair

and equitable reimbursement rates for hospitals in North Dakota in the 2009 legislative session. The rebasing study showed that to get the inpatient, psych, rehab, outpatient and physician components to cost, it would require $29 Million of State General Funds for the biennium. **Exhibit 6.**

Based on this information it is clear that Medicaid has been historically under funded. The physician component of the rebasing study had the most significant adjustment as historically, it has been the most underpaid. This has caused the healthcare systems to provide services to Medicaid patients at a loss for the past 17 years.

The second payer I would like to discuss is Medicare. The Medicare Trust Fund is predicted to go bankrupt in 2014. Therefore, Medicare is taking significant steps to cut payments and is actively looking at payment system reform. Based on a Milliman Study prepared for Altru, Trinity, MedCenter One, MeritCare and Innovis analyzing Medicare reimbursement for North Dakota compared to surrounding states, North Dakota's reimbursement is 9% less than Kansas, Iowa, South Dakota, Montana, Missouri, Nebraska and Minnesota. **Exhibit 7.** Although 9% does not appear significant, if MeritCare alone was reimbursed at the average of the surrounding States, this would equate to an additional $25 to $30 Million annually.

The last groups of payers we are going to discuss is the commercial payer. As you know, BCBS has over 84% of the market share of the commercial healthcare coverage in North Dakota. As a result, there has not been equal bargaining footing between the parties

when reimbursement contracts are negotiated. As a result, BCBS has set reimbursement rates and terms and they do not negotiate provider contracts. The choices for hospitals are either to accept the unilateral terms which are subject to change with little notice throughout the year or go without a contract. If the hospitals do not have a contract this means that patients will be billed directly for hospital services and they would be financially responsible to the hospitals for the cost of care and would have to negotiate with BCBS what portion of their bill would be covered by insurance. Since there is no free market system in North Dakota with commercial insurance carriers, North Dakota is reimbursed approximately 19% less than surrounding States including Kansas, Missouri, Iowa, Minnesota, Montana, South Dakota and Nebraska by commercial payers in North Dakota for the same level of care. **Exhibit 8.** If MeritCare was paid the average of the surrounding States on private commercial payers alone, this would mean an additional $30 Million dollars per year.

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With North Dakota receiving lower reimbursement rates from all payers in comparison to surrounding States and lower rates in comparison to costs, it sheds light on the current financial crises North Dakota healthcare systems are facing. It is important to note that

the surrounding States are not the highest paid States relating to Medicare and private payer reimbursement, in the United States. We are not comparing ourselves with the highest reimbursed States in the Nation; we are comparing ourselves with States that are similarly situated to ourselves.

Throughout the nation, healthcare systems in other States, are compensated by higher private reimbursement when the government payers are paying less than cost. This is clearly demonstrated by **Exhibit 9** which is a graph which shows the national average comparison of cost to reimbursement by Medicare, Medicaid and private payers. As you can see when the government payers lower reimbursement, the private payer reimbursement increases and the converse of that statement is also true. When government payers increase reimbursement, private payers' reimbursement lowers. However this has not happened in North Dakota. Over the years, the government payers are reimbursing below cost and BCBS which has 84% of the market for private insurers has not increased their reimbursement to cover the losses on the government payer side. North Dakota has continued to keep premiums to individuals low and this has caused lower reimbursement rates on the private commercial payer side to the healthcare providers, while the costs of providing the care have continued to rise.

The current reimbursement system in North Dakota undermines our ability to invest in modern technology and to make needed improvements and repairs to facilities. It also reduces our ability to subsidize charity care. If the situation continues, North Dakota providers will become unattractive to physicians and to patients and out migration to

other states for health care will snowball, causing the State's healthcare system to collapse.

North Dakota hospitals have been recognized nationally for providing high quality and cost-effective healthcare. **Exhibit 10.** North Dakota is not wasting medical resources which cause the cost of care to rise. In fact in North Dakota it is just the opposite. Therefore the rising costs and current financial instability of the healthcare facilities in North Dakota is not attributable to financial mismanagement and wasting of resources.

A major contributor to rising costs in health care in North Dakota is the cost of recruiting physicians to North Dakota when they can live in other areas of the country that pay significantly more. North Dakota hospitals have to pay these physicians more money in order to recruit them to North Dakota than they would receive if they worked in New York, Florida, California and Texas. Currently for MeritCare alone, annually $18 Million additional funds are expended over and above the national compensation average for physicians in certain specialty practice areas. The government payers and the private payers do not take this into consideration when deciding what reimbursement rates will be to hospitals. In addition, technology and the cost of supplies continue to rise which creates additional contributors to rising health care costs, while reimbursement declines.

The current payment policy of increasing payments for hospital and physician services at an amount that is **consistently less than actual inflationary costs**, coupled with an inability to shift this un-funded cost of Medicaid services to other third party payers like

Blue Cross Blue Shield of North Dakota, will ultimately **jeopardize the hospital system and the delivery of care in North Dakota. Healthcare systems will be unable to provide the high quality, efficient healthcare services that patients in North Dakota have become accustom to.**

The financial crises for healthcare facilities will have a broad impact to the citizens of North Dakota and will affect the economy, and jobs in addition to the inability to attract individuals to North Dakota. It is essential that North Dakota continue to be recognized for its high quality and efficient manner that it provides healthcare. It is essential to have a viable healthcare system as it contributes to North Dakota's economy.

In 2002 a study was completed by NDHA to evaluate the healthcare industries' contribution to the economy in North Dakota. In 2002 Health services represented one of the State's largest employment sectors. In 2002 roughly 10.5% of all workers in North Dakota were employed by a healthcare organization and about 5.5% were employed by community hospitals. In 2002 - 8 of the top 12 largest employers in the state were health care providers. In 2002 hospitals generated over a billion dollars in total revenue each year, and much of the revenue represents new wealth to the State. In 2000 hospitals spent $1 Billion, 21 million, with the largest expense being payroll which on average was 43% of each hospital's total annual expense budget. The 43% only included salaries and not other employee benefits. A large majority of the hospitals' expenses are spent in North Dakota. On average 83.6% of the dollars remain in the State. Of the 16.4% of the dollars going out of state the majority is spent on supplies. Clearly, it is important to the

economic stability of North Dakota for the healthcare systems to continue as strong economic engines. Also, it is essential have a strong comprehensive healthcare system if you want to encourage economic development. North Dakota is moving towards a place of economic opportunity. Our wind power, oil and our financial surplus has helped us move in that direction. We need to maintain the infrastructure to continue to move in that direction. Your influence and decision making can assist us in staying out of the deep abyss that the rest of the nation is experiencing.

In summary, it is imperative that the healthcare reimbursement ecosystem is balanced. Hospitals cannot survive under the current reimbursement system and each payer needs to evaluate and reimburse the hospitals equitably for their use of the valuable healthcare resources in this community. Hospitals are large economic drivers in the State with many North Dakotans relying on jobs in healthcare systems. In order to keep young people and business from migrating from the State and attract them to the State of North Dakota, we need to have financially viable, stable and comprehensive healthcare systems.

MeritCare, Altru, MedCenter and Trinity, are very appreciative and support the Governor's Budget and the proposed increase that brings payment for physician services closer to cost (64% of cost) as well as the positions of NDHA and NDMA. However to rebase physicians at less than cost, simply perpetuates the inequitable payment system that contributes to the overall financial strains on healthcare systems. We respectfully request that this committee accept the Governor's proposed budget with respect to Medicaid funding for both the hospital and the

physician component in addition to considering rebasing the physician component to cost. This would require an additional $14,699,550.00 in general funds for the biennium, in addition to the $4,899,850 for the physician component which has already budgeted. At this level, physician payments would rebase from 51% to about 100% of cost.

Mr. Chairman and members of the Committee, thank you for the opportunity to address you this morning. I am willing to respond to your questions.

First 6 exhibits same as attached to testimony of 1-26-09

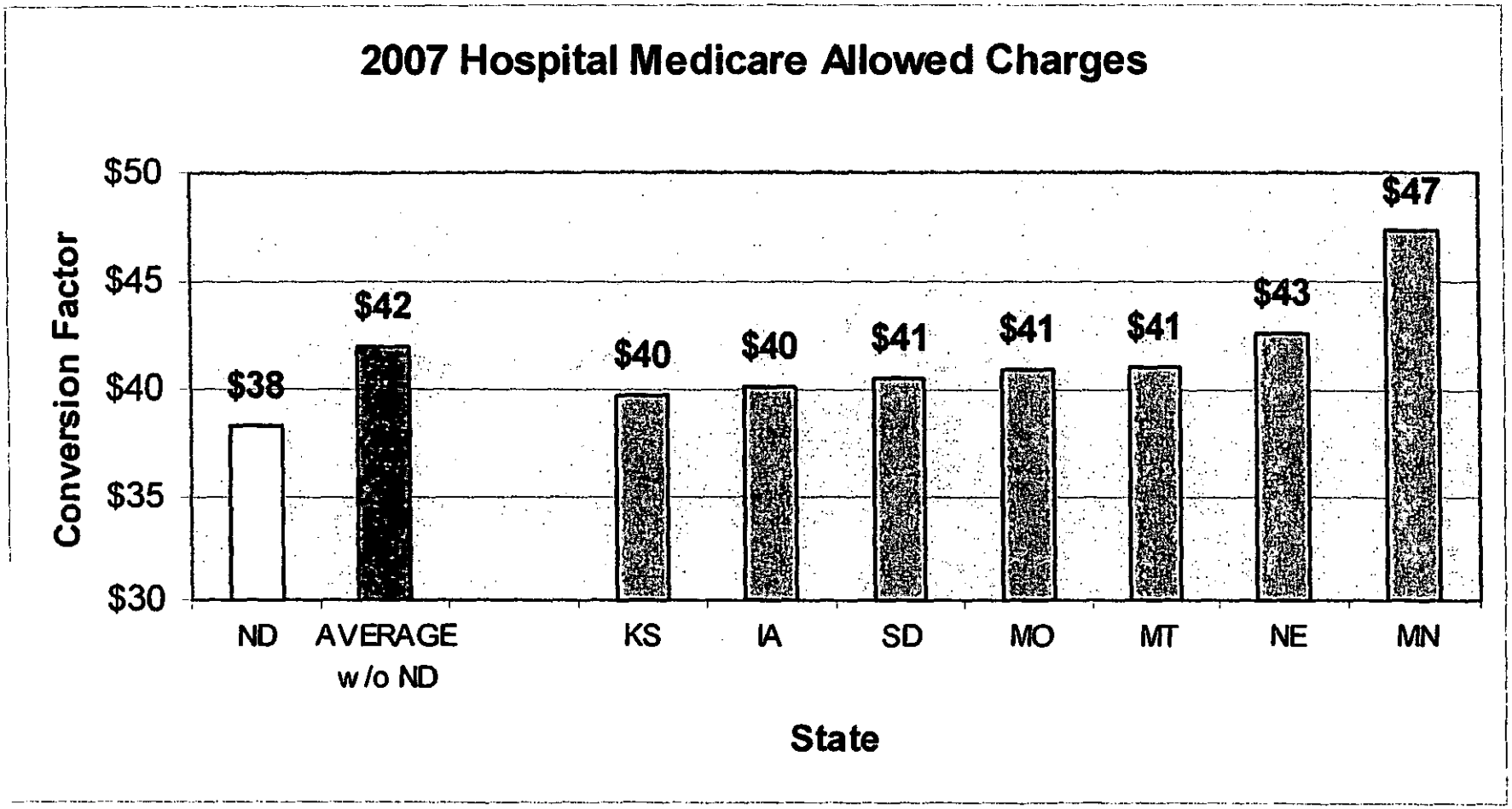
Exhibit 6

MeritCare

Cost Study for Rebasing Medicaid (biennial costs)

Service	Total Dollars Per biennium	General Funds (37%)
Inpatient	$17.0 M	$6.29 M
Psych	$2.3 M	$0.85 M
Rehab	$1.3 M	$0.49 M
Outpatient	$1.2 M	$0.48 M
Physician *	$53.0 M	$19.98 M

Exhibit 7



MILLIMAN

Medicare Comparison Study

Exhibit 8

EXECUTIVE SUMMARY

At the request of the North Dakota Medical Association (NDMA), Milliman has prepared a report comparing health insurance premiums and provider reimbursement levels in North Dakota against other nearby states. We were originally tasked with a comparison against other states in CMS' West North Central Region (Iowa, Kansas, Minnesota, Missouri, Nebraska and South Dakota). We have also added data for Montana, where available, due to similarities in the health care markets in Montana and North Dakota.

The analysis consists of five separate components each comparing North Dakota to the comparison states:

- Section I – health insurance premiums
- Section II – private payer hospital reimbursement
- Section III – private payer physician reimbursement
- Section IV – hospital operating costs
- Section V – hospital operating margins.

In general, North Dakota has lower premiums, provider costs and provider reimbursement levels than the benchmark comparison states. Table A below summarizes the key results for North Dakota and the benchmark states.

Table A
SUMMARY OF KEY RESULTS

Measure	North Dakota	Comparison States' Average	North Dakota vs Other States
I. Average Premium	$332	$399	83%
II. Private Payer Hospital Reimbursement per RVU - Geog. Adjusted	$66	$96	69%
III. Private Payer Physician Reimbursement as % of Medicare - Geog. Adjusted	152%	164%	93%
IV. Hospital Costs per RVU - Geog. Adjusted	$44	$49	91%
V. FY 2007 Total Hospital Operating Margin	1.8%	6.9%	-5.1%

The premium comparison is not adjusted for the relative costs in North Dakota, however the other measures were geographically adjusted for wage and capital cost differences using Medicare geographic adjustments.

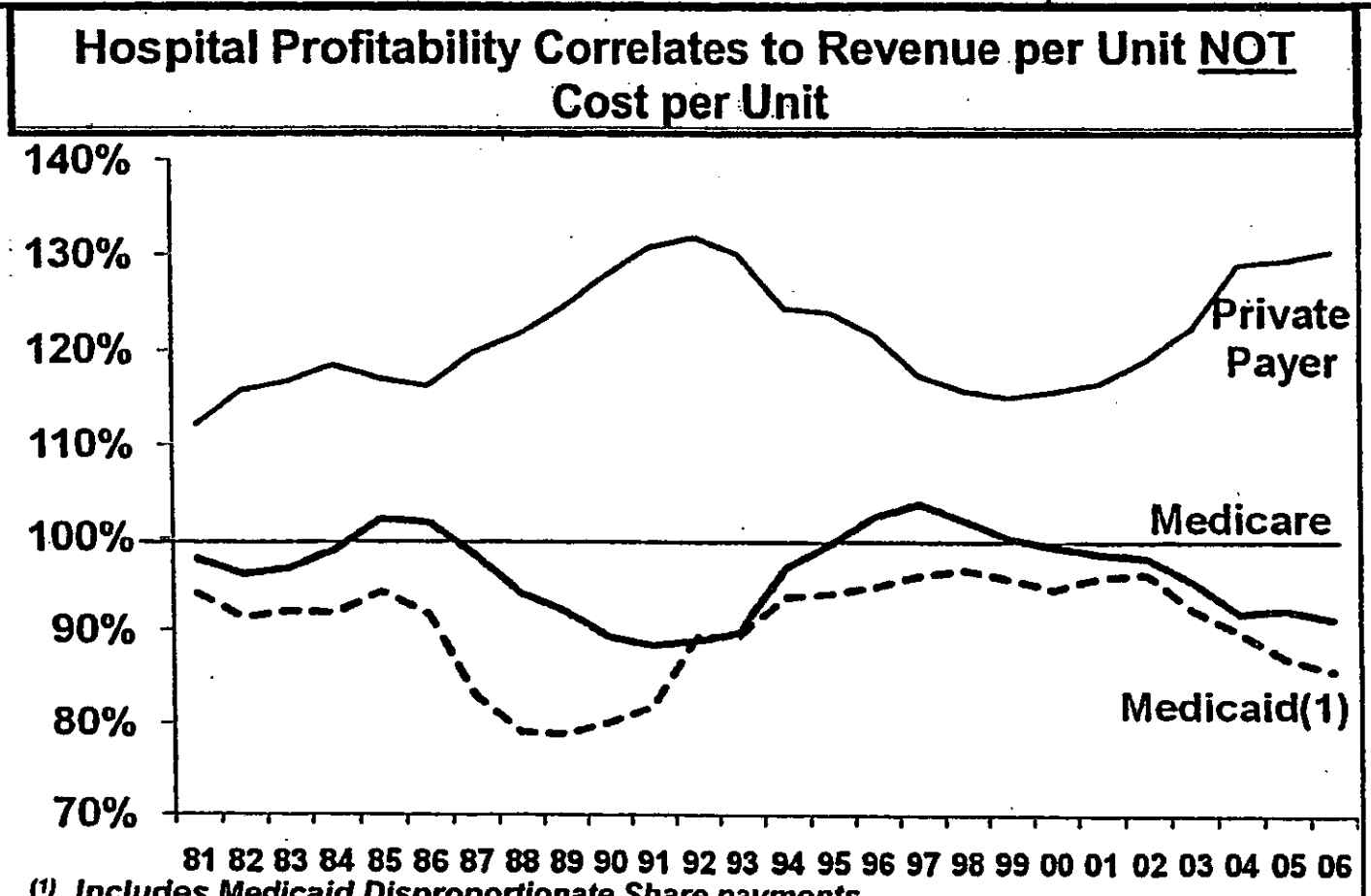
The rest of this report presents our methodology, assumptions and additional details comparing North Dakota to the comparison states.

EXHIBIT

Exhibit 9

KAUFMAN
Strategic Advisors, LLC

Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare, and Medicaid, 1981 – 2006

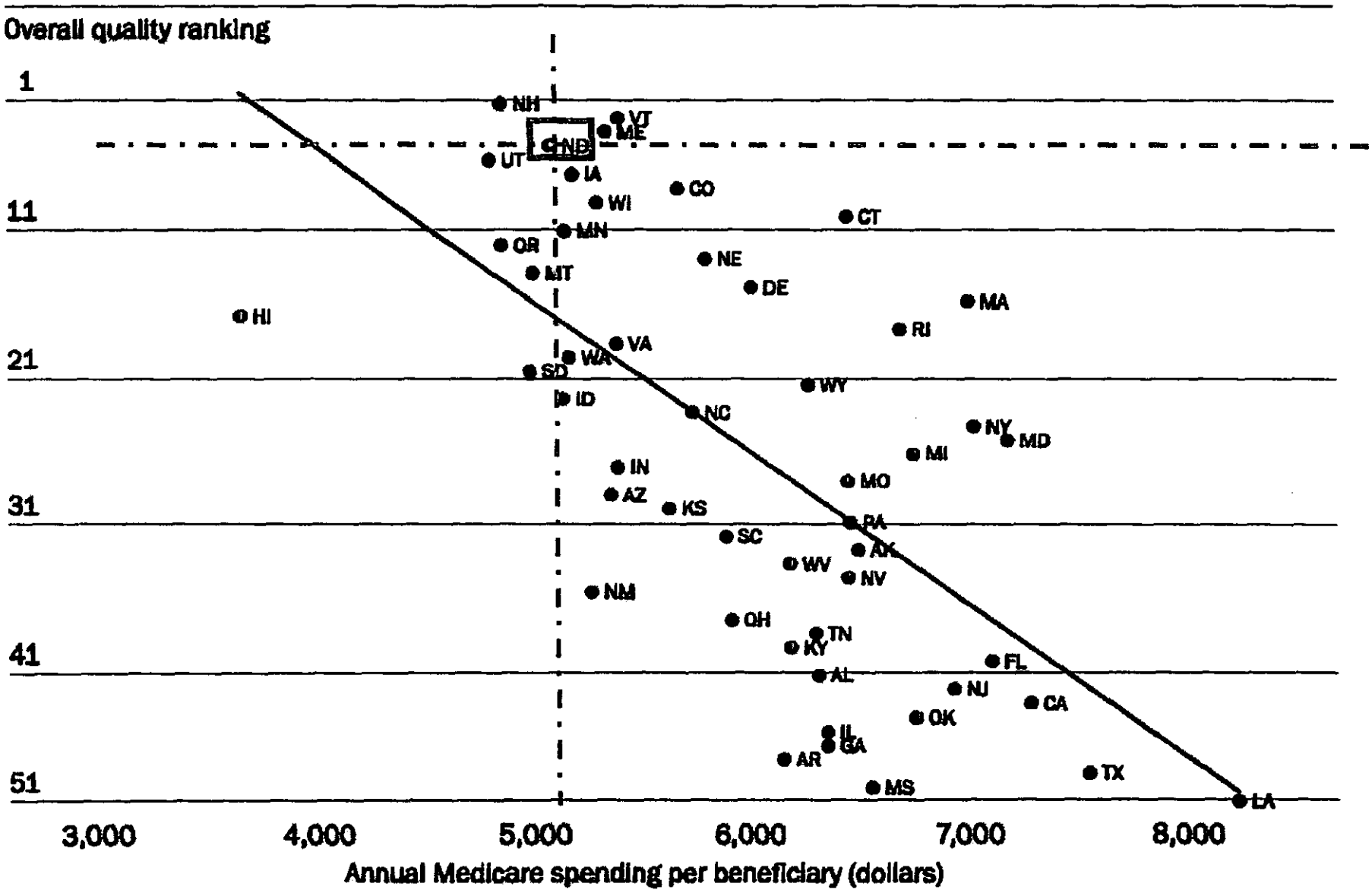


(1) *Includes Medicaid Disproportionate Share payments.*

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2006, for community hospitals.

Exhibit 10

Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001



SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
NOTE: For quality ranking, smaller values equal higher quality.

Department of Human Services
2009 - 2011 Budget
Rebasing Studies

DESCRIPTION	TOTAL	GENERAL	FEDERAL / OTHER
Physicians @100%			
1 YEAR	26,500,000	9,799,700	16,700,300
BIENNIUM	53,000,000	19,599,400	33,400,600
Physicians @75%			
1 YEAR	19,875,000	7,349,775	12,525,225
BIENNIUM	39,750,000	14,699,550	25,050,450
Physicians @50%			
1 YEAR	13,250,000	4,899,850	8,350,150
BIENNIUM	26,500,000	9,799,700	16,700,300
Physicians @25%			
1 YEAR	6,625,000	2,449,925	4,175,075
BIENNIUM	13,250,000	4,899,850	8,350,150

North Dakota Department of Human Services
Effects of Payouts on Monthly cost per unit

Month 1

	Units	Amount Paid
Provider 1 - Payout is made	-	1,000
Provider 2 - Claims processed thru MMIS	2	200
Total	2	1,200

Cost per unit Month 1	**600**
(1,200 / 2 = 600)	

Month 2

	Units	Amount Paid
Provider 1 - Based upon claims processed thru MMIS $250 to be paid ($1,000 - $250 = $750 payout remaining to be processed thru MMIS)	3	-
Provider 2 - Claims processed thru MMIS	2	200
Total	5	200

Cost per unit Month 2	**40**
(200 / 5 = 40)	

Summary

Actual claims process thru MMIS Month 1	2	200
Actual claims process thru MMIS Month 2	3	250
Actual claims process thru MMIS Month 3	2	200
	7	650

Actual Cost per unit Month 1 & 2	**93**
(650 / 7 = 93)	

Department of Human Services
HB 1012
Rebased Providers (those with cost reports)

	Hospitals	Physicians	Chiropractors	Ambulance	Total
100% Rebasing as reflected in Consultant's Report					
General	8,140,450	19,599,400	153,836	1,998,158	29,891,844
Federal	13,872,664	33,400,600	262,164	3,405,192	50,940,620
Total	22,013,114	53,000,000	416,000	5,403,350	80,832,464
90% of Rebasing Report					
General	7,326,405	17,639,460	138,452	1,798,342	26,902,659
Federal	12,485,398	30,060,540	235,948	3,064,673	45,846,559
Total	19,811,803	47,700,000	374,400	4,863,015	72,749,218
75% of Rebasing Report					
General	6,105,338	14,699,550	115,377	1,498,619	22,418,884
Federal	10,404,498	25,050,450	196,623	2,553,894	38,205,465
Total	16,509,836	39,750,000	312,000	4,052,513	60,624,349
50% of Rebasing Report					
General	4,070,225	9,799,700	76,918	999,079	14,945,922
Federal	6,936,332	16,700,300	131,082	1,702,596	25,470,310
Total	11,006,557	26,500,000	208,000	2,701,675	40,416,232
25% of Rebasing Report					
General	2,035,113	4,899,850	38,459	499,540	7,472,962
Federal	3,468,166	8,350,150	65,541	851,298	12,735,155
Total	5,503,279	13,250,000	104,000	1,350,838	20,208,117

Executive Budget Recommendation

	100% of rebased amount	25% of rebased amount	100% of rebased amount	Rebased at Medicare rates	Total
General	8,140,450	4,899,850	153,836	743,710	13,937,846
Federal	13,872,664	8,350,150	262,164	1,267,404	23,752,382
Total	22,013,114	13,250,000	416,000	2,011,114	37,690,228

HB 1012 to the SENATE	100% of rebased amount	20% of rebased amount	75% of rebased amount	75% of Executive Budget	Total
General	8,140,450	3,919,880	115,378	557,783	12,733,491
Federal	13,872,664	6,680,120	196,622	950,553	21,699,959
Total	22,013,114	10,600,000	312,000	1,508,336	34,433,450

Department of Human Services
HB 1012
Rebased Providers (those with cost reports)

	Hospitals	Physicians	Chiropractors	Ambulance	Total
DIFFERENCES					
100% Rebasing as reflected in Consultant's Report					
General	8,140,450	19,599,400	153,836	1,998,158	29,891,844
Federal	13,872,664	33,400,600	262,164	3,405,192	50,940,620
Total	22,013,114	53,000,000	416,000	5,403,350	80,832,464
90% of Rebasing Report					
General	(814,045)	(1,959,940)	(15,384)	(199,816)	(2,989,185)
Federal	(1,387,266)	(3,340,060)	(26,216)	(340,519)	(5,094,061)
Total	(2,201,311)	(5,300,000)	(41,600)	(540,335)	(8,083,246)
75% of Rebasing Report					
General	(2,035,112)	(4,899,850)	(38,459)	(499,539)	(7,472,960)
Federal	(3,468,166)	(8,350,150)	(65,541)	(851,298)	(12,735,155)
Total	(5,503,278)	(13,250,000)	(104,000)	(1,350,837)	(20,208,115)
50% of Rebasing Report					
General	(4,070,225)	(9,799,700)	(76,918)	(999,079)	(14,945,922)
Federal	(6,936,332)	(16,700,300)	(131,082)	(1,702,596)	(25,470,310)
Total	(11,006,557)	(26,500,000)	(208,000)	(2,701,675)	(40,416,232)
25% of Rebasing Report					
General	(6,105,337)	(14,699,550)	(115,377)	(1,498,618)	(22,418,882)
Federal	(10,404,498)	(25,050,450)	(196,623)	(2,553,894)	(38,205,465)
Total	(16,509,835)	(39,750,000)	(312,000)	(4,052,512)	(60,624,347)
Executive Budget Recommendation					
General	-	(14,699,550)	-	(1,254,448)	(15,953,998)
Federal	-	(25,050,450)	-	(2,137,788)	(27,188,238)
Total	-	(39,750,000)	-	(3,392,236)	(43,142,236)
HB 1012 to the SENATE					
General	-	(979,970)	(38,458)	(185,927)	(1,204,355)
Federal	-	(1,670,030)	(65,542)	(316,851)	(2,052,423)
Total	-	(2,650,000)	(104,000)	(502,778)	(3,256,778)

C

North Dakota Department of Human Services
Comparison of the '07-'09 Appropriation to the Rebased Amount
Compiled by bmw
12/05/08 8:04

Description	'07 - '09 Appropriation Total	Year 1 Rebasing only Total	% Change
Hospitals	156,680,242	22,013,114	14.05%
Physician Services	64,125,174	13,250,000	20.66%
Dental Services	13,323,341	2,445,138	18.35%
Ambulance Services	2,964,019	2,011,114	67.85%
Chiropractic Services	455,167	416,000	91.40%

North Dakota Department of Human Services
HB 1012 – Traditional Medicaid Services
Billed to Paid Percentage
Dates of Service SFY2007

Provider Type	% of Paid to Billed Amount
Physicians	40.50%
Hospitals	40.48%
Ambulance	29.08%
Chiropractors	35.13%

J

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[illegible]ministrative Assistant

Testimony on House Bill No. 1012
House Human Resources Division
House Appropriations Committee
January 26, 2009

Good morning Chairman Pollert and Committee Members. I'm Robert Thompson. I'm a physician from Grand Forks and practice as an allergist/immunologist and also have administrative duties as executive medical director through which I oversee Altru's care management team and medical specialty and clinical support divisions, including imaging and laboratory services. I was raised in Velva, ND and earned my medical degree from the UND School of Medicine & Health Sciences.

I also serve as the current president of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents and medical students.

First of all, I want to thank you for your efforts last legislative session. You provided the first significant update in payments (5% -- 4%) in recent memory. You also put into motion the studies undertaken this past interim by consultants hired by the Department of Human Services to determine what it would take to bring reimbursement for physician and hospital services in line with what it actually costs to provide those services.

Since 2002, the NDMA has expressed the concern of North Dakota's medical community that the Medicaid payment methodology has resulted in payments being substantially less than the actual cost of providing medical services to our Medicaid patients. The ramifications of this are very significant, and that is what I hope to talk with you about this morning.

Our physicians provide the safety net medical services for the most vulnerable of our population – a population of Medicaid patients who present unique, and often some of most difficult, challenges. Our Medicaid patients benefit from

the services we are able to provide them – from a North Dakota health care system that is recognized nationally as a high-quality, efficient health care system. However, we have unique healthcare workforce recruitment and retention challenges occurring in our state that are driven by our demographics, payor reimbursement policies and other practice issues. Our capital needs continue to grow, with aging facilities, technology and equipment – we have the oldest age of plant in the country. Our costs for medical equipment, new technology and supplies continue to increase.

One of our challenges is that, across the board, we are a "poor payor state." According to the methodology developed by the Department's consultant, The Public Consulting Group, physician services in the Medicaid program are reimbursed at about 51% of the cost to provide those services. The commercial market through BlueCross BlueShield of North Dakota pays for medical and hospital services at levels considerably less in North Dakota than by commercial insurers in other states in our region. In Medicare, there is substantial *geographic disparity* in patient services and physician reimbursement levels which is having an increasingly negative impact on patient care and access in North Dakota.

As physicians, we are very concerned that this continuing trend of poor payment does not bode well for the future of health care in North Dakota, and in time the access and quality in health care enjoyed in the state will deteriorate rapidly as health care resources become increasingly scarce and health care workforce and capital needs are not met. We are working on all these avenues that provide resources to sustain our health care system. We suggest that the Medicaid program must do its part to ensure fair payment for the actual cost of medical care received by its Medicaid patients, just as commercial insurers and the federal government must do their part.

Physicians are ethically bound to support access to medical care for all people, and we have been very much involved in efforts to ensure the long-term sustainability of the Medicaid program in North Dakota. We have always hoped that this focus would lead to a fair and equitable payment system that funds medical services to appropriate levels, helping to ensure that there is continued access to quality care for Medicaid patients.

We appreciate the efforts of the 2007 Legislative Assembly in appropriating funds to the Department for hiring consultants to determine what it would take financially to bring physician and hospital payments to a level that matches what it actually costs to provide services to our Medicaid patients.

We also appreciate the efforts of the Department's staff in including us in discussions with the consultant, The Public Consulting Group, which studied and determined that physician payments currently reimburse physician services at about 51% of what it costs to provide those services.

We appreciate the recognition by Governor Hoeven in the executive budget of the need to rebase physician payments. As you know, the executive budget would appropriate 25% of the amount it would take to reimburse for physician services at actual cost. This limited "rebase" would increase physician payments from 51% to about 64% of the actual cost to provide physician services, using the methodology of the consultant. Other Medicaid service providers are being rebased at much higher levels. You were provided by the Department with a schedule that identifies various funding levels to provide 50%, 75% or 100% of the amount it would take to rebase physician services to 100% of cost, which is attached to my written testimony.

Under the scenarios you received from the Department, a rebase at 50% of what the consultant said it would take to bring physician payments to actual cost would cost an additional $4,899,850 in general funds for the biennium, in addition to the $4,899,850 already budgeted. At this level, physician payments would rebase from 51% to about 75% of cost. A rebase at 75% of what the consultant said it would take to bring physician payments to actual cost would cost an additional $9,799,700 in general funds for the biennium, in addition to the $4,899,850 already budgeted. At this level, physician payments would rebase from 51% to about 89% of cost. A rebase at 100% of what the consultant said it would take to bring physician payments to actual cost would cost an additional $14,699,550 in general funds for the biennium, in addition to the $4,899,850 already budgeted. At this level, physician payments would rebase from 51% to about 100% of cost.

The North Dakota Medical Association supports the Governor's budget and the proposed increase that brings payment for physician services closer to cost (64% of cost). However, to rebase at less than cost only continues a pattern of inequitable payment that will continue to hinder our ability to maintain a health care system in our state that provides higher quality at less cost than most other states in the country. We encourage you to consider further investments that would better reflect the intent to rebase to cost, and a legislative commitment to ensuring future access to care for Medicaid patients.

Physicians in North Dakota do their part in providing good access to quality medical care for Medicaid beneficiaries while receiving reimbursement well below the cost for that care. Our Medical Association and individual physicians are committed to the long-term sustainability of the Medicaid program. We continue to participate in the Department's prescription drug cost containment and disease management initiatives, as well as discussions about future Medicaid reform options. We also help to resolve service issues for Medicaid providers and patients as they arise. Our concern is that low reimbursement rates and administrative burdens not continue to create any more difficulty for physicians in treating Medicaid patients.

We look forward to working with your Human Resources Division, Chairman Pollert, in addressing the need for equitable payment for Medicaid medical services. Thank you.

I

Resolution

Introduced By: **NDMA Council (Commission on Socio Economics)**
Subject: **Support Rebase of Medicaid Physician Payments to Actual Cost**

A resolution urging the Governor and the 2009 North Dakota Legislative Assembly to support steps to rebase Medicaid physician payments to actual cost based on the findings and conclusions of the state's consultant.

WHEREAS, in 2007, 2005 and 2003, the NDMA House of Delegates adopted resolutions urging the Governor and North Dakota Legislative Assembly to take steps to address the unfairness of state Medicaid rates that do not cover practice costs for physicians and hospitals; and

WHEREAS, in the 2007 North Dakota Legislative Assembly NDMA advocated successfully for an appropriation to the ND Department of Human Services to hire a health care consultant during the 2007-08 interim to develop a method for rebasing hospital, physician, and ambulance services payment rates under the Medicaid program to actual cost and to develop cost estimates for the 2009-11 biennium on this actual cost basis and report its findings directly to the 2009 appropriations committees; and

WHEREAS, the consultant, The Public Consulting Group, determined that the biennial budget for Medicaid physician fee schedule would need to nearly double to pay physicians for the actual cost of providing medical care to their Medicaid patients and that the weighted average cost per RVU calculated by the consultant is $77.15, as compared to the current $39.13 conversion factor; and

WHEREAS, according to the ND Department of Human Services, it will take an increase of $19.5 million in general funds ($53 million total state and federal) to rebase Medicaid physician payments to actual cost; and

WHEREAS, NDMA has participated actively within forums established by the Governor and Department of Human Services since 2002 in efforts to rebase Medicaid physician payments to ensure continued good access to medical care for Medicaid beneficiaries and initiate other reforms to the Medicaid program to ensure the program's long-term sustainability;

THEREFORE, BE IT RESOLVED BY THE 2008 HOUSE OF DELEGATES OF THE NORTH DAKOTA MEDICAL ASSOCIATION urging the Governor and the 2009 North Dakota Legislative Assembly to support steps to rebase Medicaid physician payments to actual

cost based on the findings and conclusions of the state's consultant; and

BE IT FURTHER RESOLVED, that these steps include consideration of developing a mechanism for periodic rebasing by the ND Department of Human Services of Medicaid physician and hospital payments; and

BE IT FURTHER RESOLVED that copies of this resolution be forwarded to Governor John Hoeven and the Appropriations Committee Chairs of the North Dakota Senate and House of Representatives.

Adopted September 19, 2008

Steven P. Strinden, Speaker of the House
North Dakota Medical Association

NORTH DAKOTA MEDICAL ASSOCIATION

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Testimony on Engrossed HB No. 1012
Senate Appropriations Committee
March 9, 2009

Chairman Holmberg and Committee Members, I'm Bruce Levi and I serve as executive director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents and medical students.

First of all, I want to thank you for your efforts last legislative session. You provided a significant update in payments (5% -- 4%) and also put into motion the studies undertaken this past interim by consultants hired by the Department of Human Services to determine what it would take to bring reimbursement for physician and hospital services in line with what it actually costs to provide those services.

Since 2002, the NDMA has expressed the concern of North Dakota's medical community that the Medicaid payment methodology has resulted in payments being substantially less than the actual cost of providing medical services to our Medicaid patients.

Our physicians provide the safety net medical services for the most vulnerable of our population – a population of Medicaid patients who present unique, and often some of most difficult, challenges. Our Medicaid patients benefit from the services physicians are able to provide them – from a North Dakota health care system that is recognized nationally as a high-quality, efficient health care system. However, we have unique healthcare workforce recruitment and retention challenges occurring in our state that are driven by our demographics, payor reimbursement policies and other practice issues. Our capital needs continue to grow, with aging facilities, technology and equipment – we have the oldest age of plant in the country. Our costs for medical equipment, new technology and supplies continue to increase.

One of our challenges is that, across the board, we are a "poor payor state." According to the methodology developed by the Department's consultant, The Public Consulting Group, physician services in the Medicaid program are reimbursed at about 51% of the cost to provide those services. The commercial market through BlueCross BlueShield of North Dakota pays for medical and hospital services at levels considerably less in North Dakota than by commercial insurers in other states in our region. In Medicare, there is substantial *geographic disparity* in patient services and physician reimbursement levels which is having an increasingly negative impact on patient care and access in North Dakota.

As physicians, we are very concerned that this continuing trend of poor payment does not bode well for the future of health care in North Dakota, and in time the access and quality in health care enjoyed in the state will deteriorate rapidly as health care resources become increasingly scarce and health care workforce and capital needs are not met. We are working on all these avenues that provide resources to sustain our health care system. We suggest that the Medicaid program must do its part to ensure fair payment for the actual cost of medical care received by its Medicaid patients, just as commercial insurers and the federal government must do their part.

Physicians are ethically bound to support access to medical care for all people, and we have been very much involved in efforts to ensure the long-term sustainability of the Medicaid program in North Dakota. We have always hoped that this focus would lead to a fair and equitable payment system that funds medical services to appropriate levels, helping to ensure that there is continued access to quality care for Medicaid patients.

We appreciate the recognition by Governor Hoeven in the executive budget of the need to rebase physician payments. As you know, the executive budget would appropriate 25% of the amount it would take to reimburse for physician services at actual cost. This limited "rebase" would increase physician payments from 51% to about 64% of the actual cost to provide physician services, using the methodology of the consultant. Other Medicaid service providers are being rebased at much higher levels. The House was provided a schedule by the Department that identifies various funding levels to provide 50%, 75% or 100% of the amount it would take to rebase physician services to 100% of cost. *In the House, the*

appropriation for Medicaid physician payments was decreased from 25% to 20% of the amount it would take to reimburse for physician services at actual cost. After the House action, this limited "rebase" would increase physician payments from 51% to about 60% (rather than 64% under the executive budget) of amount it would take to rebase physician services to 100% of cost, using the methodology of the consultant. The House also decreased the second year "inflator" from 7% to 6% for physician payments.

Under the scenarios received from the Department, a rebase at 50% of what the consultant said it would take to bring physician payments to actual cost would cost an additional $4,899,850 in general funds for the biennium, in addition to the $4,899,850 in the executive budget. At this level, physician payments would rebase from 51% to about 75% of cost. A rebase at 75% of what the consultant said it would take to bring physician payments to actual cost would cost an additional $9,799,700 in general funds for the biennium, in addition to the $4,899,850 in the executive budget. At this level, physician payments would rebase from 51% to about 89% of cost. A rebase at 100% of what the consultant said it would take to bring physician payments to actual cost would cost an additional $14,699,550 in general funds for the biennium, in addition to the $4,899,850 in the executive budget. At this level, physician payments would rebase from 51% to about 100% of cost.

The North Dakota Medical Association supports the executive budget and the proposed increase that brings payment for physician services closer to cost (64% of cost). However, to rebase at less than 100% of cost only continues a pattern of inequitable payment that will continue to hinder our ability to maintain a health care system in our state that provides higher quality at less cost than most other states in the country. We encourage you to consider further investments that would better reflect the intent to rebase to 100% of cost, and a legislative commitment to ensuring future access to physician services for Medicaid patients.

Physicians in North Dakota do their part in providing good access to quality medical care for Medicaid beneficiaries while receiving reimbursement well below the cost for that care. Our Medical Association and individual physicians are committed to the long-term sustainability of the Medicaid program. We continue to participate in the Department's prescription drug

cost containment and disease management initiatives, as well as discussions about future Medicaid reform options. We also help to resolve service issues for Medicaid providers and patients as they arise. Our concern is that low reimbursement rates and administrative burdens not continue to create any more difficulty for physicians in treating Medicaid patients.

We look forward to working with the Committee in addressing the need for equitable payment for Medicaid medical services. Thank you.

B

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Human Services Budget

January 26, 2009

Testimony – Human Services Appropriations Committee
North Dakota EMS Association
Mark Weber, NDEMSA President

Good Morning Chairman Pollert and members of the committee. My name is Mark Weber, I am the President of the North Dakota Emergency Medical Services (EMS) Association and the EMS Director at the Heart of America Medical Center in Rugby. I thank you for the opportunity to testify in support of the Ambulance Medicaid Rebasing.

Currently Medicaid reimbursement for ambulance services is well below the cost of providing service especially in the rural areas. For the last few years we have been working closely with the Department of Human Services toward a fair reimbursement rate for ambulance services. We were involved with the ambulance rebasing study and appreciate being allowed to assist the department. We believe the 2009-2011 budget reflects a increase that is long overdue. This increase will put the reimbursement rate close to the Medicare reimbursement levels. Which in most rural areas of ND is less than half of the actual costs of providing service?

Obviously there are many issues facing ND Ambulance Services, funding is a primary concern. By increasing the Medicaid reimbursement rates for ambulance services you will help keep services available.

Chairman Pollert, thank you for this opportunity to testify and I would be happy to answer questions the committee may have.

North Dakota Department of Human Services
HB 1012 – Traditional Medicaid Services
Ambulance Codes - Billed to Paid Percentage

Code	Procedure Code Description	Amount Billed	Amount Paid	% of Paid to Billed Amount
A0425	GROUND MILEAGE	$1,154,636.25	$501,468.46	43.43%
A0426	ALS, NON-EMERGENCY TRANSPORT	$120,028.84	$40,127.00	33.43%
A0427	ALS, EMERGENCY TRANSPORT	$1,580,720.50	$479,199.16	30.32%
A0428	BLS, NON-EMERGENCY TRANSPORT	$117,683.93	$24,399.82	20.73%
A0429	BLS, EMERGENCY TRANSPORT	$701,085.06	$208,717.63	29.77%
A0430	TRANSPORT (FIXED WING)	$289,300.48	$66,759.04	23.08%
A0431	TRANSPORT (ROTARY WING)	$355,681.20	$57,561.12	16.18%
A0435	FIXED WING AIR MILEAGE	$349,262.27	$195,574.51	56.00%
A0436	ROTARY WING AIR MILEAGE	$246,221.85	$57,804.27	23.48%
A0998	AMBULANCE RESPONSE/TREATMENT	$67,171.24	$20,205.00	30.08%

In 2007 SB2012, appropriation for ambulance providers was given for general funds of $125,000 (federal match at $222,029) for a total of $347,029 along with the 4% + 5% inflationary increase. With input from the NDEMSA, the additional appropriation was allocated to Ground Mileage Rates, BLS Non-Emergency Transport, & BLS Emergency Transport.

Department of Human Services
Medical Services
HB 1012
Ambulance Medicaid / Medicare Rate Comparison

HCPCS	Code Description	Medicaid Fee	Medicare Fee	Medicaid to Medicare %
A0425 - BLS	GROUND MILEAGE, BLS	$5.41	$6.87	78.75%
A0425 - ALS	GROUND MILEAGE, ALS	$6.17	$6.87	89.81%
A0426	ALS, NON-EMERGENCY TRANSPORT	$239.37	$228.59	104.72%
A0427	ALS, EMERGENCY TRANSPORT	$282.56	$361.93	78.07%
A0428	BLS, NON-EMERGENCY TRANSPORT	$128.96	$190.49	67.70%
A0429	BLS, EMERGENCY TRANSPORT	$207.15	$304.79	67.96%
A0430	TRANSPORT (FIXED WING)	$882.67	$2,623.22	33.65%
A0431	TRANSPORT (ROTARY WING)	$882.67	$3,049.87	28.94%
A0435	FIXED WING AIR MILEAGE	$9.41	$8.07	116.60%
A0436	ROTARY WING AIR MILEAGE	$9.41	$21.53	43.71%

Notes

- *Medicaid Fees Effective 07/01/2008*
- *Medicare Fees Effective 01/01/2009 using Medicare Urban Base Rates and Mileage*

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Human Services Budget HB1012

March 4th, 2009

Testimony – Senate Appropriations Committee
North Dakota EMS Association
Mark Weber, NDEMSA President

Good Morning Chairman Holmberg and members of the committee. My name is Mark Weber, I am the President of the North Dakota Emergency Medical Services (EMS) Association and the EMS Director at the Heart of America Medical Center in Rugby. I thank you for the opportunity to testify in support of the Ambulance Medicaid Rebasing.

Currently Medicaid reimbursement for ambulance services is well below the cost of providing service, especially in the rural areas. The 2007 legislative body provided funding for a rebasing study of ambulance service Medicaid reimbursement. The study found that the cost to provide an ambulance transport in rural ND is $830.32 per transport. ND Medicaid reimburses $207.15 for a BLS base rate and $5.41/mile so in Rugby we would receive $212.56 when we transport a patient that has Medicaid as their payer, which is a $617.76 shortfall.

For the last few years we have been working closely with the Department of Human Services toward a fair reimbursement rate for ambulance services. We were involved with the ambulance rebasing study and appreciate being allowed to assist the department. We believe the 2009-2011 budget reflects an increase that is long overdue. This increase will put the reimbursement rate close to the Medicare reimbursement levels $307.77 per run which in most rural areas of ND is still less than half of the actual costs of providing service?

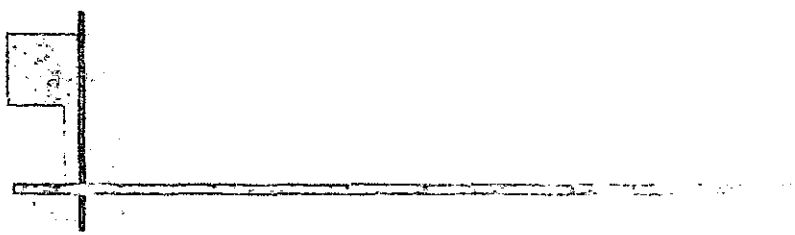
You will notice that the rebasing study recommends a 67.85% increase in ambulance reimbursement. That sounds like a large increase unless you look at what we have been receiving for the service we provide. (see: Ambulance Codes-Billed to Paid Percentage)

The House Human Appropriations Committee decreased the rebasing to 75% of the Governors recommendation. We believe this is a significant increase however it still does not cover even half of what it costs us to provide the service.

Obviously there are many issues facing ND Ambulance Services, funding is a primary concern. By increasing the Medicaid reimbursement rates for ambulance services you will help keep services available.

Chairman Holmberg, thank you for this opportunity to testify and I would be happy to answer questions the committee may have.

North Dakota



Critical Access Hospital (CAH) Vital Signs!

September 2008

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Slides 3-9	General Info
Slides 10,11	Flex Monitoring Statistics
Slides 12-14	BCBS Info
Slides 15-20	Eric Shell Information
Slides 21-25	Statement of Operation Info for 18 ND Facilities
Slide 26	Closing Slide

Meeting Objectives

- Share Information About ND Critical Access Hospitals (CAH's)
- Provide Information Relating to the Financial Status of North Dakota CAH's
- Receive Input
- Request Support

Discussions...

- Advocacy to Date
  - Meetings with BCBS of ND
  - Presentation by National Consultant to BCBS of ND Board and Management
  - Create Awareness Among ND CAH's
  - Legislative Advocacy
  - Medicaid Reimbursement
  - Community Education

North Dakota Hospitals

- **Critical Access Hospital – 34**
  - Reimbursed by Medicare 101% of Allowed Cost
  - BCBS Pay Rurals 125% Urban Fee Schedule
  - Medicaid Reimbursement Based on Cost
  - Other Commercial Business is Limited
- **State, Indian, Psych, Rehab, Long Term**
- **Acute - 9**
  - Reimbursed by Medicare Via PPS
  - Reimbursed by BCBS ND Using Fee Schedule
  - Fee Schedule Reimbursement from Medicaid

Critical Access Hospital (CAH)

- Medicare Designation for Small/Rural Facilities
- 25 or Less Licensed Beds
- Located at Least 35 Miles From Nearest Facility
- Average Inpatient Length of Stay 96 Hours or Less
- ER Services Available 24 Hours Per Day
- Agreement With a Network Facility
- Paid 101% of Allowed Cost for Services Provided to Medicare Beneficiaries

ND CAH's

- Provide Services in Rural/Frontier Areas
- Important Contributor to the Social/Economic Well Being of Rural Communities
- Many Provide Wide Array of Services

  Hospital, Nursing Home, Clinic, Ambulance, Home Care, Meals on Wheels, Assisted Living, Basic Care, Independent Living Apartments, Wellness, Durable Medical Equipment, Home Oxygen, etc.

  - *Not All of Which are Profitable*

ND CAH Challenges

- Sustainability
- Maintaining Necessary Resources
  - Staff
  - Equipment & Facilities
  - Clinic/Practitioners
  - Financial Viability

Financial Viability

- Low Volume, High Cost Per Unit
- High Amount of Fixed Cost
- Serve a Large Geographic Area/Lack of Critical Mass
- Large Medicare Population
- Large Medicaid Population For Some Providers
- Insurance Reimbursement
  - Typically Commercial Market (30) Provides a Postive Margin for Facilities, no in North Dakota
  - BCBS of North Dakota

Flex Monitoring Team Info

A consortium of Rural Health Research Centers from the University of Minnesota, North Carolina and Southern Maine. Under contract with the Federal Office of Rural Health Policy, the Team is conducting performance monitoring for CAH's for the FLEX Program.

The information is designed for public use!
Available at www.flexmonitoring.org

CAH Financial Indicators 2006

Description	*National*	***ND***	*SD*	*Minn.*	*Montana*	*Nebraska*
Total Margin 2006	3.56%	**-1.65%**	3.39%	4.40%	3.22%	5.08%
Medicare Inpt. Rev/Day	$1,470	**$1,024**	$1,268	$1,747	$1,374	$1,410
Medicare Outpt. Cost/Chg	52%	**60%**	51%	49%	66%	59%
Salary Exp/Total Exp.	44%	**51%**	48%	43%	48%	46%
Average Age of Plant	10.6	**12.8**	10.2	9.6	12.9	9.7
Acute/Swing Ave. Census	6.0	**3.6**	3.8	5.2	3.3	4.7

Flex Monitoring Team, October 2005, July 2006, Summer 2007, Summer 2008

Why Is The ND CAH Indicator For Total Margin So Different Then our Neighbors?

- ND CAH's are Poorly Managed?
- ND CAH's Provide Poor Quality Care?
- ND CAH's are more Diversified?
- ND CAH's Don't Charge Enough?
- Medicaid Reimbursement?
- Commercial (BCBS) Reimbursement?
- Other Issues?

BCBS Reimbursement Comparison

State	***CAH Outpatient Reimbursement***
State 1,2,3	92.5% - 100% Billed Charges
State 4	98% Billed Charges
ND CAH's	BCBS of ND Pays:

* Inpatient DRG, Outpatient Fee Schedule

  ND is 50 – 65% of Charges

* Clinic Fee Schedule Based on Medicare

  @ Example 99212 - $56.00

  @ Example 99213 - $92.00

  @ Example 99214 - $138.00

  @ Medicare per Visit May be $110 - $135

Average Regional Premium Comparison

Per Enrolled Employee at Private Sector Establishments That Offer Health Insurance For 2005

	Single	Family
US Average	$332	$894
Wyoming	$365	$956
Wisconsin	$352	$915
Montana	$325	$836
Nebraska	$315	$817
Iowa	$307	$800
Minnesota	$328	$904
South Dakota	$316	$859
North Dakota	$286	$694
Region Average	$325	$848

Source: Agency for Health Research and Quality, 2005 Medical Expenditure Panel Survey-Insurance Component

Presentation to Blue Cross of North Dakota Leadership

CAH Financial Analysis Report on Margins

August 28, 2007

Fargo, North Dakota

STROUDWATER ASSOCIATES
Eric Shell, CPA, MBA
eshell@stroudwaterassociates.com

- Project Overview
- Rural Hospital Economics
- ND Opportunities
  - Third Party Contracts
  - Outpatient Services
  - Departments with >1 RCCs
  - Non-Hospital Businesses
  - Rural Health Clinics
  - Bad Debt Expense
- Summary

Common Findings

Medicare Cost reports are well prepared

Third party payers generally result in marginal loss or profit on a fully allocated cost basis

Many CAHs provide a wide array of "mission related" entities, many of which are not profitable

- Clinics, nursing homes, ambulance, home care, assisted living, etc.

Mark up ratios at most ND CAHs below peers

- Project Overview
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Top North Dakota CAH Opportunities

Third Party Contracts

Growth in Outpatient Volume

CAH Departments with Cost to Charge > 1

Non-Hospital Business

Rural Health Clinic Losses

Bad Debt Expense

- Project Overview
- Rural Hospital Economics
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Common Findings

Medicare Cost reports are well prepared

ND CAH's are Efficient

Third party payers generally result in marginal loss or profit on a fully allocated cost basis

Many CAHs provide a wide array of "mission related" entities, many of which are not profitable

- Clinics, nursing homes, ambulance, home care, assisted living, etc.

Mark up ratios at most ND CAHs below peers

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  - Bad Debt Expense
- Summary

Guiding Principle

Commercial business is an important source of profits and profits generated on this business must more than compensate for non-allowable "costs"

Issue

One major third party payer in North Dakota with limited competition

- Market power or market responsibility
- Payer cost of providing care in urban areas vs. rural areas

Reported that standard contract exists for all ND CAHs

- Inpatient – DRG based system; Outpatient – Fee schedule

For CAHs that have analyzed allowed amounts relative to fully allocated costs, generally breakeven to losses

So how do they compare to other Blue Cross Plans across the Country?

- Project Overview
- Rural Hospital Economics
- ND Opportunities
  - Third Party Contracts
  - Outpatient Services
  - Departments with >1 RCCs
  - Non-Hospital Businesses
  - Rural Health Clinics
  - Bad Debt Expense
- Summary

Top North Dakota CAH Opportunities

Third Party Contracts

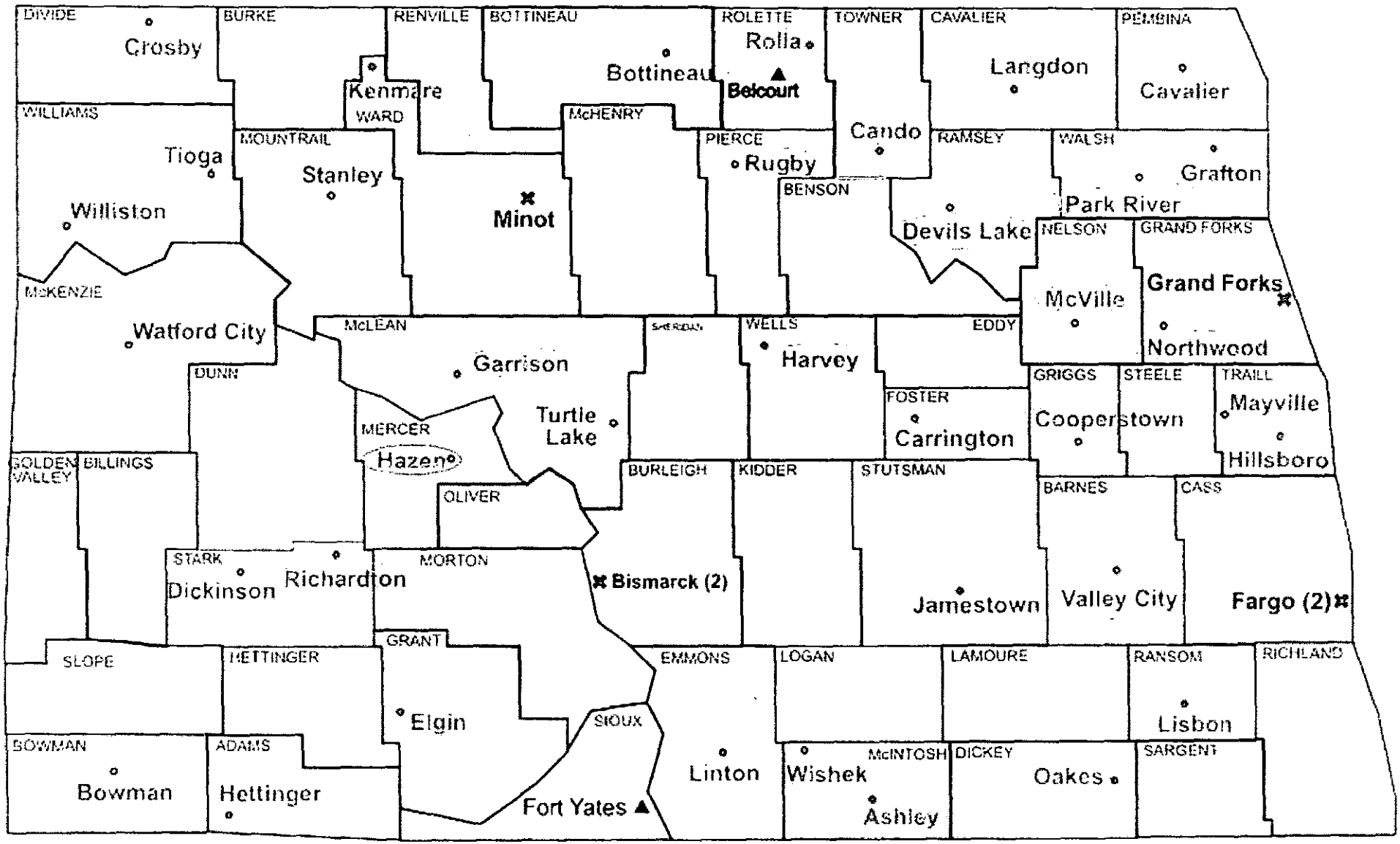
Growth in Outpatient Volume? (Possible?)

Non-Hospital Business (Good & Bad)

Rural Health Clinic Losses

Bad Debt Expense

North Dakota Hospitals and Critical Access Hospitals



Center for Rural Health

- Rural Hospital
- Tertiary Hospital-CAH Network
- Indian Health Service Hospital
- Critical Access Hospital

2007 Statement of Operations Average From 27 North Dakota CAH's

	Average	
Patient/Other Revenue	$7,781,546	
Deductions	$1,693,319	
Net Revenue	$6,088,227	
Expenses	$6,351,698	
Net Operating Margin	- $263,470	-3.4%
Non Operating Rev.	$194,617	
NET INCOME/LOSS	- $68,854	-0.9%
Median Loss		-2.0%

2007 ND CAH Combined Statement of Operations

Observations

22 of 27 Facilities had Negative Operating Margins

Average Operating Loss was -3.4% or -$263,470

19 of 27 Facilities had Negative Net Margins in 2007

Average Net Loss (Mean) was -0.9% or -$68,854

Median Net Loss was -2.0%

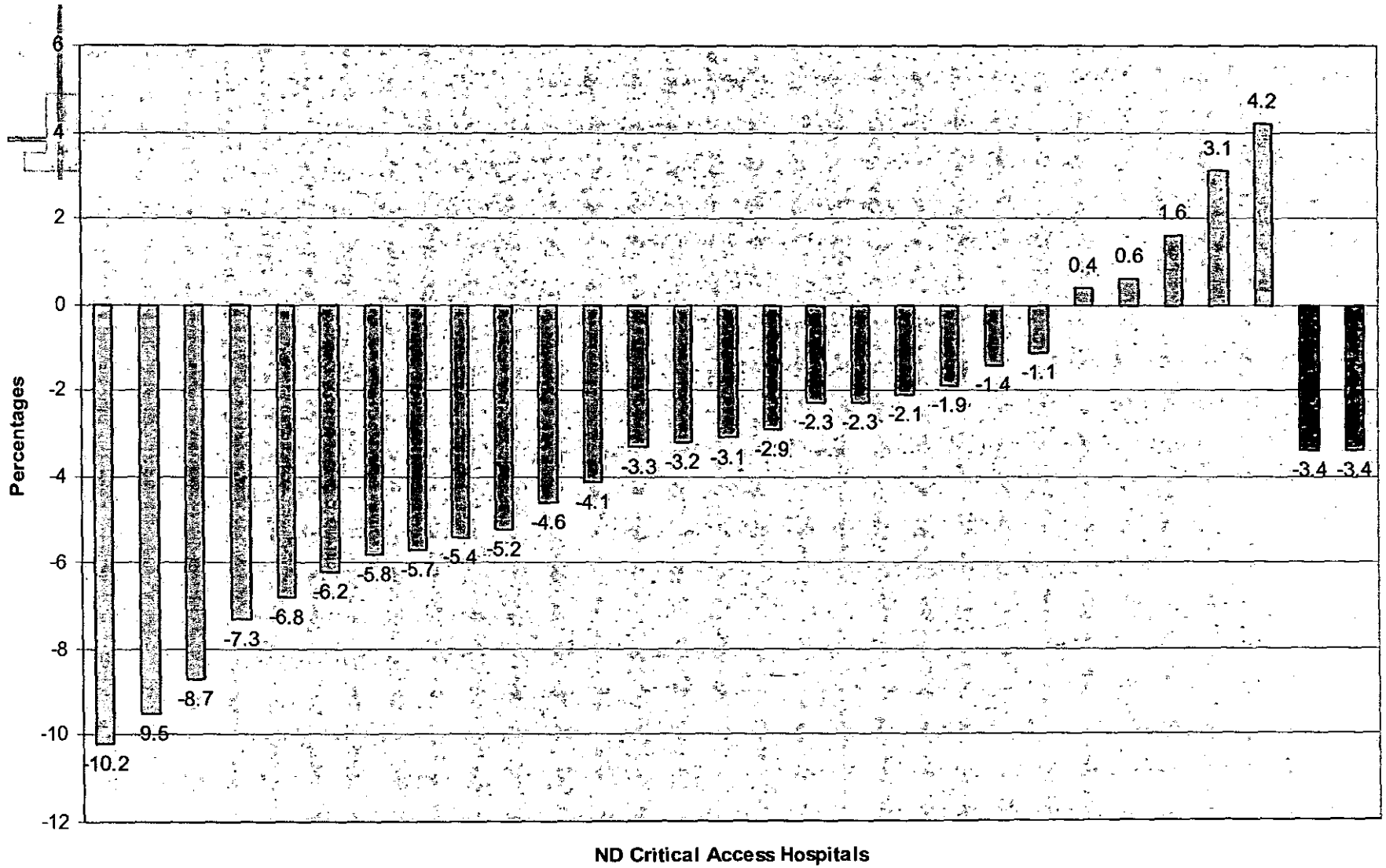
2007 CAH Statement of Operations (Continued)

- Total BCBS Contractual $9,957,376
- Average BCBS Contractual was $366,000
- Average Bad Debt Expense was $140,000

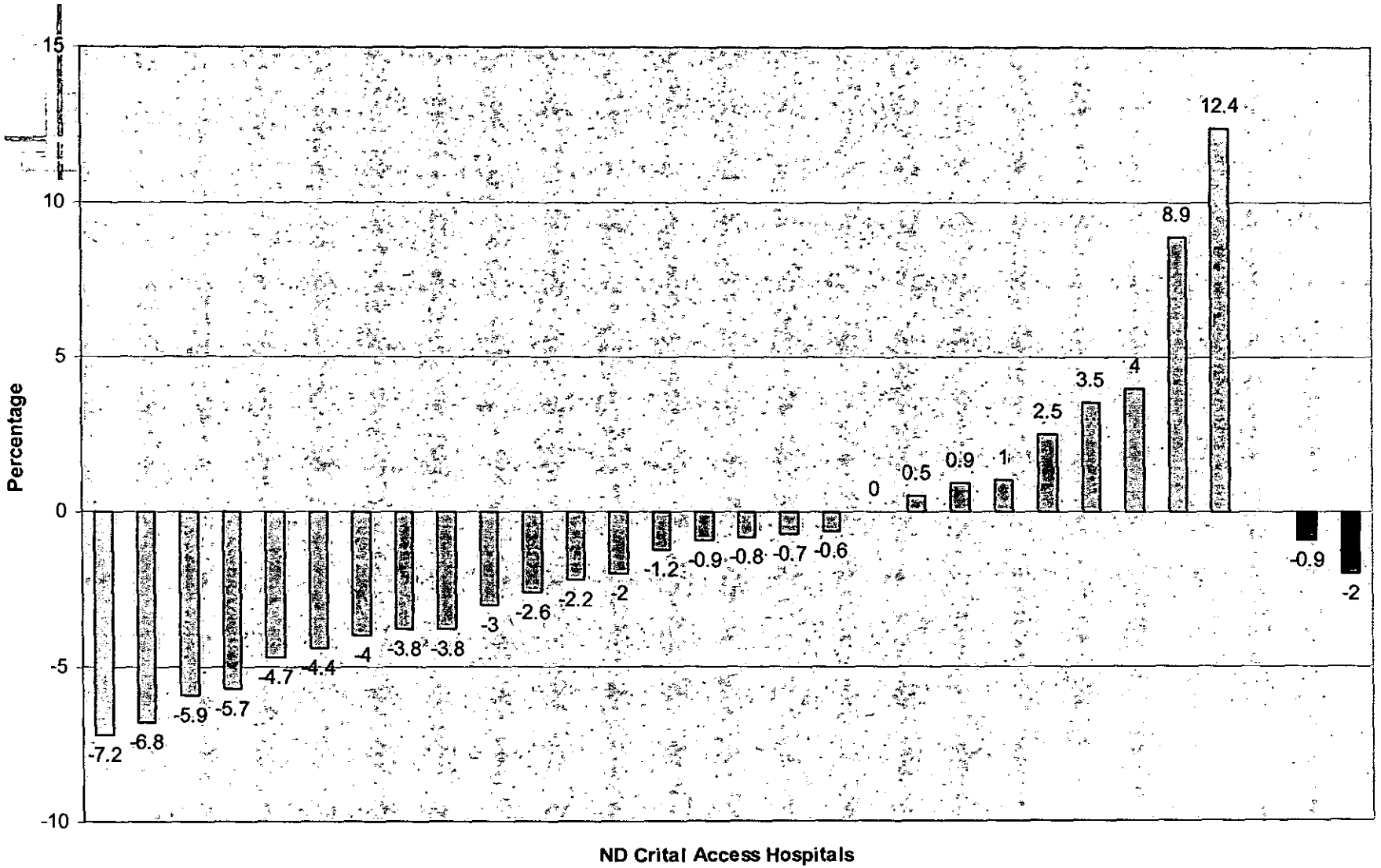
- Average Non Operating Revenue $194,000
  Facilities Work Hard on Other Sources of Income

- 22 of 27 Facilities Own/Operate a Clinic
- 15 of 27 Facilities Own/Operate LTC

Operating Margin Fiscal Year 2007



Total Margin - Fiscal Year 2007



Statement of Operations Continued

- Availability of an Adequate Workforce is a Challenge
- Hard to Fund Equipment Needs from Operations
- Capital Does Not Exist for Facility Improvements or IT Implementation

- **Current Losses are Not Sustainable**

Discussion...

- What are Your Thoughts & Observations?
- What We Would Like?
  - Maintain The Delivery of Vital Healthcare Services
  - Maintain the Quality of Care we Provide
  - Continue to Contribute to the Economic and Social Viability of our Rural Communities
  - Ask That Rural Healthcare be a Priority in the Legislative Agenda
  - Continue Advocacy!
- Questions/Comments?

J

North Dakota Department of Human Services
HB 1012 – Traditional Medicaid Services
Critical Access Hospital Detail
To the House

At the end of the 2007 Legislative Session (April 2007), there were 31 Critical Access Hospitals (CAHs) in North Dakota.

Since that time the following hospitals have received designation as Critical Access:

Towner County Medical Center (Cando)	July 2007
Heart of America Medical Center (Rugby)	September 2007
Mercy Hospital (Devils Lake)	January 2008
Mercy Hospital (Williston)	September 2008

This brings the total of Critical Access Hospitals to 35.

There are two additional hospitals that plan to convert to critical access:

- Jamestown in progress
- Dickinson contingent on Richardton transitioning to a Skilled Nursing Facility.

2007 SB 2012 (DHS Appropriation) contained 4.3 million (total) to increase the reimbursement for CAHs (for inpatient and outpatient hospital services) to 100% of cost. This change was implemented July 1, 2007. (The $4.3 million was calculated by a vendor under contract with the ND Healthcare Association.)

By analyzing the increases paid to CAHs during the first year of the biennium, the Department is estimating to spend $2.7 million (total).

North Dakota
Chiropractic
Association

Good afternoon Chairman Holmberg and members of the Senate Appropriations Committee.

My name is Rob Hasse. I am a chiropractic physician from West Fargo, ND and the president of the ND Chiropractic Association.

I would like to thank the committee for allowing public testimony on the issues that are before you. I would like to address the topic of rebasing chiropractic services payment rates.

We feel that we provide a much needed service to the people of North Dakota in a very cost effective, efficient manner. The one population that is underserved by chiropractic in this state is the Medicaid population. Many chiropractors cannot afford to provide this service to the Medicaid population. That is the main reason that during the 2007 legislative session we asked the legislature to consider increasing reimbursement for chiropractic services because the reimbursement was less than 50% of the cost to provide the service. We were grateful for the consideration of this legislature supporting an increase that brought our reimbursement up to the 50% level of cost. However, this was still significantly less than the cost to provide this service. The total 2007-09 budget for chiropractic is $455,167. We also had the opportunity to participate in the Medicaid services study this past interim where the cost of chiropractic services was analyzed. This resulted in rebasing of chiropractic services to 100% of the cost determined by the study, resulting in an increased budget to $987,572). The House reduced the rebasing amount to 75% of the cost determined by the study.

We were grateful to be considered in the study with PCG (Public Consulting Group). We did find the initial information difficult to deal with and I made a few phone calls to PCG and DHS and made trip to Bismarck to meet with DHS and the PCG group to discuss our concerns. We were able to work out the details that made it workable for the chiropractors so that we could provide you with the most accurate information that we could.

We believe that the information gathered during this study justified the rebasing. Most MA chiropractic services provided are for manipulative codes. (98940-98941). There are a number of studies that have shown chiropractic care to be more cost effective than traditional medical care for neuromusculoskeletal problems. We also believe that there will be more of a cost shift to DHS and not a cost increase due to providers more willing to see patients that are better served by seeing chiropractors.

NDCA appreciates the Legislature's consideration to rebase MA services for chiropractic care and we would request that you consider restoring MA reimbursement for services to 100% of the cost as included in the governor's budget for chiropractors that service the Medicaid population of ND.

Chairman Holmberg and members of the committee, thank you for your time this afternoon. I will answer any questions the committee may have.

P.O. Box 2144 • Bismarck, ND 58502-2144 • 701-530-2141

H

Testimony – January 26, 2009
HB 1012
House Appropriations – Human Resources Division
Chairman Pollert

Good morning Chairman Pollert and members of the House Appropriations Committee, Human Resources Division.

My name is Eric Froehling. I am a chiropractic physician from Wishek, ND. Today I am representing the North Dakota Chiropractic Association.

First of all I would like to thank the committee for allowing me the time to speak about the topic of rebasing chiropractic services payment rates.

We feel chiropractic care in North Dakota is of great quality and is very efficient and effective. Unfortunately, we feel the Medicaid population in need of chiropractic care in ND has been underserved because many chiropractors could not afford to provide this service. During the 2007 Legislative Session, we asked the Legislature to consider increasing reimbursement for chiropractic services because reimbursement was less than 50% of the cost to provide the services. We appreciated the consideration of this committee and the Legislature supporting an increase that brought reimbursement up to around the 50% level, however it was still significantly below cost to provide the service. The total 2007-09 budget for chiropractic is $455,167. Additionally, we participated in the Medicaid services study this past interim where cost of chiropractic services was analyzed, resulting in a rebasing of chiropractic services as determined by the study and included in the DHS budget ($987,572).

We are grateful the legislature included us in the cost study for the various provider groups and we believe the cost study shows that rebasing is justified. Nearly all the MA chiropractic services provided are for codes 940 and 941 for manipulation services. A number of studies have shown chiropractic care to be more cost effective for musculoskeletal problems than traditional medical care. Maintaining and adding chiropractic access (by doctors continuing and more willing to treat Medicaid patients) by rebasing reimbursement to cover the cost of providing services may actually turn out to be more of a cost shift, not a cost increase to DHS.

Chairman Pollert and members of the committee, thank you for your time today. The NDCA supports HB 1012, and we ask for your favorable consideration of the proposed rebasing of providers, including chiropractic services, to maintain and provide medical care for the Medicaid population in ND.

A

Testimony before the House Appropriations Committee **January 26, 2009**

HB 1012 as it relates to Dental Medical Assistance Reimbursement

Chairman Pollert and members of the Committee: My name is Dr. Dennis Sommers. I am a practicing dentist in Minot and serve as President of the North Dakota Dental Association (NDDA). I present this testimony in support of HB 1012 with regard to Governor Hoeven's dental Medicaid budget proposal.

The 2000 Surgeon General's report "Oral Health Care in America" noted that dental decay is the most common chronic childhood disease and that low income children suffer twice as much tooth decay as more affluent children. By and large, the segment of North Dakota's population for which Medicaid services are provided does not engage itself in this legislative process. Children, the primary beneficiary of dental Medicaid services in North Dakota, are not equipped to voice their needs. The NDDA is here to speak for them. The NDDA supports the state's efforts to address shortcomings in providing dental services to low income families.

Governor Hoeven's budget proposes funding dental Medicaid at a level similar to that which was passed by the ND House and Senate two years ago. Although such funding was approved by both chambers during the 2007 legislature, the appropriation was cut by 87% in the final hours by conference committee when different starting dates appeared in each chamber's bill. Governor Hoeven's budget reaffirms efforts of the 2007 legislature funding dental Medicaid based on 75% of billed charges – a target shown in other states to be successful to increase unmet treatment needs, provider participation and geographic access while stabilizing per-enrollee costs and increasing both provider and enrollee satisfaction.

The Centers for Medicare & Medicaid Services (CMS) 2008 NATIONAL DENTAL SUMMARY points out:

> "...a State must adhere to certain federal requirements. ... for most individuals under the age of 21, dental services are a mandatory benefit as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service as defined in section 1905(r) of the Social Security Act."

Such statutory requirements are intended to ensure all eligible Medicaid beneficiaries under 21 are both informed of ***and have access to*** dental services. How are we doing? Measurements by CMS ranked North Dakota dead last in 2006 with only 19% of eligible Medicaid enrollees accessing dental care. With a national average of 50 to 55 percent of adults and children seen by dentists annually, North Dakota's Medicaid access to care falls woefully short. We should all recognize the need to improve dental access for North Dakota's low-income families – especially children.

The CMS 2008 Summary further reports dental Medicaid program improvements can be expected to yield significant savings in treatment costs on an individual level since on average, ongoing treatment costs to maintain oral health per individual will decrease over time. Further substantial savings will be seen since care provided in dental office settings reduces the frequency of emergency room visits by Medicaid enrollees where treatment is primary palliative and recurring rather than definitive and corrective. This is particularly likely for very young children with catastrophic treatment needs that often require costly hospital services in addition to significant dental treatment. These costs can account for approximately 30% of typical Medicaid dental program expenditures. Savings for high-needs children also could be achieved with the aid of sedation, when appropriate for some children, rather than general anesthesia in a hospital setting. However, North Dakota does not yet reimburse adequately for such sedation services. Engaging the capacity of private-sector dentists with adequate Medicaid funding will maximize use of taxpayer dollars in providing dental care to the state's low-income population while at the same time reducing the need for investments in "safety-net" clinic capacity such as those clinics now operating in Bismarck, Fargo and Grand Forks.

Next week, dentists in communities across North Dakota will be working to improve access for North Dakota's less fortunate population through Give Kids a Smile projects, an American Dental Association (ADA) nationwide event where dentists volunteer care for children. Since 2000, North Dakota dentists have also given time and resources through the Donated Dental Services Program, providing just under a million dollars of free dentistry for disabled and elderly North Dakotans. Dentists in many communities voluntarily provide yearly dental screenings for Head Start kids. Through these projects and more, dentists demonstrate their generosity on a daily basis. While 90% of North Dakota dentists are scheduled providers of Medicaid dentistry, services cost more to deliver

than dentists are reimbursed through Medicaid. As small business operators dentists are unable to open their doors to all Medicaid patients. With the majority of dentists forced to limit the numbers of Medicaid patients they see, 20% of dentists now provide 80% of the state's Medicaid services.

The governor's budget is an extremely important step in achieving the access to dental care North Dakota is mandated by the Social Security Act to provide. During other testimony on this subject Committee members have often asked, "What guarantee can you offer that funding will improve access to care?" The ADA's report found at http://www.prnewswire.com/mnr/ada/20973/ answers this question. The report states that experience in states like Georgia, Indiana, Michigan, Tennessee and South Carolina shows that raising reimbursement to levels that approximate the 75th percentile of prevailing fees can significantly increase access and utilization of dental services by the Medicaid-eligible and participation by dentists, especially when such initiatives are actively promoted by state dental organizations and commercial intermediaries. We have every reason to believe similar results can and will be achieved in North Dakota with adoption of the dental Medicaid funding proposals in Governor Hoeven's budget.

A "Dental Medicaid in North Dakota Fact Sheet" is included for your review with this testimony. The North Dakota Dental Association urges your support of Governor Hoeven's dental Medicaid budget proposals as a way to:

- Fulfill the intent of the 2007 legislature's vote
- Enable the state to meet access requirements mandated by the Social Security Act
- Reduce costs connected to dental related emergency room visits
- Improve overall health and well being of North Dakota's Medicaid recipients

Thank you.

Dr. Dennis Sommers
President
North Dakota Dental Association.

DENTAL MEDICAID IN NORTH DAKOTA
FACT SHEET-2009

- Oral health is essential to overall health, especially for children, developmentally-delayed patients, elderly, and medically-compromised individuals.

- The North Dakota Oral Health Coalition has adopted Medicaid reimbursement as a prime issue and urges the ND Legislature to improve access to care for Medicaid eligible by increasing reimbursement.

- As access to care deteriorates, Medicaid patients increasingly show up at Emergency Rooms for dental problems. No definitive treatment can be provided. However the costs are significantly higher than if provided in a dental office.

- Low Medicaid fee reimbursement is the number one reason that dentists limit their participation in Medicaid. Poor patient compliance, failed appointments, and limitations in allowed treatment are other reasons that dentists limit participation.

- Federal courts have determined that adequate access exists for Medicaid patients when at least 50% of dentists see any and all Medicaid patients presenting for treatment. In ND, only 20% of dentists see any and all Medicaid patients that present for treatment (UND Center for Rural Health). This percentage was 49% in 1992.

- ND Dental Medicaid reimburses dentists below the cost of providing dental services to Medicaid patients (ND Department of Human Services).

- The majority of participating dentists can afford to do relatively little Medicaid. Only 20% of the participating dentists perform the majority of the Medicaid services provided in the state.

- Other states have increased fees significantly and subsequently saw significant increases in dentist participation.

- Adequate dentist reimbursement, along with efficient claims submission and payment, will improve access to care for North Dakota's most vulnerable citizens, reduce costly and inappropriate Emergency Room treatment, and prevent more expensive specialty care for this population. Care for the most vulnerable population must be a shared responsibility between dentists and the state of North Dakota.

- Oral Health is integral to the healthy physical, social-emotional and intellectual development of every child. Unfortunately, many children across America suffer from poor oral health and a lack of access to oral health care.

- The 2000 Surgeon General's Report, "Oral Health in America," noted that not only is dental caries the most common chronic disease of childhood, but that low-income children suffer from twice as much tooth decay as more affluent children.

B

TESTIMONY BEFORE THE HOUSE APPROPIRATIONS
HUMAN RESOURSES DIVISION
REGARDING HOUSE BILL 1012
JANUARY 26, 2009

Chairman Pollert, members of the committee, my name is David Zentner and I am a member of the North Dakota Oral Health Coalition.

The coalition was formed in 2005 and is a collaborative, statewide group comprised of a diverse number of public and private agencies, organizations and individuals dedicated to improving dental care in our state. The mission of the Coalition is to develop and promote innovative strategies to achieve optimal oral health for all North Dakotans.

Oral health care is an important component of overall primary health care for both children and adults. A statewide needs assessment of low-income individuals sponsored by the North Dakota Community Action Agency in 2006 reported that oral health care was a major unmet need. Forty percent of respondents ranked dental health care among the top three unmet needs along with food and utilities.

According to the U.S. Surgeon General's Report on Oral Health, tooth decay, although preventable, is a chronic disease that affects children's ability to concentrate and learn, as well as their speech development, eating habits, activity levels and self-esteem. It is the most common chronic disease of childhood and in the U.S. tooth decay is five times more common than asthma and seven times more common than hay fever in our children. Tooth decay, left untreated can cause pain and tooth loss.

The North Dakota Department of Health 2004-2005 Oral Health Survey of School Children disclosed that 56% of third grade children had cavities and/or fillings which is substantially higher than the Healthy People 2010 of 42 percent. Children in pain cannot learn, eat properly and can suffer failure to thrive.

Many children and adults do not have access to appropriate dental care because they are unable to find a dentist who is willing to provide services to eligible Medicaid recipients. Only about 20% of the dentists in North Dakota provide about 80% of the dental care that is currently delivered to Medicaid recipients. Dentists indicate that the number one reason they do

not serve Medicaid patients is the low pay rates they receive from the Department of Human Services.

We believe that increased Medicaid payments to dentists will result in an increase in the number of dental providers willing to serve Medicaid recipients. It is imperative that the state experiences an improvement in access to dental care for our low-income citizens. Increased payments to dentists are an important component in reaching that goal.

The coalition is also supportive of the expansion of the Healthy Steps program to 200% of the federal poverty level. This expansion will result in increased access to dental services for the children of our state.

The Dental Coalition urges you to include the increase in payments to dentists and the expansion of the Healthy Steps program as proposed by Governor Hoeven in the appropriation for the Department of Human Services.

I would be happy to respond to any questions you may have.

B

Department of Human Services
Dental Services Information for Amendments

	Total	General	Federal /Other
Executive Budget Funding - Rebase @ Min of 75% of Average Billed Charges with 7/7 Inflation	4,183,836	1,546,085	2,637,751
Rebase @ Min of 65% Average Billed Charges	1,061,930	392,701	669,229
Inflation at 0/7	514,375	189,876	324,499
Total Rebase @ 65% & 0/7 Inflation	**1,576,305**	**582,577**	**993,728**
Difference Between Executive Budget & Rebase @ 65% with 0/7 Inflation	(2,607,531)	(963,508)	(1,644,023)

Executive Budget Funding - Rebase @ Min of 75% of Average Billed Charges with 7/7 Inflation	4,183,836	1,546,085	2,637,751
Rebase @ Min of 70% Average Billed Charges	1,692,360	625,834	1,066,526
Inflation at 0/7	535,541	197,704	337,837
Total Rebase @ 70 % & 0/7 Inflation	**2,227,901**	**823,538**	**1,404,363**
Difference Between Executive Budget & Rebase @ 65% with 0/7 Inflation	(1,955,935)	(722,547)	(1,233,388)

C

Testimony presented by Brad King DDS
Before the House Appropriations Subcommittee
January 26, 2009
Regarding House Bill 1012 (Dental Medicaid)

Adult Medicaid Statistics

The average dental clinic runs an overhead of 60-65% so any services paid at less than that is provided at a loss. At 60- 65% the dentist is working for free with no compensation.

Procedure	Blue Cross UCR	Medicaid Fee	Percentage
2 surf silver filling	$135	$61.10	45%
2 surf white filling	$161	$72.17	44.8%
Crown	$849	$255.39	30%
Root Canal	$610	$248.64	40.8%
Full Upper Denture	$1440	$575.70	40%
Tooth Extraction	$135	$44.42	32.8%

Between July 1 and Dec. 31 2008 Prairie Rose Family Dentists in Bismarck provided $121,313 in Medicaid services and was reimbursed $42,185 during that time. We run an overhead of about 55%. So over the last 6 months we paid approximately $24,500 out of our own pockets over to treat Medicaid patients

D

Good Morning, I am Linda Kleinjan. I am the practice administrator of Face and Jaw Surgeons. This is a group practice for the specialty of Oral and Maxillofacial Surgery with clinics in Bismarck, Fargo, Grand Forks and Minot. The practice has six surgeons and approximately 45 employees in the locations in North Dakota.

Oral and Maxillofacial Surgery is a specialty of Dentistry with emphasis on tooth removal, correction of deformities and malformations of the jaws, pathology

of the face and neck, treatment of facial trauma, facial and dental infections etc.

Today I wish to relay to you the ongoing difficulties that our surgeons have with the North Dakota Medicaid system. Medicaid is a necessary support system for the non-insured, underinsured, disabled and poor within our state. Its policies and fee structure also cover the incarcerated, both adult and juvenile within the control of the North Dakota Department of Corrections,

as well as certain other institutionalized individuals.

From its inception the Medicaid system has been under-funded for the dental needs of its recipients. Currently, our practice sees Medicaid patients on a daily basis both in our clinics, as well as, in the hospitals that our surgeons serve. These patients often require comprehensive evaluation, medical consultation before treatment, and extensive and complicated surgical care. Under the current system, reimbursement

covers only 2/3 of the costs of delivering care. That is, our overhead which excludes all compensation to the surgeons is over 64% of billed charges, while state reimbursement is only 45% of billed charges. This means that for every Medicaid patient treated by our practice we suffer an actual out of pocket expense greater than the revenue received for that patients care. For just one of our surgeons in Bismarck in 2008 this resulted in a expense loss of over $44,450. With six

surgeons and 4 clinics the total expense losses are very significant to the practice. In an era in which government has or will mandate electronic medical record keeping (estimated at $150-200,000 for our practice) and electronic prescriptions ($3,000 per surgeon) without any method of recouping this costs, Medicaid losses have forced us to consider discontinuation of service to Medicaid recipients. The very concept of such a decision is abhorrent to our surgeons, who strongly believe that health care to relieve pain and suffering is

the right and expectation of all the residents of our state.

The Medicaid system over the past decade has had difficulties with claims processing, computer coding, pre-determination of recipient liability after treatment, payment delays and limited personnel to service the professional dental community. These issues make the current system difficult for providers and their staffs to efficiently deliver care in a timely and cost effective manner. Delays in acute surgical care

usually cause the care to become more complicated and therefore more costly.

Our practice does not wish to discontinue care to any patient group, especially the most vulnerable group within our communities, however if relief is not forthcoming, the financial stability of our practice will dictate such a discontinuation. We hope that you will consider the needs of the Medicaid patient population and adequately fund the system so that we may continue to serve our

patients in the future as we have for over thirty years.

Thank you for allowing me to make these comments today, and I will be happy to answer your questions.

washingtonpost.com

For Want of a Dentist

Pr. George's Boy Dies After Bacteria From Tooth Spread to Brain

By Mary Otto
Washington Post Staff Writer
Wednesday, February 28, 2007; B01

Twelve-year-old Deamonte Driver died of a toothache Sunday.

A routine, $80 tooth extraction might have saved him.

If his mother had been insured.

If his family had not lost its Medicaid.

If Medicaid dentists weren't so hard to find.

If his mother hadn't been focused on getting a dentist for his brother, who had six rotted teeth.

By the time Deamonte's own aching tooth got any attention, the bacteria from the abscess had spread to his brain, doctors said. After two operations and more than six weeks of hospital care, the Prince George's County boy died.

Deamonte's death and the ultimate cost of his care, which could total more than $250,000, underscore an often-overlooked concern in the debate over universal health coverage: dental care.

Some poor children have no dental coverage at all. Others travel three hours to find a dentist willing to take Medicaid patients and accept the incumbent paperwork. And some, including Deamonte's brother, get in for a tooth cleaning but have trouble securing an oral surgeon to fix deeper problems.

In spite of efforts to change the system, fewer than one in three children in Maryland's Medicaid program received any dental service at all in 2005, the latest year for which figures are available from the federal Centers for Medicare and Medicaid Services.

The figures were worse elsewhere in the region. In the District, 29.3 percent got treatment, and in Virginia, 24.3 percent were treated, although all three jurisdictions say they have done a better job reaching children in recent years.

"I certainly hope the state agencies responsible for making sure these children have dental care take note so that Deamonte didn't die in vain," said Laurie Norris, a lawyer for the Baltimore-based Public Justice Center who tried to help the Driver family. "They know there is a problem, and they have not devoted adequate resources to solving it."

Maryland officials emphasize that the delivery of basic care has improved greatly since 1997, when the

state instituted a managed care program, and 1998, when legislation that provided more money and set standards for access to dental care for poor children was enacted.

About 900 of the state's 5,500 dentists accept Medicaid patients, said Arthur Fridley, last year's president of the Maryland State Dental Association. Referring patients to specialists can be particularly difficult.

Fewer than 16 percent of Maryland's Medicaid children received restorative services -- such as filling cavities -- in 2005, the most recent year for which figures are available.

For families such as the Drivers, the systemic problems are often compounded by personal obstacles: lack of transportation, bouts of homelessness and erratic telephone and mail service.

The Driver children have never received routine dental attention, said their mother, Alyce Driver. The bakery, construction and home health-care jobs she has held have not provided insurance. The children's Medicaid coverage had temporarily lapsed at the time Deamonte was hospitalized. And even with Medicaid's promise of dental care, the problem, she said, was finding it.

When Deamonte got sick, his mother had not realized that his tooth had been bothering him. Instead, she was focusing on his younger brother, 10-year-old DaShawn, who "complains about his teeth all the time," she said.

DaShawn saw a dentist a couple of years ago, but the dentist discontinued the treatments, she said, after the boy squirmed too much in the chair. Then the family went through a crisis and spent some time in an Adelphi homeless shelter. From there, three of Driver's sons went to stay with their grandparents in a two-bedroom mobile home in Clinton.

By September, several of DaShawn's teeth had become abscessed. Driver began making calls about the boy's coverage but grew frustrated. She turned to Norris, who was working with homeless families in Prince George's.

Norris and her staff also ran into barriers: They said they made more than two dozen calls before reaching an official at the Driver family's Medicaid provider and a state supervising nurse who helped them find a dentist.

On Oct. 5, DaShawn saw Arthur Fridley, who cleaned the boy's teeth, took an X-ray and referred him to an oral surgeon. But the surgeon could not see him until Nov. 21, and that would be only for a consultation. Driver said she learned that DaShawn would need six teeth extracted and made an appointment for the earliest date available: Jan. 16.

But she had to cancel after learning Jan. 8 that the children had lost their Medicaid coverage a month earlier. She suspects that the paperwork to confirm their eligibility was mailed to the shelter in Adelphi, where they no longer live.

It was on Jan. 11 that Deamonte came home from school complaining of a headache. At Southern Maryland Hospital Center, his mother said, he got medicine for a headache, sinusitis and a dental abscess. But the next day, he was much sicker.

Eventually, he was rushed to Children's Hospital, where he underwent emergency brain surgery. He began to have seizures and had a second operation. The problem tooth was extracted.

After more than two weeks of care at Children's Hospital, the Clinton seventh-grader began undergoing six weeks of additional medical treatment as well as physical and occupational therapy at another hospital. He seemed to be mending slowly, doing math problems and enjoying visits with his brothers and teachers from his school, the Foundation School in Largo.

On Saturday, their last day together, Deamonte refused to eat but otherwise appeared happy, his mother said. They played cards and watched a show on television, lying together in his hospital bed. But after she left him that evening, he called her.

"Make sure you pray before you go to sleep," he told her.

The next morning at about 6, she got another call, this time from the boy's grandmother. Deamonte was unresponsive. She rushed back to the hospital.

"When I got there, my baby was gone," recounted his mother.

She said doctors are still not sure what happened to her son. His death certificate listed two conditions associated with brain infections: "meningoencephalitis" and "subdural empyema."

In spite of such modern innovations as the fluoridation of drinking water, tooth decay is still the single most common childhood disease nationwide, five times as common as asthma, experts say. Poor children are more than twice as likely to have cavities as their more affluent peers, research shows, but far less likely to get treatment.

Serious and costly medical consequences are "not uncommon," said Norman Tinanoff, chief of pediatric dentistry at the University of Maryland Dental School in Baltimore. For instance, Deamonte's bill for two weeks at Children's alone was expected to be between $200,000 and $250,000.

The federal government requires states to provide oral health services to children through Medicaid programs, but the shortage of dentists who will treat indigent patients remains a major barrier to care, according to the National Conference of State Legislatures.

Access is worst in rural areas, where some families travel hours for dental care, Tinanoff said. In the Maryland General Assembly this year, lawmakers are considering a bill that would set aside $2 million a year for the next three years to expand public clinics where dental care remains a rarity for the poor.

Providing such access, Tinanoff and others said, eventually pays for itself, sparing children the pain and expense of a medical crisis.

Reimbursement rates for dentists remain low nationally, although Maryland, Virginia and the District have increased their rates in recent years.

Dentists also cite administrative frustrations dealing with the Medicaid bureaucracy and the difficulties of serving poor, often transient patients, a study by the state legislatures conference found.

"Whatever we've got is broke," Fridley said. "It has nothing to do with access to care for these children."

Health Provider List

Dickinson Dentists

Badlands Dentistry
Dr. Sharon Carver, DDS
389 15th St W
Dickinson, ND 58601
483-1385

Badlands Dentistry
Dr. Amanda Johnson, DDS
389 15th St W
Dickinson, ND 58601
483-1385

Dickinson Dental Center,
Dr. Shannon Galster DDS
2 W 1st St
Dickinson, ND 58601
483-6999

Family Dental Clinic,
Dr. Jason Dahl DDS
1119 Sims St
Dickinson, ND 58601
227-1193

Dr. Morton Krieg, DDS
188 Osborn Dr -mailing PO Box 1096
Dickinson, ND 58601
483-8113

Neuberger Dental Clinic
Dr. Neuberger, DDS
239 14th St W
Dickinson, ND 58601
483-3462

Selle Family Dental
Dr. Brent Selle, DDS
1560 Western Dr
Dickinson, ND 58601
483-9801

Apollonia Dental
Dr. Manolovits, DDS
1019 Villard St W
483-0857
Dickinson, ND 58601

Outlying Area Dentists

Dr. Bonnie Anderson, DDS
PO Box E
Bowman, ND 58623
523-5651

Dr. Anderson, DDS
820 2nd Ave W
New England, ND 58647

Apollonia Dental
Dr. Manolovits, DDS
223 Brown Ave
Mott, ND 58646
824-2991

Richardton Dental Clinic
Dr. Gregory Johnson, DDS
200 3rd Ave W
Richardton, ND 58652
974-2118

Dr. Patrick Kelly, DDS
608 Hwy 12 W
Bowman, ND 58623
523-3255

Dr. Roger Leutz, DDS
811 ½ Main Ave
Hebron, ND 58638
878-4700

Dr. Nelson, DDS
E Hwy 12
Hettinger, ND 58639
567-4302

Dr. Jason Dahl, DDS
22 Central Ave
Beach, ND 58621
872-4652

Bismarck

Dr. Goebel, DDS
407 E Ave C
Bismarck, ND 58501
258-8509

Recap of SFY 2008 dental claims, amounts paid, & add'l funds request
Dental Services to be paid at a minimum of 75% of Average Billed Charges

	Children	% of Billed Charges Paid	Adult	% of Billed Charges Paid	Children & Adult Combined	% of Billed Charges Paid
Total Claims	5,460,426.26		5,905,042.06		11,365,468.32	
Total Paid	4,036,879.96	74%	3,466,875.14	59%	7,503,755.10	66%
Add'l Funds for all claims being paid at a minimum of 75% of avg Billed Charges	210,623.32		1,011,945.61		1,222,568.92	
Total to be Paid	4,247,503.28	78%	4,478,820.75	76%	8,726,324.02	77%

Service	Yearly Cost	Biennial Cost	General Funds	Federal Funds
Children	210,623	421,246	155,777	265,469
Adults	1,011,946	2,023,892	748,390	1,275,502
Biennial Cost to Set the Dentist Fee Schedule to a Minimum of 75% of Average Billed Charges:		**2,445,138**	**904,167**	**1,540,971**

NOTE:
The total percentage to be paid is greater than 75%, as a number of dental procedures, predominantly children's procedures, are currently paid at a percentage greater than 75% of average billed charges.

Recap of SFY 2008 dental claims, amounts paid, & add'l funds request
Dental Services to be paid at a minimum of 60% of Average Billed Charges

	Children	% of Billed Charges Paid	Adult	% of Billed Charges Paid	Children & Adult Combined	% of Billed Charges Paid
Total Claims	5,460,426.26		5,905,042.06		11,365,468.32	
Total Paid	4,036,879.96	74%	3,466,875.14	59%	7,503,755.10	66%
Add'l Funds for all claims being paid at a minimum of 60% of avg Billed Charges	22,896.30		267,482.67		290,378.97	
Total to be Paid	4,059,776.26	74%	3,734,357.81	63%	7,794,134.07	69%

Service	Yearly Cost	Biennial Cost	General Funds	Federal Funds
Children	22,896	45,792	16,934	28,858
Adults	267,483	534,966	197,830	337,136
Biennial Cost to Set the Dentist Fee Schedule to a Minimum of 60% of Average Billed Charges:		**580,758**	**214,764**	**365,994**

NOTE:
The total percentage to be paid is greater than 60%, as a number of dental procedures, predominantly children's procedures, are currently paid at a percentage greater than 60% of average billed charges.

I

North Dakota Dental Cost Survey

Background

Public Consulting Group, Inc. is assisting the North Dakota Department of Human Services to complete an analysis of the current Medicaid rates for Dental services. In order to complete this effort, the attached cost survey has been developed and reviewed by the Department of Human Services, Medical Services Division to ensure adequate cost data is obtained for rate setting purposes. The purpose of this tool is to capture the total costs, total revenue, and number of encounters rendered by your practice. Report data from your fiscal year 2007.

Please submit all data to Public Consulting Group. We will supply only aggregate or de-identified data in our report. However, if the Department receives a request for the data under the North Dakota open records law; they may have to disclose the data and source. If you are concerned about disclosure of your data, we encourage you to request that the data be designated "trade secret" information when you submit it. If we receive a request to disclose data, as a private company we will deny it. If the Department receives a request for data, they will engage the Attorney General's office to determine whether the data is public or not. Telling us that you would like the data designated "trade secret" may help in the release of only aggregate information.

The following instructions should serve as a guide in completing the cost survey spreadsheet entitled ***ND Dental Cost Survey***. If questions arise at any point in completing the survey please do not hesitate to contact the following individual:

Joe Weber
Public Consulting Group
1-800-210-6113 x 1476
jweber@pcgus.com

Options for Completing the Cost Survey

The cost survey form can completed in a number of ways, specifically there are three methods in which the form can be completed. The options include the following: 1) paper based form 2) an electronic form, and 3) an online form. However, PCG prefers to receive all responses electronically when possible.

1) Paper Based Form
Enclosed is a paper copy of the cost reporting form. If you choose to utilize the paper form, please return the completed cost survey to PCG either by email, mail, or by fax.

Cost Surveys returned by mail should be sent to:

Joe Weber
Public Consulting Group
148 State Street, 10th Floor
Boston, MA 02109

Providers wishing to return their completed cost surveys via fax should send them to **Joe Weber at (617) 426-4069.**

If you wish to return the completed cost surveys via email, please email the completed form to: jweber@pcgus.com.

2) Electronic Cost Survey Form
If you prefer to complete the cost survey electronically in a Microsoft Excel form, please request a copy of the form electronically from PCG by sending an email to jweber@pcgus.com. Once you have completed the form, please email them to jweber@pcgus.com.

3) Online Cost Survey Form
Instead of emailing PCG to obtain an electronic copy of the cost survey form, you can also access the file by downloading the form through our File Transfer Protocol (FTP) site. To access the form, please click on the following link, https://secureftp.pcgus.com/. When prompted, enter the username and password provided below:

User Name: Nddentists
Password: dQP5x3
* USER NAME AND PASSWORD IS CASE SENSITIVE

Once in the site, you should see a hyperlink that states "inbox", click on this hyperlink. Next you should see an excel file entitled, ***"ND Dental Cost Survey"***. Please download the template to your computer by clicking on the hyperlink. Before any changes are made to the form, please **click file save as and rename the file and save it to your hard drive**. For example, rename the form from "ND Dental Cost Survey", by adding your practice name at the end of the file, such as ***"ND Dental Cost Survey_Smith & Associates"***

Once the form has been completed the form will need to be emailed to the following address: jweber@pcgus.com.

PLEASE DO NOT REPOST YOUR COMPLETED FORM TO THE FTP SITE, AS THIS WILL ALLOW OTHER CLINICIANS TO SEE YOUR FINANCIAL DATA. Should you inadvertently post your information to the FTP site, please contact Joe Weber at PCG at 1-800-210-6113 x 1476 as soon as possible for deletion of data. All completed forms, should be sent via email to the address outlined above.

Cost Report Survey Completion Instructions

Step #1: Contact information

Fill out the contact information on the right side of the survey with name, Medicaid Provider Number, phone number, and email address. Finally please indicate the end of your fiscal year end for 2007, i.e. 12/31/2007, 6/30/2007, etc.

Step #2: Total Expenses

Complete this section by reporting the expenses by category for the cost centers described in Line #1-5. Expenses should be reported as dollar amounts. Expenses should be classified into the following categories:

Salary Expenses: Report total annual salary paid to personnel in each cost center.

Purchased Services: Report total expenses incurred by purchasing services through a contractual agreement with a third party.

Supplies and Other Expenses: Report expenses here that cannot be classified as Salary or Purchased Services.

FTE's: Report full-time equivalent for each cost center where personnel is employed in rows in terms of hours worked per year (i.e. 2080 hours = 1 FTE).

Cost Center Definitions:

Line #1: Fringe Benefits – Report any fringe benefits expense incurred by the practice for all employees. This may include Employee Insurance, Paid Time Off, Employee Retirement Contribution, Unemployment Benefit Plans, FICA, Medicare, or Other Fringe Benefits.

Line #2: Dentist – Report the expenses incurred for all Dental professionals exclusive of Fringe Benefits or Administrative Support. This should include expenses incurred for activities related to the provision of treatment services, receiving supervision and/or consultation.

Line #3: Administrative Support - Report administrative support costs incurred by the practice. This may include the costs for receptionist(s), any business office functions such as Bookkeeping, Accounting, and Billing, or any Legal services utilized by the practice.

Line #4: Facility Operations and Maintenance – Report expenses related to the operations and maintenance of your office include utilities, janitorial services, etc.

Line #5: Other Costs – Report any additional expenses that cannot be classified in cost centers listed. Please provide a brief description of the items.

Step #3: Net Revenue

Complete this section by reporting the net revenue by the payer sources identified in the survey, i.e. Medicare, Medicaid, Self Pay, etc. Please report revenue not related to direct billable services in the line labeled "Other Revenue". Revenue should be reported as dollar amounts.

Step #4: Service Encounters

The second page of our cost survey tool includes space for providing service encounter information. If you are completing the form electronically, please use the tab called "Utilization" to enter the service information. Please complete this section by reporting the total number of services provided during your fiscal year 2007 by CDT (Code on Dental Procedures and Nomenclature) Code. Again, services should be reported as the total number of units provided by CDT Code (please provide all services not just services provided to Medicaid recipients). We understand the list of codes available for dentists is extensive. With that said, please enter only those CDT codes in which services were rendered during your 2007 fiscal year end period. Please omit any codes for which no service volume occurred during the 2007 fiscal year.

Providers completing the paper form of this survey may make additional copies of this schedule as needed to account for every service provided. Providers completing the electronic version of the survey may add additional lines in the document as is necessary to account for all services. Again, PCG strongly prefers to receive all documentation electronically when possible.

North Dakota Dental
Cost Survey

Contact Information

Name:

Medicaid Provider Number:

Phone Number:

Email Address:

Fiscal Year End (e.g. 6/30, 12/31):

Total Expenses: Please report fiscal year 2007 expenses incurred by your operations for each cost center below.					
Line #	Cost Center Description	Salary	Purchased Services	Supplies and Other Expense	FTE's (2080 hours = 1 FTE)
1	Fringe Benefits				
2	Dentist				
3	Administrative Support (includes legal fees, accounting fees, billing dept. fees etc.)				
4	Facility Operations and Maintenance				
5	Other Costs, Specify _____				
	Total	$ -	$ -	$ -	$ -

Net Revenue: Please report fiscal year 2007 net revenue for each payor source below.								
	Description	Medicaid	Medicare	Commercial	Self Pay	Uninsured	Other	Total Revenue
	Revenue from billable Direct Services							$ -
	Other Revenue (Misc. Income, Rent, etc....)							$ -
	Total Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -

B

M E M O R A N D U M

To: House Appropriation Committee

From: Joe Cichy, Exec. Director

Date: February 3, 2009

RE: **HB 1012**

Attached is documentation showing Medicaid financing improvements and recorded results from the American Dental Association that clearly show that increases in dental Medicaid reimbursement increase access to care for the Medicaid population. We have every reason to believe that dentists in North Dakota will significantly increase their participation providing Medicaid services as has happened in other states which have enacted similar measures. We can expect even more in North Dakota because of the nature of our people and the fact that they want to help these folks who experience financial difficulty.

Last session House Bill 1246 was voted out of both the House and Senate by a significant majority of the legislators. However, because the final appropriation was reduced by 87% of that which the original bill proposed it failed to provide the impact needed to solve access problems in the state.. However, the Governor has now included in his budget a reimbursement level which will provide the participation necessary to meet the needs of our Medicaid population. The rebasing at 75% of 2007 billed charges plus the 7% and 7% is necessary to set the DHS fee scheduled at a level that will increase access. The 75% of average billed charges may mistakenly seem generous. In contrast to the medical community where reimbursement "at cost" includes compensation for the physician, dentists evaluate costs of providing services without factoring in anything for their professional services. When considering the additional expenses related to no shows and recipient liability (not calculated into the department's numbers), the reimbursement for most dentists as proposed will still remain at or below overhead costs to provide services excluding any dentist compensation.

The survey prepared by the consultant to DHS intended to identify overhead costs in the dental office had many significant flaws. There was no proto-type to follow. This was the first time this attempt to establish dental costs had been made in the country. First, confidentiality could not be assured. We are dealing with many single practitioner practices where personal information could be easily tracked to that practitioner along with pay scales for their employees and pay schedules for their procedures. This could have created significant problems. Also, most offices do not have the computer equipment to easily provide this information, particularly with the number of codes that needed to be included. The survey was burdensomely long and complicated and had very poor explanations and directions for the practitioner to follow. The NDDA attempted to work with the consultant, but the various proposals we presented were dismissed out of hand. It would be unfair to use the failure of the consultant as a reason to deny Dental Medicaid reimbursement at a level that improves access to care for the Medicaid population.

American Dental Association
www.ada.org

Medicaid Financing Improvements and Reported Results

Extrapolated data from *State Innovations to Improve Access to Oral Health Care for Low-Income Children: A Compendium Update*

Financing and Reimbursement	Reported Results
ALABAMA	
March 2000: Medicaid dental reimbursements were increased in March 2000, to the same level as BC/BS of Alabama, i.e., 100% of Blue Cross/Blue Shield (BC/BS) rates (for all but nine dental procedure codes).	**December 2001:** Medicaid reported results of fee increase These results showed: • 18.6% increase in providers, • enrollment of 150+ new dentists to the Medicaid program, and • a decrease from 19 to 11 counties with one or no Medicaid enrolled dentists. At the end of two years: • A 38.7% increase in the number of dentists in Medicaid and an increase of 40.2% in the number of children receiving dental services. By July 2004: • Number of enrolled dental providers totaled 673, an increase of 363 new providers since October 2000. As of February 2004, there has been a 54% increase in the number of beneficiaries receiving at least one dental service since the increase in Medicaid dental reimbursement rates and implementation of the wider array of other initiatives comprising the Smile Alabama! initiative.

211 East Chicago Avenue Chicago, Illinois 60611-2678
p 312-440-2500 f 312-440-7494

DELAWARE	
January 1998: Initiated in January 1, 1998, Medicaid reimburses 85% of each dentist's submitted charges (e.g., if a dentist charges $100 for a dental exam, the program pays $85).	**January 1998:** The number of dentists participating in Medicaid increased initially from one to 75. As of August 2004, 130 of approximately 378 license dentists in the state were enrolled in the Medicaid program. The number of children treated in private dental offices has increased from 2,000 in 1998, to approximately 11,686 in state fiscal year 2003.

GEORGIA	
July 2000: Fifty-six of the most-used dental procedures were increased to between 75% and 80% of the average customary fees charged by Georgia dentists.	**2000 Forward:** As of October 2001, after the major reimbursement increase of July 2000 and other administrative program changes, the number of private dentists accepting Medicaid patients increased to more than 1,355 of the state's approximate 4,000 dentists (34%), up from only 259 enrolled dentists before July 2000. As of August 2004, of the 3,992 licensed dentists in the state, there were about 3,552 actively providing care. Data provided by the Department of Community Health indicated that dental provider enrollment in Medicaid for the fiscal year 2004 was 2,138, compared to 1,897 for the fiscal year 2003 (a 13% increase).

INDIANA	
In 1995 and 1997, the Office of Medicaid Policy and Planning implemented dental rate increases of approximately 10% and 11%, respectively. When access to care did not increase significantly, the state implemented a 147% increase, effective May 1998. This increase resulted in marketplace-level reimbursement equivalent to the 75th percentile of the rates reported by the 1995 ADA Survey of Dental Fees for the East North Central Region.	Based on Office of Medicaid Policy and Planning quarterly monitoring reports, in May 2001, more children were receiving dental services. The combined effects of several improvements including increased fees resulted in the following statistics, as of January 2003: • Provider participation increased from 916 dentists in 1997 to 1,443 dentists in 2002, and • children's annual dental visit rates increased from 15% in 1997 to 31% in 2002.

SOUTH CAROLINA	
In January 2000, fees were increased to the 75th percentile of private-sector fees. Once the 2000 fee increase was implemented, the South Carolina Dental Association began a recruitment campaign to increase dentist participation in the Medicaid program, sending information packets to licensed dentists and calling each individual dentist.	The number of Medicaid participating dentists increased from 619 in 1999—prior to the 2000 reimbursement rate increase and implementation of other innovations—to 886 by June 2001. As of February 2003, there were 1,071 enrolled dental providers. As of July 1, 2004, there were 1,165 individual enrolled providers.

MICHIGAN	
On May 1, 2000, Michigan established a demonstration program known as *Healthy Kids Dental* (HKD) in 22 of Michigan's 83 counties. Dental reimbursements for the services provided through the Health Kids Dental demonstration program are *identical to those in the commercial dental plan* contracted to administer the children's dental plans. Covered dental procedures under the program are paid at competitive market rates, with no patient co-payment requirements.	During HKD's first 12 months, 183 additional dentists who previously did not participate in the Medicaid program signed up to participate in HKD. Additionally, in the DeltaPremier counties, 85 % of dentists who already participated in a private Delta program also began to treat Medicaid-enrolled children through HKD. The increase in locally available dentists also reduced the distance that HKD children had to travel for care, and as a result, the proportion of Medicaid-enrolled children who received dental care in their county of residence nearly doubled under HKD. Within a relatively short period of time, for children enrolled for 12 months, the data shows a 39 % increase in the number of children seen under HKD; and for children enrolled for part of the year, there was a 55% increase of those seen under HKD. A study of dentists' attitudes toward the Healthy Kids Dental program indicates that dentists have high levels of satisfaction, are more likely to accept Medicaid children as patients, and believe they can spend more time on oral hygiene education with patients.

TENNESSEE	
October 2002: It was estimated that, before October 2002, dentists were paid on average about 40% of their cost for each dental procedure. Effective October 1, 2002, the reimbursement level for dentists was increased. Participating dentists are now reimbursed at the lesser of billed charges or the 75th percentile of the fees published in the 1999 American Dental Association (ADA) Survey of Fees for the East South Central region.	The dental provider network has grown by 81% since inception of the dental improvements. Approximately 25% of licensed and practicing dentists actively participate in the TennCare program. Eighty-six percent of participating dentists are accepting new TennCare patients into their practices, indicating additional capacity in the existing dental network to treat TennCare enrollees. Based on continuing review of GeoAccess status, it was determined in August 2004 that TennCare children in urban areas have good access to pediatric and general dental providers. While no provider network deficiencies are noted in rural areas, recruitment remains active, and dentists continue to join the network.

UTAH	
In July 1997, all dentists in rural counties and those in the urban counties of Davis, Weber, Salt Lake, and Utah who agreed to treat 100 Medicaid patients for the year became eligible to receive a payment incentive. The incentive program is ongoing as of July 2004. The incentive pays 120% of the established Medicaid fee—a 20% increase over fee-for-service reimbursement rates.	The dental reimbursement incentive program that began in 1997 increased by approximately 16% the number of patients receiving a dental visit in the following year. During the subsequent three years following implementation of the incentive program, 10% more dentists began treating Medicaid patients.

MEDICAID COMPENDIUM

To assist members and other dental stakeholders in advocating for improvements to their dental Medicaid programs, the ADA has published a series of policy briefs highlighting state innovations to help state legislators understand the necessity of establishing market-based reimbursement for dental Medicaid services. In addition, these briefs offer ways to improve the administration of the Medicaid program and expand efforts to encourage patient compliance with dental appointments and improve public awareness about the importance of oral health. These briefs, based on information published in the September 2003 ADA report "State Innovations to Improve Access to Oral Health Care for Low-Income Children: A Compendium," will be released this month at the Washington Leadership Conference.

http://www.prnewswire.com/mnr/ada/20973/

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Department of Human Services
Dental Services Information for Amendments

	Total	General	Federal /Other
Executive Budget Funding - Rebase @ Min of 75% of Average Billed Charges with 7/7 Inflation	4,183,836	1,546,085	2,637,751
Rebase @ Min of 75% Average Billed Charges	2,445,138	904,167	1,540,971
Inflation at 0/7	560,040	206,796	353,244
Total Rebase @ 75% & 0/7 Inflation	**3,005,178**	**1,110,963**	**1,894,215**
Difference Between Executive Budget & Rebase @ 75% with 0/7 Inflation	(1,178,658)	(435,122)	(743,536)

March 9, 2009

Testimony before the Senate Appropriations Committee
HB 1012 as it relates to Dental Medical Assistance Reimbursement

Chairman Holmberg and members of the Committee: My name is Dr. Dennis Sommers. I am a practicing dentist in Minot, North Dakota and serve as President of the North Dakota Dental Association. This testimony is presented in support of HB 1012 with regard to Governor Hoeven's dental Medicaid budget proposal.

The 2000 Surgeon General's report "Oral Health Care in America" noted that dental decay is the most common chronic childhood disease and that low income children suffer twice as much tooth decay as more affluent children. By and large, the segment of North Dakota's population for which Medicaid services are provided does not engage itself in this legislative process. Children, the primary beneficiary of dental Medicaid services in North Dakota, are not equipped to voice their needs. The North Dakota Dental Association is here to speak for them. The NDDA supports the state's efforts to address shortcomings in providing dental services to low income families.

Governor Hoeven's budget proposes dental Medicaid funding at a level similar to that which was passed by the ND House and Senate two years ago. Although such funding was approved by both chambers during the 2007 legislature, the appropriation was cut by 87% in the final hours by conference committee when different starting dates appeared in each chamber's bill. Governor Hoeven's budget reaffirms efforts of the 2007 legislature funding dental Medicaid based on 75% of billed charges – a target shown in other states to be successful to increase unmet treatment needs, provider participation and geographic access while stabilizing per-enrollee costs and increasing both provider and enrollee satisfaction.

It is essential to recognize that the Governor's budget proposal funding dental Medicaid at a level of 75% of average fiscal 2008 billed charges was not decided upon arbitrarily nor was it plucked from thin air. This proposal does not represent "guesswork" or just "hopeful optimism" that through this level of funding the existing crisis in delivery of dental Medicaid services in the state *might* be

addressed. Instead, **seventy-five percent is a figure that when used in other states has been demonstrated to be effective in jump-starting access to care for dental Medicaid.** State budgetary changes in amounts less than 75% have been notably less effective. The ND House Appropriations subcommittee – with no rationale or stated assurance of success in doing so – arbitrarily turned back the voltage on the defibrillator needed to resuscitate the nearly breathless dental Medicaid system by reducing Governor Hoeven's funding proposal. They did this knowing the monetary requirements needed for a successful Medicaid program. There is no shortage of fiscal power in our state's surplus. There exists the fiscal ability to solve this crisis. Failure to fund dental Medicaid at a level shown to be effective and as proposed by Governor Hoeven risks perpetuation of the dental access problems which keep basic dental care out of the reach of many of our state's developmentally disabled, indigent children, elderly and otherwise disadvantaged citizens. **Please work to reinstate funding including inflationary factors of the dental Medicaid portion of HB 1012 at levels proposed by Governor Hoeven.**

The Centers for Medicare & Medicaid Services (CMMS) 2008 NATIONAL DENTAL SUMMARY points out:

> "...a State must adhere to certain federal requirements. ... for most individuals under the age of 21, dental services are a mandatory benefit as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service as defined in section 1905(r) of the Social Security Act."

Such statutory requirements are intended to ensure all eligible Medicaid beneficiaries under 21 are both informed of ***and have access to*** dental services. How are we doing? Measurements by CMMS ranked North Dakota dead last in 2006 with only 19% of eligible Medicaid enrollees accessing dental care. With a national average between 50 and 55 percent of adults and children seen by dentists annually, North Dakota's Medicaid access to care falls woefully short. We should all recognize the need to improve dental access for North Dakota's low-income families – especially children.

According to the American Dental Association, individual dentists give away an average of $35,000 to $40,000 in charitable dental care (free and discounted care for low-income individuals) per year. North Dakota's dentists are extremely generous donating time and talents to help ND's less fortunate population through Give Kids a Smile projects, an American Dental Association (ADA) nationwide

event where dentists volunteer care for children. Since 2000, North Dakota dentists have also provided care through the Donated Dental Services Program with just under a million dollars in free dentistry provided for disabled and elderly North Dakotans. Dentists in ND communities voluntarily provide yearly dental screenings for Head Start kids. Included with such generosity, 90% of North Dakota dentists are providers of Medicaid services; services that cost more to deliver than dentists are paid through Medicaid reimbursement. Although dentists are very generous, they operate as small businesses and are unable to open doors wide to subsidize the state's Medicaid system. With the majority of dentists forced to limit numbers of Medicaid patients they see, 20% of dentists now provide 80% of the state's dental Medicaid services.

The governor's budget is an extremely important step in achieving the access to dental care North Dakota is mandated by the Social Security Act to provide. During other testimony on this subject Committee members have often asked, "What guarantee can you offer that funding will improve access to care?" The ADA's report found at http://www.prnewswire.com/mnr/ada/20973/ answers this question. The report states that **experience in states like Georgia, Tennessee, Indiana, Michigan and South Carolina shows that raising reimbursement to levels that approximate the 75th percentile of prevailing fees can significantly increase access and utilization of dental services by the Medicaid-eligible** and participation by dentists, especially when such initiatives are actively promoted by state dental organizations and commercial intermediaries. We have every reason to believe similar results can and will be accomplished in North Dakota with adoption of the dental Medicaid funding proposals in Governor Hoeven's budget.

The CMMS 2008 Summary further reports dental Medicaid **program improvements can be expected to yield significant savings in treatment costs** on an individual level since on average, ongoing treatment costs to maintain oral health per individual will be less over time. This is particularly likely for very young children, with catastrophic treatment needs that often require costly hospital services in addition to significant dental treatment. These costs can account for approximately 30% of typical Medicaid dental program expenditures. Engaging the capacity of private-sector dentists with adequate Medicaid funding will maximize use of taxpayer dollars in providing dental care to the state's low-income population. Further, substantial savings will be seen since **dental care provided in dental office settings reduces the frequency of emergency room**

visits by Medicaid enrollees where treatment is primarily palliative and recurring rather than definitive and corrective.

A "Dental Medicaid in North Dakota Fact Sheet" is included for your review with this testimony. The North Dakota Dental Association urges your support of Governor Hoeven's dental Medicaid budget proposals in order to:

- Fulfill the intent of the 2007 legislature's vote
- Enable the state to meet access requirements mandated by the Social Security Act
- Reduce costs related to dental related emergency room visits
- Improve overall health and well being of Medicaid recipients

Thank you.

Dr. Dennis Sommers, President

North Dakota Dental Association

NORTH DAKOTA
Optometric Association

HB 1012

Good Afternoon Mr. Chairman and Members of the Committee,

For the record, my name is Nancy Kopp. I represent the North Dakota Optometric Association.

I appear before you in support of the portion of HB 1012 that provides funding, as included in the Governor's proposal, for optometric services, eye exams and eyeglasses for children and adults.

Early detection of vision conditions is important, in that 80% of learning is visual.

We ask for your support of the current proposal of an annual eye exam and eyewear for children and once every 2 years, for adults.

As you may know, optometric services was not part of the rebasing process for providers in the interim. Current reimbursement for optometric services, is at the SCHIP level and medical services, is at the physician rate.

95% of optometrists are participating providers.

In closing, I would like to remind you that NDOA optometrists provide eye exams and glasses at no charge to the uninsured, through our Vision USA-ND Project, in conjunction with ND Lions Clubs and the Dakota Medical Foundation. Last year we had 293 applications.

I would be happy to answer any questions.

North Dakota Optometric Association
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HOUSE BILL 1012 – Medical Services
Appropriations – Human Resources Division Committee

Testimony by Mathew C. Schwarz
January 26, 2009

same given to Senate

Good Morning Chairman Pollert and Members of the Committee.

My name is Matt Schwarz. I am here as a parent to speak in support of the funding in the Governor's budget ~~for the OAR~~ providing $644,330 for Intense Medical Needs In Family Homes.

This directly impacts our family.

My wife Marcia and our daughter Jessica have Myotonic Muscular Dystrophy. Jessica is 30 years of age and lives in our home because of her intense medical needs. Jessica is on life support and gets Family Support Services through Community Options, her human service provider. She goes out into the community and generally does well but needs close monitoring and line-of-sight supervision for her medical needs 24/7. I personally take a night shift each week to care for her in addition to gaps in services and coordinating all of her needs with medical providers and support staff.

Jessica's intense medical needs require staff at Community Options to have an incredible amount of knowledge about her delicate medical needs including suctioning through a tracheotomy tube, sterile technique, an understanding of all the medical equipment including ventilator, oxygen, pulse oximeters, medications, etc. It also requires an understanding of vital signs that show if Jessica is on the verge of distress such as her disposition, skin color, amounts and color sputum suctioned out, monitoring her food intake and her daily output, etc. to mention just a few.

We have been fortunate with caregivers that do an excellent job of caring for our daughter. We feel Community Options screens their staff very carefully to give us their best personnel. However, there is a pay discrepancy for the caregivers that provide support in a setting involving intense medical needs for recipients like our daughter Jessica. Because of their responsibilities, capabilities, and learned skills they should receive a higher wage than workers with less responsibility and skills.

Without adequate compensation these caregivers often find better paying jobs. Aside from the extra stress and risks to our daughter getting the services by new personnel, the cost of re-training is costly. It is difficult to maintain a quality continuum of care when good and knowledgeable caregivers leave to take better paying jobs. When Jessica gets ill and ends up in the hospital the costs for everyone (including the Medicaid program) skyrocket instantly! Years ago our goal was to keep Jessica out of the hospital for at least a one year interval. Now we have intervals that sometimes go 2-3 years with very short hospital stays. High quality services provided by our caregivers are directly related to this outcome.

Additionally, service providers like Community Options not only need the additional funding the DHS and Governor included in the budget to reward those individuals who provide this higher level of care with better wages, but also for better training and improved quality assurance programs. Service providers need this additional funding for healthcare professionals to better train and monitor caregivers at appropriate intervals in family homes where more intense medical services are provided .

This concludes my written testimony. I will be happy to answer any questions you may have.

The home tele-monitoring program utilized in our agency has shown that tele-monitored patients score higher on fourteen out of sixteen health outcomes compared to the program's non-monitored patients.

Home tele-monitoring strives to encourage shared decision making between providers and patients. The patient can take a more active role in their health care and feel more confident making decisions related to their care thus empowering the patient to be more accountable for their own health which assists in reducing costs across the continuum of care.

The medical cost of treating chronic disease accounts for more than 75% of the nation's $1.4 trillion medical care costs. Home tele-monitoring will provide interventions to the patient in the least costly setting, at the right time, and in the right place. Tele-monitoring reduces the overall number of visits a nurse must make thus reducing the cost of providing the care.

The goals and objectives of the program relate directly to the need for accessible, quality driven, and affordable management of chronic disease. We want our patients to improve with interventions that are provided. As the demographics change and the population ages, people want involvement in their care and a sense of control regarding their health care options.

These services are not reimbursed by ND Medicaid. NDAHC is requesting that ND Medicaid reimburse Home Health Agencies for home tele-monitoring visits at the same rate as a skilled nursing visit. Minnesota Medicaid's reimbursement structure includes reimbursement of tele-monitored visits at the same rate as skilled nursing visits. NDAHC would advocate for similar reimbursement by ND Medicaid, but would recommend that the definition of home tele-monitoring visits be broad enough to account for changing technology.

The reimbursement of home tele-monitoring visits by certified Home Health Agencies would enable a greater number of agencies to provide this important technology. This will provide greater efficiencies in the delivery of patient care no matter where the patient might reside.

Enhancements and new technology will launch the program beyond its current capabilities expanding its value to customers for many years to come.

Chairman Pollert and members of the committee, thank you for the opportunity to testify before you today - I urge your favorable recommendation for reimbursement of home tele-monitoring by the State of North Dakota.

Thank you for your time and attention. I'd be happy to answer any questions the committee may have.

North Dakota Department of Human Services

Medicaid and SCHIP Income Disregards and Deductions

(As of December 2008)

Disregarded Income - ***disregards are not considered an income source***

The following types of income are disregarded in determining eligibility for Medicaid/SCHIP:

1. State or tribal money payments for foster care, subsidized guardianship, or the subsidized adoption program;
2. Temporary Assistance for Needy Families (TANF) benefit and support services payments;
3. Benefits received through the Low Income Home Energy Assistance Program;
4. Refugee cash assistance payments;
5. County general assistance payments;
6. Payments from the Child and Adult Food Program for meals and snacks to licensed families who provide day care in their home;
7. Family subsidy program payments;
8. Housing assistance payments;
9. Per capita judgment funds paid to members of any Indian tribe under Pub. L. 92-254, Pub. L. 93-134, or Pub. L. 97-403;
10. Income derived from submarginal lands, conveyed to Indian tribes and held in trust by the United States, as required by Pub. L. 94-114;
11. Income earned by a child who is a full-time student, or a part-time student who is not employed one hundred hours or more per month;
12. Supplemental Security Income (SSI) - *SCHIP disregards all SSI. Medicaid disregards lump sum SSI payments. Medicaid counts SSI if the client chooses to be eligible under the children and family category. If they choose to be eligible under the aged and disabled category, they get an income level equal to the level that established SSI eligibility.*
13. Compensation received by volunteers participating in certain federal volunteer programs;
14. Payments made to recipients under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

15. All income, allowances, and bonuses received as a result of participation in the Job Corps Program;
16. Payments received for the repair or replacement of lost, damaged or stolen assets;
17. Occasional small gifts;
18. In-kind income except in-kind income received in lieu of wages;
19. A loan from any source that is subject to a written agreement requiring repayment by the recipient;
20. Income tax refunds and earned income credits;
21. Homestead tax credits;
22. Educational loans, scholarships, grants, awards, Workforce Safety & Insurance vocational rehabilitation payments, and work-study received by a student.
23. Any fellowship or gift (or portion of a gift) used to pay the cost of tuition and fees at any educational institution;
24. Training funds received from Vocational Rehabilitation;
25. Training allowances of up to thirty dollars per week provided through a tribal native employment works program, or the Job Opportunities and Basic Skills Training program;
26. Needs-based payments, support services, and relocation expenses provided through programs established under the Workforce Investment Act (WIA), and through the Job Opportunities and Basic Skills program;
27. Training stipends provided to victims of domestic violence by private, charitable organizations, such as the Seeds of Hope Gift Shop, or the Abused Adult Resource Center, for attending their educational programs;
28. Tax-exempt portions of payments made as a result of the Alaska Native Claims Settlement Act;
29. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens, and eligible Aleuts made under the Wartime Relocation of Civilians Reparations Act;
30. Agent Orange payments;
31. Crime Victims Reparation payments;
32. German reparation payments made to survivors of the holocaust, and reparation payments made under sections 500 through 506 of the Austrian General Social Insurance Act;
33. Assistance received under the Disaster Relief and Emergency Assistance Act of 1974 or some other federal statute, because of a

presidentially declared major disaster (but not disaster assistance unemployment compensation);

34. Allowances paid to children of Vietnam veterans who are born with spina bifida, or to children of women Vietnam veterans who are born with certain covered birth defects;
35. Netherlands Reparation payments based on Nazi, but not Japanese, persecution during World War II, Public Law 103-286;
36. Radiation Exposure Compensation, Public Law 101-426;
37. The first $2,000 per year of lease payments deposited in IIM accounts;
38. Interest or dividend income earned on liquid assets;
39. Additional pay received by military personnel as a result of deployment to a combat zone;
40. Fifty dollars per month of current child support, received on behalf of children in the SCHIP unit;
41. Reimbursements from an employer, training agency or other organization for past or future training, or volunteer related expenses; and
42. All wages paid by the Census Bureau for temporary employment related to census activities.

Income Deductions - ***deductions are subtracted after the income is calculated***

The following income deductions are allowed in determining Medicaid/SCHIP eligibility:

1. Mandatory payroll deductions and union dues withheld, or ninety dollars, whichever is greater;
2. Mandatory retirement plan deductions;
3. Expenses of a blind person reasonably attributed to earning income;
4. Reasonable child care expenses, not otherwise reimbursed, that the Medicaid/SCHIP Unit is responsible to pay, if necessary to engage in employment or training;
5. Non-voluntary child and spousal support payments if actually paid;

6. For individuals who are employed or in training, thirty dollars may be deducted as a work or training allowance (does not apply to children in school);
7. The cost of premiums for health insurance for members of the unit who are not eligible for Medicaid/SCHIP; and
8. Medical expenses for necessary medical or remedial care for members of the unit who are not eligible for Medicaid/SCHIP.

Additional Income Deductions allowed for Medicaid

The following additional income deductions are allowed in determining Medicaid eligibility

1. Reasonable expenses, such as food and veterinarian expenses, necessary to maintain a dog that is trained to detect seizures for a member of the Medicaid unit.
2. Premiums for long term care insurance.
3. Transportation expenses necessary to secure medical care.
4. Reasonable adult dependent care expenses.
5. The cost to purchase or rent a car safety seat for a child through age ten is allowed as a deduction if a seat is not otherwise reasonably available.
6. A disregard of $20 per month for aged, blind and disabled applicants or recipients.
7. Guardian or conservator fees, up to a maximum of five percent of countable gross monthly income.
8. For all aged, blind, or disabled applicants or recipients, sixty-five dollars plus one-half of the remaining monthly gross earned income.

Department of Human Services
S-CHIP Scenarios
Reprojections and Updated BCBS Premiums

S-CHIP Budget @ 160% Compared to Reprojection @ 200% It is estimated 200% will add 1,158 children			
	Current SCHIP Budget @ 160%	SCHIP Budget @ 200% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload & Cost
Monthly Average Caseload	5,567	4,395	(1,172)
Ending Caseload	5,907	5,000	(907)
General	8,431,055	6,243,672	(2,187,383)
Federal	24,143,800	17,879,974	(6,263,826)
Total	32,574,855	24,123,646	(8,451,209)

S-CHIP Budget @ 160% Compared to Reprojection @ 160% It is estimated 160% will add 439 children			
	Current SCHIP Budget @ 160%	SCHIP Budget @ 160% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload and Cost
Monthly Average Caseload	5,567	3,941	(1,626)
Ending Caseload	5,907	4,281	(1,626)
General	8,431,055	5,598,799	(2,832,256)
Federal	24,143,800	16,033,737	(8,110,063)
Total	32,574,855	21,632,536	(10,942,319)

S-CHIP Budget @ 160% Compared to Reprojection @ 175% It is estimated 175% will add 829 children			
	Current SCHIP Budget @ 160%	SCHIP Budget @ 175% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload and Cost
Monthly Average Caseload	5,567	4,191	(1,376)
Ending Caseload	5,907	4,671	(1,236)
General	8,431,055	5,954,214	(2,476,841)
Federal	24,143,800	17,051,266	(7,092,534)
Total	32,574,855	23,005,480	(9,569,375)

S-CHIP Budget @ 160% Compared to Reprojection @ 185% It is estimated 185% will add 980 children			
	Current SCHIP Budget @ 160%	SCHIP Budget @ 185% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload and Cost
Monthly Average Caseload	5,567	4,279	(1,288)
Ending Caseload	5,907	4,822	(1,085)
General	8,431,055	6,079,139	(2,351,916)
Federal	24,143,800	17,408,925	(6,734,875)
Total	32,574,855	23,488,064	(9,086,791)

Note:
The Executive Budget was based upon a preliminary premium from BCBS of $243.93.
The Department has just received the final 09-11 premium of $228.71 from BCBS.

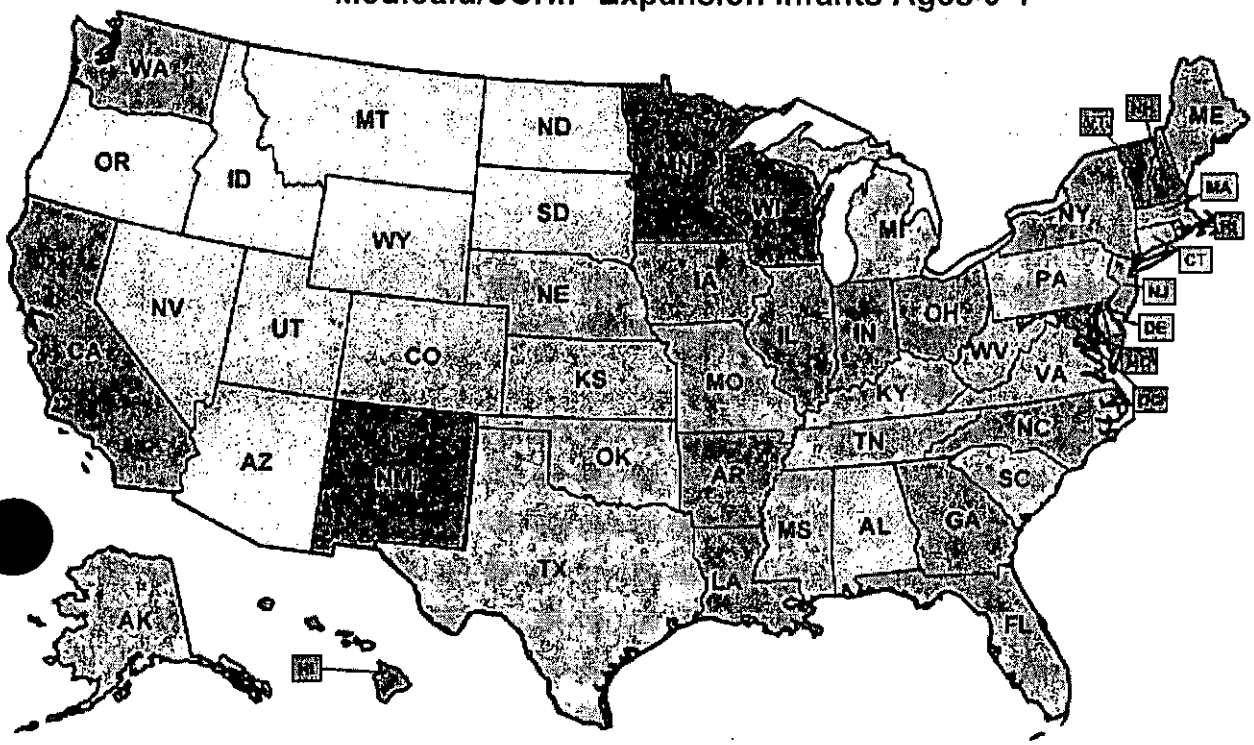
Income Eligibility Levels for Children's Regular Medicaid and Children's SCHIP-Funded Medicaid Expansions by Annual Incomes and as a Percent of Federal Poverty Level (FPL), 2009

Bar Graph | Table | Map | Map & Table

Rank by: State name (alphabetical) View by: % | $

Rank Order: ▲▼

Medicaid/SCHIP Expansion Infants Ages 0-1



133% - 150%

175% - 185%

200%

235% - 300%

	Medicaid/SCHIP Expansion Infants Ages 0-1	Medicaid/SCHIP Expansion Children Ages 1-5	Medicaid/SCHIP Expansion Children Ages 6-19
United States	133% [1]	133% [1]	100% [1]
Alabama	133%	133%	100%
Alaska	175%	175%	175%
Arizona	140%	133%	100%
Arkansas	200%	200%	200% [4]
California	200% [2]	133%	100%
Colorado	133%	133%	100%
Connecticut	185%	185%	185%

Delaware	200%	133%	100%
District of Columbia	300%	300%	300%
Florida	200%	133% [3]	100% [3,4]
Georgia	200% [5]	133%	100% [4]
Hawaii	300%	300%	300%
Idaho	133%	133%	133%
Illinois	200% [5,6]	133% [6]	133% [6]
Indiana	200%	150%	150%
Iowa	200% [7]	133% [7]	133% [7]
Kansas	150% [8]	133% [8]	100% [8]
Kentucky	185%	150%	150%
Louisiana	200% [9]	200% [9]	200% [9]
Maine	200%	150%	150% [10]
Maryland	300%	300%	300%
Massachusetts	200% [6]	150% [6]	150% [6]
Michigan	185%	150%	150%
Minnesota	280% [11]	275% [11]	275% [11]
Mississippi	185%	133%	100%
Missouri	185%	150%	150%
Montana	133% [12]	133% [12]	100% [12]
Nebraska	185%	185%	185% [13]
Nevada	133%	133%	100%
New Hampshire	300%	185%	185%
New Jersey	200% [5]	133%	133%
New Mexico	235%	235%	235%
New York	200% [6]	133% [6]	100% [4,6]
North Carolina	200%	200%	100%
North Dakota	133%	133%	100%
Ohio	200% [14]	200% [14]	200% [4,14]
Oklahoma	185% [15]	185% [15]	185% [15]
Oregon	133%	133%	100%
Pennsylvania	185%	133%	100%
Rhode Island	250%	250%	250%
South Carolina	185% [16]	150% [16]	150% [16]
South Dakota	140%	140%	140%
Tennessee	185% [17,18]	133% [17,18]	100% [17,18]
Texas	185%	133%	100%
Utah	133%	133%	100%
Vermont	300% [19]	300% [19]	300% [19]
Virginia	133%	133%	133%
Washington	200%	200%	200%
West Virginia	150% [20]	133% [20]	100% [20]
Wisconsin	250% [6,21]	250% [6,21]	250% [4,6,21]
Wyoming	133%	133%	100%

Notes: Data as of January 2009 unless otherwise noted.
To be eligible in the infant category, a child has not yet reached his or her first birthday. To be eligible in the 1-5 category, the child is age one or older, but has not yet reached his or her sixth birthday. To be eligible in the 6-19 category, the child is age six or older, but has not yet reached his or her 19th birthday.
The income eligibility levels noted may refer to gross or net income depending on the state. Income eligibility levels listed are either for

regular Medicaid where states receive "regular" Medicaid matching payments or show eligibility levels for the state's SCHIP-funded Medicaid expansion program where the state receives the enhanced SCHIP matching payments for these children. The eligibility level listed is the higher of these two standards.
Eligibility levels shown as percent of the FPL. Currency figures based on FPL for a family of three in 2008: $17,600 for 48 contiguous states and District of Columbia, $22,000 for Alaska, $20,240 for Hawaii.

Sources: Source 1: Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009. Data based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, January 2009. Available at http://www.kff.org/medicaid/7855.cfm. State data are from Source 1.

Source 2: Medicaid Eligibility, Department of Health and Human Services, Centers for Medicare and Medicaid Services. US figures from Source 2.

Definitions: **The Federal Poverty Level (FPL)** was established to help government agencies determine eligibility levels for public assistance programs such as Medicaid. FPL is represented in this resource as poverty guidelines as opposed to the slightly different poverty thresholds.

Footnotes:

1. US Figure is the federal minimum eligibility level based on the CMS Eligibility Report; 2008.

2. In California, infants born to women on the Access for Infants and Mothers (AIM) program are automatically enrolled in SCHIP unless the child is enrolled in employer-sponsored insurance or no-cost full scope Medi-Cal. The income guideline for these infants, through their second birthday, is 300 percent of the federal poverty line.

3. Florida operates two SCHIP-funded separate programs. Healthy Kids covers children ages five through nineteen, as well as younger siblings in some locations. Medi-Kids covers children ages one through four.

4. The state has adopted the Medicaid option to cover children aging out of foster care, referred to as the Chafee option. In Arkansas, a small group of foster care children can continue in their U-18 and Medically Needy Foster Care categories and receive Medicaid until they are 21 years old. In Florida, the state amended its state law to extend Medicaid coverage to children aging out of foster care until their 21st birthday. Previously, the state only covered children aging out of foster care until their 20th birthday. In Georgia, a child aging out of IV-E Medicaid can sign a consent form to remain in foster care and receive Medicaid coverage up to 21. Ohio and Wisconsin adopted this option in January 2008. New York adopted this option in January 2009.

5. Georgia, Illinois, and New Jersey cover infants in families with income at or below 200 percent of the federal poverty line who are born to mothers ›lled in Medicaid. Georgia and New Jersey cover infants not born to Medicaid enrolled mothers in families with income at or below 185 percent of the ·al poverty line. Illinois covers infants not born to Medicaid-enrolled mothers in families with income at or below 133 percent of the federal poverty line.

Illinois, Massachusetts, New York, and Wisconsin provide state-financed coverage to children with incomes above SCHIP levels. Eligibility is 300% for Wisconsin.

7. Iowa passed legislation in 2008 to expand childrens eligibility up to 300 percent of the federal poverty line in July 2009 dependent on funding and other federal policy issues.

8. Kansas passed legislation in May 2008 that would expand SCHIP eligibility from 200 percent of the federal poverty line to 250 percent of the federal poverty line depending on federal funding and resolution of August 17th directive. There would be an 8 month waiting period for the expansion population.

9. Louisiana passed legislation in June 2008 to expand to 300 percent of the federal poverty line, but have currently implemented up to 250 percent of the federal poverty line. They also passed legislation to adopt the Chafee option, but implementation has been delayed due to hurricanes. Louisiana created a separate SCHIP program in 2008.

10. Maine has not adopted the Chafee option (see footnote 4 for definition), however the state does cover individuals under 21 at or below 150 percent of the federal poverty line. Children in Maine who age out of foster care can voluntarily choose to remain in foster care while finishing school and can keep their MaineCare coverage.

11. In Minnesota, the infant category under "regular" Medicaid includes children up to age 2. Under "regular" Medicaid, income eligibility for infants is up to 275 percent of the federal poverty line, and under SCHIP, eligibility for infants is between 275 percent and 280 percent of the federal poverty line. Under "regular" Medicaid, income eligibility for children ages 2-19 is up to 150 percent of the federal poverty line, and under the Section 1115 waiver, income eligibility for children in this age group is between 150 and 275 percent of the federal poverty line. The Section 1115 waiver provides coverage for children up to age 21.

12. Montana passed Initiative 155 in November 2008 which increases income eligibility in CHIP to 250 percent of the federal poverty line, will offer health coverage to all uninsured Montana children with a sliding scale premium, includes presumptive eligibility, increases the waiting period for children, removes the asset test for children and creates a single store front for Medicaid and CHIP. The implementation date is October 2009.

Nebraska there is former ward coverage for children that continue to finish schooling and extends up to age 21.

14. Ohio submitted a state plan amendment to expand their SCHIP-funded Medicaid coverage to children in families up to 300 percent of the federal poverty line. The state hopes to implement this expansion in January 2009, pending CMS approval.

15. Oklahoma passed legislation to increase the income eligibility guideline to 300 percent of the federal poverty line under its current section 1115

percent of the federal poverty line and the future expansion of 218 percent of the federal poverty line is pending further CMS guidance and SCHIP reauthorization.

16. South Carolina implemented a separate SCHIP program for children with income between 150 and 200 percent of the federal poverty line in April 2008.

17. In Tennessee, enrollment under the states waiver program, called TennCare Standard, is closed to new applicants. The only children currently receiving TennCare Standard are children who lose Medicaid, have no access to insurance, and have family income below 200 percent of the federal poverty line, or who are medically eligible (have a health problem that prevents them from getting health insurance). In 2007 the state created a separate SCHIP program for children in families with income up to 250 percent of the federal poverty line. Eligible children may have access to health insurance but must be uninsured.

18. For Tennessee, the Medicaid figures shown represent the income eligibility guidelines under regular Medicaid. Enrollment under the states waiver program is closed to new applicants; some children who lose Medicaid can enroll (see footnote 4). In 2007 the state created a separate SCHIP program for children in families with income up to 250 percent of the federal poverty line. Children not eligible for regular Medicaid and children closed out of TennCare Standard who meet the SCHIP income guidelines can enroll in the separate SCHIP program.

19. In Vermont, Medicaid covers uninsured children in families with income at or below 225 percent of the federal poverty line; uninsured children in families with income between 226 and 300 percent of the federal poverty line are covered under a separate SCHIP program. Underinsured children are covered under Medicaid up to 300 percent of the federal poverty line. This expansion of coverage for underinsured children was achieved through an amendment to the states Medicaid Section 1115 waiver.

20. West Virginia has passed legislation to expand SCHIP to 250 percent of the federal poverty line in January 2009 pending approval of their state plan amendment.

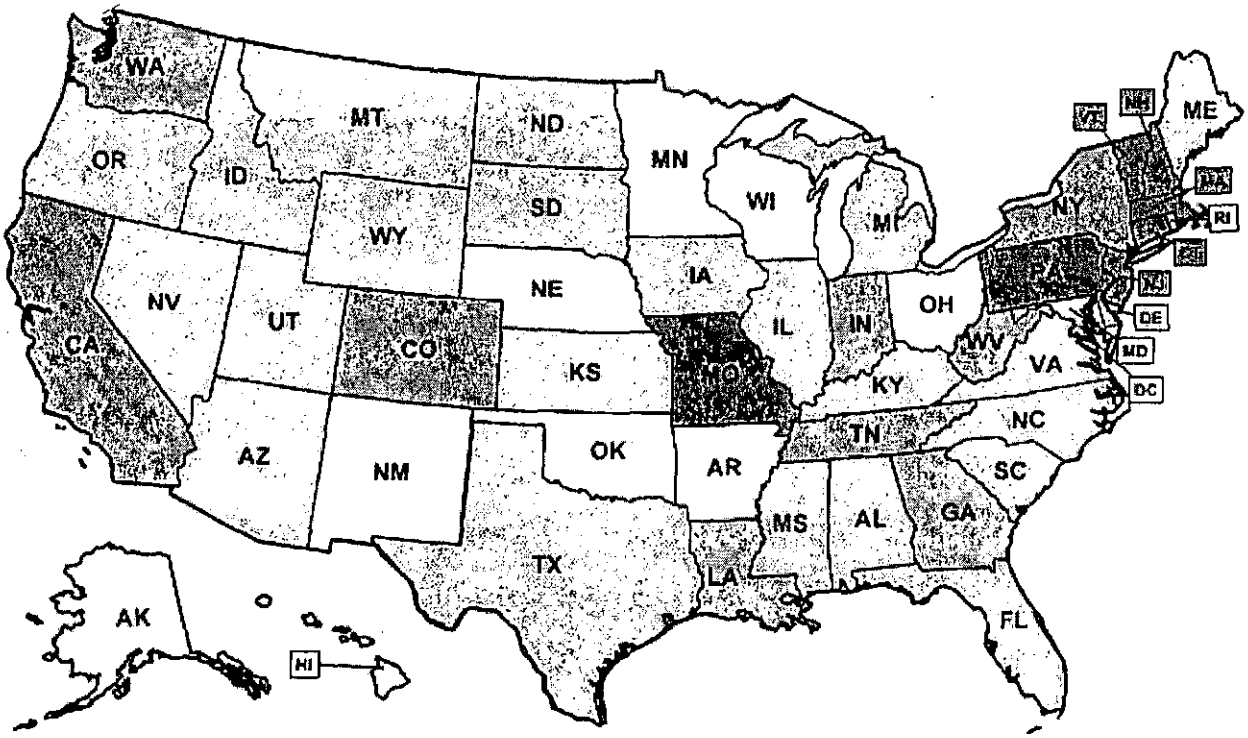
21. Wisconsin implemented BadgerCare Plus in February 2008. Badgercare Plus has no income limit for children. The state will receive Medicaid reimbursement for children up to 250 percent of the federal poverty line and children with incomes between 251 percent and 300 percent of the federal poverty line are covered with state funds.

Income Eligibility Levels for Children's Separate SCHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, 2009

Bar Graph | Table | Map | Map & Table

Rank by: State name (alphabetical) View by: % | $

Rank Order: ▲▼



150% - 200%

205% - 250%

300% - 350%

	Income Eligibility --Separate SCHIP Prog
United States	NA [1]
Alabama	200%
Alaska	NA
Arizona	200%
Arkansas	NA
California	250%
Colorado	205%
Connecticut	300%
Delaware	200%
District of Columbia	NA
Florida	200% [2]

Hawaii	NA
Idaho	185%
Illinois	200% [3]
Indiana	250%
va	200%
sas	200%
Kentucky	200%
Louisiana	250% [4]
Maine	200%
Maryland	NA
Massachusetts	300% [3]
Michigan	200%
Minnesota	NA
Mississippi	200%
Missouri	300%
Montana	175%
Nebraska	NA
Nevada	200%
New Hampshire	300%
New Jersey	350%
New Mexico	NA
New York	250% [3]
North Carolina	200%
North Dakota	150%
o	NA
lahoma	NA
regon	185%
Pennsylvania	300%
Rhode Island	NA
South Carolina	200% [5]
South Dakota	200%
Tennessee	250% [6]
Texas	200%
Utah	200%
Vermont	300% [7]
Virginia	200%
Washington	250%
West Virginia	220%
Wisconsin	NA [8]
Wyoming	200%

Notes: Data as of January 2009.
The income eligibility levels noted may refer to gross or net income depending on the state. "Regular" Medicaid refers to coverage under Medicaid eligibility standards for children in place prior to SCHIP; states receive "regular" Medicaid matching payments as opposed to enhanced SCHIP matching payments for these children.
Eligibility levels shown as percent of the FPL. Currency figures based on FPL for a family of three in 2008: $17,600 for 48 contiguous states and District of Columbia, $22,000 for Alaska, $20,240 for Hawaii.

Sources: Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009. Data based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, January 2009. Available at http://www.kff.org/medicaid/7855.cfm.

The Federal Poverty Level (FPL) was established to help government agencies determine eligibility levels for public assistance programs such as Medicaid. FPL is represented in this resource as poverty guidelines as opposed to the slightly different poverty thresholds.
NA: Not applicable because state does not have separate SCHIP program.

Notes:

1. Not applicable because there are no national eligibility levels.

2. Florida operates two SCHIP-funded separate programs. Healthy Kids covers children ages five through nineteen, as well as younger siblings in some locations. Medi-Kids covers children ages one through four.

3. Illinois, Massachusetts, and New York provide state-financed coverage to children with incomes above SCHIP levels. Eligibility is unlimited in Illinois and is 400% in Massachusetts and New York.

4. Louisiana created a separate SCHIP program in 2008.

5. South Carolina implemented a separate SCHIP program for children with income between 150 and 200 percent of the federal poverty line in April 2008.

6. In 2007 the state created a separate SCHIP program for children in families with income up to 250 percent of the federal poverty line. Children not eligible for regular Medicaid and children closed out of TennCare Standard who meet the SCHIP income guidelines can enroll in the separate SCHIP program.

7. In Vermont, Medicaid covers uninsured children in families with income at or below 225 percent of the federal poverty line; uninsured children in families with income between 226 and 300 percent of the federal poverty line are covered under a separate SCHIP program. Underinsured children are covered under Medicaid up to 300 percent of the federal poverty line. This expansion of coverage for underinsured children was achieved through an amendment to the states Medicaid Section 1115 waiver.

8. Wisconsin implemented BadgerCare Plus in February 2008. Badgercare Plus has no income limit for children. The state will receive Medicaid reimbursement for children up to 250 percent of the federal poverty line and children with incomes between 251 percent and 300 percent of the federal poverty line are covered with state funds.

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Testimony
House Bill 1012
House Appropriations - Human Resources Committee
Representative Chet Pollert, Chairman
January 27, 2009

Chairman Pollert and members of the Committee: my name is Carlotta McCleary. I am the Executive Director of ND Federation of Families for Children's Mental Health (NDFFCMH). NDFFCMH is a parent run advocacy organization that focuses on the needs of children and youth with emotional, behavioral and mental disorders and their families, from birth through transition to adulthood.

NDFFCMH supports increasing the net income eligibility from 150% to 200% of the poverty line for the state children's health insurance program. Expanding the net income eligibility allows more children to access mental health care. For many children, mental health care is a key component of the array of services needed for healthy childhood development.

Mental disorders affect about one in five American children and one in ten experience serious emotional disturbances that severely impair their functioning, according to the Surgeon General's comprehensive report on mental health. **Moreover, low-income children enrolled in Medicaid and SCHIP have the highest rates of mental health problems.**

Sadly, over two-thirds of children struggling with mental health disorders do not receive mental health care. The President's New Freedom Commission on Mental Health found that without early and effective identification and interventions, childhood mental disorders can lead to a downward spiral of school failure, poor employment opportunities, and poverty in adulthood. Untreated mental illness may also increase a child's risk of coming into contact with the juvenile justice system, and children with mental disorders are at a much higher risk for suicide.

NDFFCMH works with many families whose children have an Autism Spectrum Disorder. We support the Department of Human Services (DHS) budget that includes an autism waiver for children birth through five. Many of our children and adults do not currently meet the eligibility that ND DHS has set in its Developmental Disability Waiver.

We know that the needs go far beyond the current Autism Waiver proposal. Children and youth with autism spectrum disorder continue to have needs across their life span. Their needs do not stop at the age of five. Many of the transitioning age youth lack the adaptive skills necessary to become independent adults. There is a need for ongoing support for employment as well as supportive living arrangements. NDFFCMH would like to see an autism waiver expanded to include children as well as adults.

NDFFCMH supports increasing Family Foster Care payments to the nationally recommended level. We believe this will help recruit family foster homes.

Transition age youth with mental health disorders are not unique in experiencing difficulties as they transition to adulthood, they are more likely than their peers to experience poor outcomes, including areas of employment and education. Left without access to necessary services and supports, successful transitions to adulthood cannot be realized.

NDFFCMH supports the Department's budget which includes funding for youth facilities in Bismarck and Fargo, each providing eight residential beds for youth in transition. In addition to shelter, participating youth will have access to counseling, case management and other services through the regional human service centers.

NDFFCMH supports the development of a coordinated service delivery system to maximize continuity of care and access to services. Young adults who are transitioning to the adult mental health system should be able to benefit from the infrastructure that would be developed to access such services as peer support programs, independent living and life support skills as well as employment, housing and education supports.

NDFFCMH would like to see Peer-to-Peer Support Program enhanced to include funding for state-wide implementation. This is a very successful program.

Partnerships Program has been a very successful with positive outcomes for children and their families. NDFFCMH supports the increase of 1 FTE for Partnership Program at SEHSC.

Finally, NDFFCMH thanks you for your continued support for children with emotional, behavioral and mental disorders and their families.

Thank you for your time.

Carlotta McCleary, Executive Director
ND Federation of Families for Children's Mental Health
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ND Department of Human Services
Medical Services
Cost To Increase Healthy Steps Eligibility From 150% (Net) To 165% (Net) Of Federal Poverty Level
2009-2011 Biennium
Premium Cost of $243.93

	# of Children	Total	General	Federal
Premium Cost From 150% (Net) to 165% (Net) of FPL :	608	2,217,812	573,970	1,643,842
.75 FTE [1] to Increase to 165% of FPL:		51,953	13,445	38,508
Total Cost From 150% (Net) to 165% (Net) of FPL:		2,269,765	587,415	1,682,350

Considerations:

The Federal "extension" of SCHIP is scheduled to expire March 30, 2009. SCHIP Reauthorization action has begun at the Federal level. If increased federal funds are not provided during SCHIP reauthorization, general funds would be needed to fund this increase in eligibility level.

Any increase in the income threshold for SCHIP will have an impact on the Caring for Children Program. (As of November 1, 2008, the income threshold for the Caring Program is 200% (net).)

The number of potential eligibles for the 165% (net) scenario above, is based on the number of families who applied for coverage from October 1, 2006 through September 30, 2007, and would have been eligible at 165% (net). It is possible that this number is understated, as it based on the number of families who previously applied for coverage. Families with incomes up to 165% (net) may not have applied for coverage.

As of April 1, 2008, 150% FPL is $31,800 (annually) for a family of four: and 165% FPL is $34,980 (annually) for a family of four.

[1] This reflects an off-set of overtime for Healthy Steps eligibility staff currently in the Medical Services 2009-2011 budget request. The full impact on the state-office Healthy Steps eligibility staff of increasing SCHIP to 150% is unknown; therefore, overtime was budgeted to cover the additional staff time needed to process the expecteed increase in applications. Therefore, the actual estimate for .75 FTE is $89,969; however, after offsetting the overtime already budgeted, the net cost of the FTE needed to go to 165% (net) of FPL is $51,953.

ND Department of Human Services
Medical Services
Cost To Increase Healthy Steps Eligibility From 150% (Net) To 175% (Net) Of Federal Poverty Level
2009-2011 Biennium
Premium Cost of $243.93

	# of Children	Total	General	Federal
Premium Cost From 150% (Net) to 175% (Net) of FPL :	829	3,084,739	798,330	2,286,409
1 FTE [1] to Increase to 175% of FPL:		71,430	18,486	52,944
Total Cost From 150% (Net) to 175% (Net) of FPL:		3,156,169	816,816	2,339,353

Considerations:

The Federal "extension" of SCHIP is scheduled to expire March 30, 2009. SCHIP Reauthorization action has begun at the Federal level. If increased federal funds are not provided during SCHIP reauthorization, general funds would be needed to fund this increase in the eligibility level.

Any increase in the income threshold for SCHIP will have an impact on the Caring for Children Program. (As of November 1, 2008, the income threshold for the Caring Program is 200% (net).)

The number of potential eligibles for the 175% (net) scenario above, is based on the number of families who applied for coverage from October 1, 2006 through September 30, 2007, and would have been eligible at 175% (net). It is possible that this number is understated, as it based on the number of families who previously applied for coverage. Families with incomes up to 175% (net) may not have applied for coverage.

As of April 1, 2008, 150% FPL is $31,800 (annually) for a family of four: and 175% FPL is $37,100 (annually) for a family of four.

[1] This reflects an off-set of overtime for Healthy Steps eligibility staff currently in the Medical Services 2009-2011 budget request. The full impact on the state-office Healthy Steps eligibility staff of increasing SCHIP to 150% is unknown; therefore, overtime was budgeted to cover the additional staff time needed to process the expected increase in applications. Therefore, the actual estimate for 1 FTE is $109,446; however, after offsetting the overtime already budgeted, the net cost of the FTE needed to go to 175% (net) of FPL is $71,430.

ND Department of Human Services
Medical Services
Cost To Increase Healthy Steps Eligibility From 150% (Net) To 185% (Net) Of Federal Poverty Level
2009-2011 Biennium
Premium Cost of $243.93

	# of Children	Total	General	Federal
Premium Cost From 150% (Net) to 185% (Net) of FPL :	980	3,599,431	931,533	2,667,898
1 FTE [1] to Increase to 185% of FPL:		71,430	18,486	52,944
Total Cost From 150% (Net) to 185% (Net) of FPL:		3,670,861	950,019	2,720,842

Considerations:

The Federal "extension" of SCHIP is scheduled to expire March 30, 2009. SCHIP Reauthorization action has begun at the Federal level. If increased federal funds are not provided during SCHIP reauthorization, general funds would be needed to fund this increase in the eligiblity level.

Any increase in the income threshold for SCHIP will have an impact on the Caring for Children Program. (As of November 1, 2008, the income threshold for the Caring Program is 200% (net).)

The number of potential eligibles for the 185% (net) scenario above, is based on the number of families who applied for coverage from October 1, 2006 through September 30, 2007, and would have been eligible at 185% (net). It is possible that this number is understated, as it based on the number of families who previously applied for coverage. Families with incomes up to 185% (net) may not have applied for coverage.

As of April 1, 2008, 150% FPL is $31,800 (annually) for a family of four: and 185% FPL is $39,220 (annually) for a family of four.

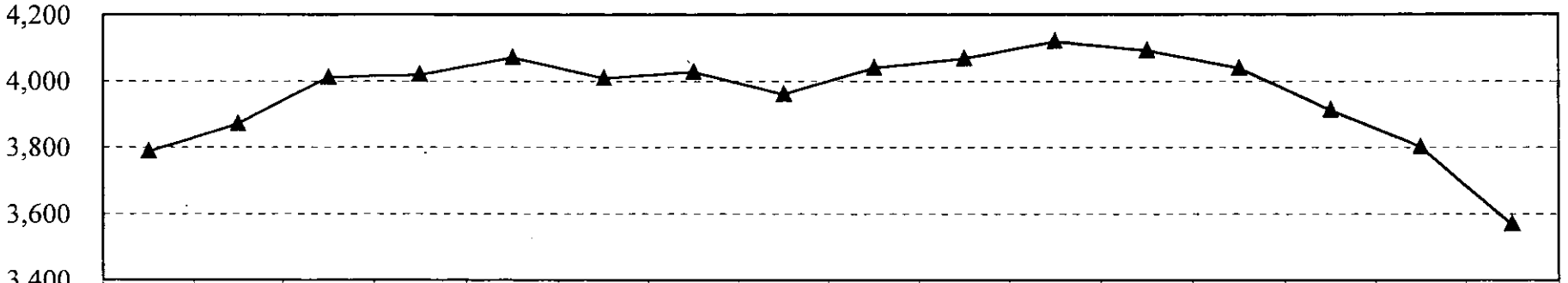
[1] This reflects an off-set of overtime for Healthy Steps eligibility staff currently in the Medical Services 2009-2011 budget request. The full impact on the state-office Healthy Steps eligibility staff of increasing SCHIP to 150% is unknown; therefore, overtime was budgeted to cover the additional staff time needed to process the expected increase in applications. Therefore, the actual estimate for 1 FTE is $109,446; however, after offsetting the overtime already budgeted, the net cost of the FTE needed to go to 185% (net) of FPL is $71,430.

North Dakota Department of Human Services

Attachment D

Healthy Steps Enrollment by Month

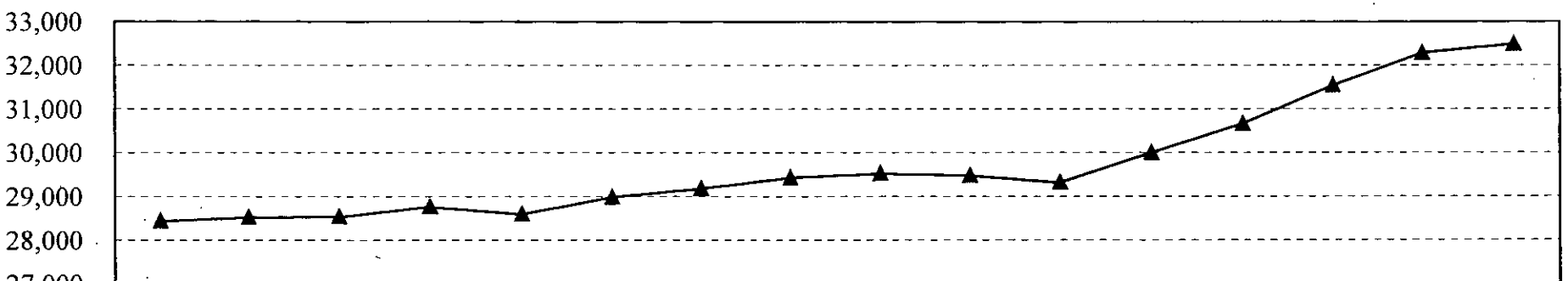
August 2007 - November 2008



Aug 07	Sep '07	Oct '07	Nov '07	Dec '07	Jan '08	Feb '08	Mar '08	Apr '08	May '08	Jun '08	Jul '08	Aug '08	Sep '08	Oct '08	Nov '08
3,787	3,871	4,011	4,019	4,071	4,008	4,027	3,959	4,039	4,067	4,119	4,091	4,038	3,911	3,800	3,568

Children Enrolled in Medicaid by Month

August 2007 - November 2008



Aug 07	Sep '07	Oct '07	Nov '07	Dec '07	Jan '08	Feb '08	Mar '08	Apr '08	May '08	Jun '08	Jul '08	Aug '08	Sep '08	Oct '08	Nov '08
28,435	28,522	28,531	28,758	28,590	28,977	29,173	29,420	29,508	29,462	29,306	29,984	30,652	31,532	32,274	32,479

4

1/20/09-cj-hgw\0911 legis\hs enroll & elig

North Dakota Department of Human Services
Medical Services Division
HEALTHY STEPS OUTREACH STATISTICS
House Bill 1012 to the Senate

Senate Bill 2012 in 2007 appropriated $453,000 to the Department of Human Services to conduct Healthy Steps Outreach.

The contract was awarded to the North Dakota Caring Foundation, Inc. in the amount of $332,333, ends June 30,2009.

East & West Total Contacts & Organizations Visited: 10/08 - 1/09

	October	November	December	January	Total
Total Individuals^	86	104	294	74	**558**
Total Organizations*	40	50	41	14	**145**
Total Contacts & Organizations	**126**	**154**	**404**	**88**	**703**

*Organizations include Social Service offices, Public and Private Schools, Public Health Units, Head Starts, Clinics and Hospitals, and Child Care Centers.

^Individuals are the number spoken with at each organization.

(Western Outreach Healthy Steps Coordinator on maternity leave in January 2009).

Healthy Steps Outreach Marketing/Media Materials Handed Out

Month/Year	Brochures	Applications	Kids Now Cards	Total
Oct-08	840	180	130	1,150
Nov-08	1775	510	1115	3,400
Dec-08	965	479	340	1,784
Jan-09	800	225	700	1,725
Oct- 08 - Jan 09	**4380**	**1394**	**2285**	**8059**

877-KIDS-NOW Help-Line Calls

Month	2008
September*	185
October*	104
November	93
December	82
Total 2008	464

Month	2009
January	93
February^	155
Total 2009	**248**

*Increase due to a back to school campaign conducted by North Dakota Caring Foundation, BCBSND, Dakota Medical Foundation and North Dakota Department of Human Services.

Media TV/Radio Campaign started on 2/4/08 and will end last week of February.

^The number of calls are through February 20th.

The next Media TV/Radio Campaign will be in April/May

North Dakota Department of Human Services
HB1012 to Senate
Continuous Eligibility

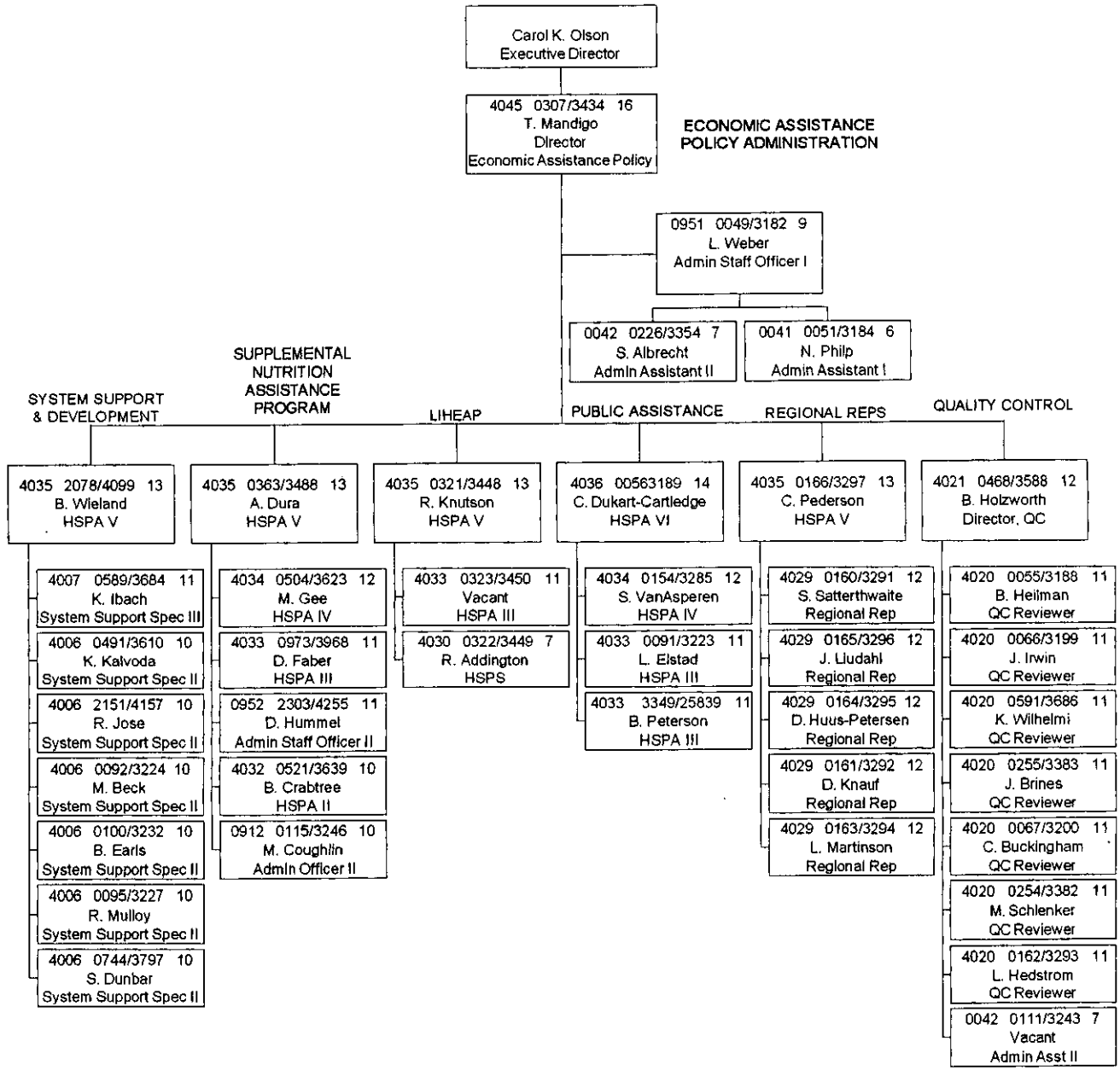
Monthly Average			
	Recipients Eligible	**Cost per Eligible**	**Amount Paid**
June, July, and August 2008 (3 months)	25,910	$189.94	$4,921,345
July 2007 thru May 2008 (11 months)	24,303	$198.51	$4,824,388
First 3 months of Continuous Eligibility as compared to previous 11 months	1,607	($8.57)	$96,957

- When the compounding of the Medicaid enrollment increases is considered, the increased cost will be greater than $100,000 per month.

Program Changes June 2008 through January 2009

- Increase in the Number of Children Enrolled in Medicaid is 4,489
- Increase in Months of Eligibility of 9.34% (June 2008 through August 2008)
- Decrease in closed cases due to Failure to Provide Information
  - Average January 2008 through May 2008: 996
  - Average June 2008 through January 2009: 204

North Dakota Department of Human Services
Economic Assistance Policy Division



2007 - 2009 Budget:
39.8 FTEs

Revised 1/5/09

C

Testimony
House Bill 1012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
January 12, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, I am Tove Mandigo, Economic Assistance Policy Division Director in the Department of Human Services. I am here today to provide you an overview of Economic Assistance Policy Division, for the Department of Human Services.

Programs

Economic Assistance Policy (EAP) is responsible for eligibility policy for Basic Care Assistance, and state administration of Child Care Assistance, the Low Income Home Energy Assistance Program (LIHEAP), the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF). This includes:

- Distribution of benefits to recipients and payments to providers;
- Direction, supervision, and training of county social service board administration of EAP programs;
- Implementation of applicable state and federal law;
- Operation of electronic eligibility determination and reporting systems; and
- Preparation of required state and federal reports.

Economic Assistance Policy also does Quality Control reviews of SNAP, Healthy Steps, Medicaid, TANF eligibility determinations, and estate recovery of Medicaid expenditures.

Caseload / Customer Base

EAP will direct and supervise county social services' determinations or redetermination of eligibility for the following:

Basic Care Assistance: approximately 455 residents of licensed Basic Care facilities.

Child Care Assistance: approximately 4,164 children from 2,519 families each month, and will pay about 1,573 licensed, certified, or approved child care providers a total of $931,660 per month.

Supplemental Nutrition Assistance Program (SNAP formerly Food Stamps): 30,786 families each month, and will pay about 450 grocers in North Dakota a total of $8,514,016 in federal funds per month.

Low Income Heating and Energy Assistance Program: approximately 15,500 households each heating season, and will pay about 400 energy providers. About $26.3 million in federal funds is budgeted for heating assistance and weatherization for each year of the biennium.

Temporary Assistance for Needy Families (TANF): approximately 2,851 families with 4,828 children, providing an average monthly cash benefit of $343 for each family, while the Job Opportunities and Basic Skills (JOBS) program will work with 1,425 adult heads of households to find jobs and promote family self-sufficiency at an average cost of $210 per individual.

Kinship Care: will use TANF funds to provide an average monthly cash benefit of $350 for about 50 children who would otherwise be in foster care.

Program Trends / Major Program Changes

TANF:

North Dakota is one of only ten states meeting the federally required 50% work participation rate without the addition of the caseload reduction credit. In order to meet the federally required work participation rate, the Department contracted not only with Job Service North Dakota, but also Career Options. Career Options was in a position to give the kind of wrap-around services on a case-by-case basis necessary for challenging clients.

Diversion Assistance - Front-end

Diversion Assistance was designed to provide aid to families whose earned income has been reduced and who are in need of short-term assistance to provide for financial needs until self-sustaining income begins again. Diversion Assistance is designed to be an alternative to receiving ongoing TANF cash assistance. Due to receipt of federal guidelines on Diversion Assistance that became effective October 1, 2008, the effectiveness of the program is minimal. Therefore, pay after performance is being developed.

Pay After Performance

The pay after performance program has an anticipated implementation date of April 2009. Work-eligible individuals will be required to meet work requirements before their needs will be met. This means a child only payment will be made, and, if the work-eligible individual meets the

work requirements, unless there is good cause, a supplemental payment will be made to meet their needs. If the work-eligible individual does not meet the work requirements, a sanction will be imposed. Pay after performance will be effective for the first four months of an application.

Benefits

- System will process case according to policy without case closure
- Work-eligible individuals will participate in required hours before receiving a benefit
- Anticipate increase work participation rate

LIHEAP: The LIHEAP caseload has remained fairly stable but the fuel costs have steadily increased. This is a totally federally funded program. The federal government recently funded an additional $5.1 billion nationwide, so states could meet the fiscal demands of increasing fuel costs. With this additional funding, trends would indicate that North Dakota will meet the needs of the LIHEAP clients in the 2009-2011 biennium.

SNAP: There has been a sharp increase in the number of clients seeking food assistance during the 2007-2009 biennium. This appears to be the result of an outreach effort on the part of the federal government, coupled with the implementation of simplified reporting and the 2008 Farm Bill. Simplified reporting allows a client to report earnings on a semi-annual basis as opposed to monthly.

Child Care Assistance: The Department implemented a certificate program to meet federal regulations that identifies a constant amount to be paid for three to six months, depending on the family circumstances. This resulted in higher average monthly caseload and cost per case.

Prior to the certification program, each family's payment had to be calculated monthly.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 20011 Budget	Increase / Decrease
Salary and Wages	4,568,776	5,310,083	741,307
Operating	10,092,283	10,834,553	742,270
Capital Assets	205	-	(205)
Grants	203,750,869	314,460,054	110,709,185
Total	218,412,133	330,604,690	112,192,557
General Funds	7,784,373	9,826,276	2,041,903
Federal Funds	191,369,536	302,739,433	111,369,897
Other Funds	19,258,224	18,038,981	(1,219,243)
Total	218,412,133	330,604,690	112,192,557
FTE	39.80	39.80	-

The Salary and Wages line item increased by $741,307 and can be mainly attributed to the following:

- The salary and health insurance package that adds $475,306 in total funds of which $212,910 is general funds;
- $75,703 in total funds is for the continuation of the year two 4% increase of which $38,261 is general funds;
- An increase of $79,682 to cover an underfunding of salaries from the 2007-2009 budget; and
- The remaining $110,616 increase is a combination of increases and decreases needed to sustain the salary of the 39.8 FTEs in this area of the budget.

The Operating line item increased by $742,270, and is a combination of the increases and decreases expected next biennium. Some of the significant changes are noted below:

- $1,565,878 increase to the JOBS program due to the need for increased client services, as a large portion of the individuals remaining on TANF are challenging clients;
- $464,144 increase in Parental Responsibility Initiative for the Development of Employment (PRIDE) to provide for a statewide program;
- $188,308 increase to provide for federally required estate collection activities;
- $1,016,486 decrease to SNAP EBT (Electronic Benefit Transfer) provider payments due to the completion of the EBT reprocurement process, and the resulting decrease in the monthly cost per case of $1.91; and
- $502,969 decrease in the Payment Error Rate Measurement contract due to the cyclical nature of the three-year federal eligibility review requirements.

The Grants line item increased by $110,709,185, and is a combination of the increases and decreases expected next biennium. Some of the significant changes are noted below:

- $97,366,572 increase in SNAP benefits, all federal funds, based upon federal outreach, implementation of simplified reporting, and the 2008 Farm Bill;
- $12,022,292 increase in LIHEAP benefits, all federal funds, based upon increasing heating costs and available federal funds;
- $454,479 increase in Indian County Allocation, all general funds, based upon the statutory funding formula;
- $1,907,617 decrease in TANF grants, mainly due to the decrease in the number of clients, and consists of a $1,217,016 increase

in general funds, a $1,316,576 decrease in federal funds, and a $1,808,057 decrease in other funds or Child Support collections;

- $2,629,386 increase in Child Care Assistance grants, consist of a $350,197 increase in general funds, of which $274,408 was included in the Executive Budget to increase provider rates for centers and group facilities; and
- $155,162 increase in the Supplemental Nutrition Assistance Program Education Plan, all federal funds, based upon NDSU budget projections.

This concludes my testimony on the 2009 – 2011 budget request for the Economic Assistance Policy area of the Department. I would be happy to answer any questions.

Economic Assistance

Detail of Budget Account Code 621000 - Operating Fees & Services

Operating Fees & Services	Amount	General	Federal/Other
Spring Showcase Speakers' Fees	$ 25,000	$ 12,500	$ 12,500
JOBS Administration	752,510		752,510
JOBS Client Services	6,418,568		6,418,568
New Hires National Database Information	5,632		5,632
TANF Special Project - PRIDE	909,242		909,242
Alternative to Abortion 211 Service	10,800		10,800
Alternative to Abortion Provider Services	381,037		381,037
County Contract Staff	26,100	11,822	14,278
Food Stamp Program Employment & Training Program	199,814		199,814
Payment Error Rate Measurement	525,531	198,303	327,228
Estate Settlements Contract	188,308	76,081	112,227
E Funds EBT Card Contractor	769,155	46,149	723,006
Other Miscellaneous Fees & Services	27,479	4,267	23,212
Total Operating Fees & Services Budget Account Code	$ 10,239,176	$ 349,122	$ 9,890,054

Economic Assistance

Detail of Budget Account Code 582000 - Rentals/Leases

Rentals & Leases	Amount	General	Fed/Other
Regional Representatives located at Various Humans Service Centers	$ 12,466	$ 4,860	$ 7,606
System Support & Development Staff Located at Northbrook ($11.66 per sq. foot)	42,312	19,165	23,147
Quality Control Staff Located at Various Human Service Centers	25,519	12,563	12,956
Miscellaneous Booth Rentals	6,640	1,872	4,768
Total Rentals & Leases Budget Account Code	$ 86,937	$ 38,460	$ 48,477

DEPARTMENT HUMAN SERVICES

Summary by Subdivision and Bgt_Acct with Funding Sources

2009 - 2011

Class FB	Budget Account Code		Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-01 ECONOMIC ASSISTANCE POLICY - GRANTS								
32530 F	F_3991 Operating - General Fund		259,411	842,860	239,454	(294,498)	0	548,362
32530 F	F_3992 Operating - Federal Funds		8,750,232	8,493,381	4,314,965	1,477,456	0	9,970,837
32530 F	F_3993 Operating - Other Funds		9,722	125,000	12,262	(125,000)	0	0
32530 F	F_3995 Operating - County Funds		574,592	631,042	315,399	(315,688)	0	315,354
		Subtotal:	9,593,957	10,092,283	4,882,080	742,270	0	10,834,553
32550 B	683000 Other Capital Payments		1,981	205	197	(205)	0	0
		Subtotal:	1,981	205	197	(205)	0	0
32550 F	F_5991 Land & Cptl Imprv - Gen Fund		971	101	98	(101)	0	0
32550 F	F_5992 Land & Cptl Imprv - Fed Funds		1,010	104	99	(104)	0	0
		Subtotal:	1,981	205	197	(205)	0	0
32560 B	712000 Grants, Benefits & Claims		173,552,168	203,750,869	100,255,760	110,709,185	0	314,460,054
		Subtotal:	173,552,168	203,750,869	100,255,760	110,709,185	0	314,460,054
32560 F	F_6991 Grants - General Fund		5,167,135	5,270,066	4,948,875	2,037,772	0	7,307,838
32560 F	F_6992 Grants - Federal Funds		150,948,257	179,978,621	85,200,811	109,449,968	0	289,428,589
32560 F	F_6993 Grants - Other Funds		4,307,907	5,137,089	2,036,257	(1,816,097)	0	3,320,992
32560 F	F_6994 Grants - Swap Funds		13,128,869	13,365,093	8,069,817	1,037,542	0	14,402,635
		Subtotal:	173,552,168	203,750,869	100,255,760	110,709,185	0	314,460,054
		Subdivision Budget Total:	187,175,778	218,412,133	107,261,319	111,717,251	475,306	330,604,690
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS		**General Funds:**	6,870,983	7,784,373	6,011,780	1,828,993	212,910	9,826,276
		Federal Funds:	162,283,705	191,369,536	90,815,804	111,107,501	262,396	302,739,433
		Other Funds:	4,317,629	5,262,089	2,048,519	(1,941,097)	0	3,320,992
		SWAP Funds:	13,128,869	13,365,093	8,069,817	1,037,542	0	14,402,635
		County Funds:	574,592	631,042	315,399	(315,688)	0	315,354
		IGT Funds:	0	0	0	0	0	0
		Subdivision Funding Total:	187,175,778	218,412,133	107,261,319	111,717,251	475,306	330,604,690

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code		Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-01 ECONOMIC ASSISTANCE POLICY - GRANTS									
S101		FULL-TIME EQUIVALENTS (FTEs)		39.800	39.800	0.000	0.000	0.000	39.800
32510	B	511000	Salaries - Permanent	3,014,060	3,230,845	1,564,408	290,594	1	3,521,440
32510	B	513000	Temporary Salaries	0	118,151	0	(66,407)	(1)	51,743
32510	B	514000	Overtime	12,253	28,392	11,999	0	(1)	28,391
32510	B	516000	Fringe Benefits	1,001,359	1,191,388	546,875	41,814	162,958	1,396,160
32510	B	599110	Salary Increase	0	0	0	0	267,599	267,599
32510	B	599160	Benefit Increase	0	0	0	0	44,750	44,750
			Subtotal:	4,027,672	4,568,776	2,123,282	266,001	475,306	5,310,083
32510	F	F_1991	Salary - General Fund	1,443,466	1,671,346	823,353	85,820	212,910	1,970,076
32510	F	F_1992	Salary - Federal Funds	2,584,206	2,897,430	1,299,929	180,181	262,396	3,340,007
32510	F	F_1993	Salary - Other Funds	0	0	0	0	0	0
			Subtotal:	4,027,672	4,568,776	2,123,282	266,001	475,306	5,310,083
32530	B	521000	Travel	109,112	203,607	50,262	(4,638)	0	198,969
32530	B	531000	Supplies - IT Software	10,235	10,758	6,910	2,388	0	13,146
32530	B	532000	Supply/Material-Professional	2,482	2,595	1,219	(210)	0	2,385
32530	B	535000	Miscellaneous Supplies	3,710	2,435	132	(2,435)	0	0
32530	B	536000	Office Supplies	7,221	12,222	4,524	113	0	12,335
32530	B	541000	Postage	7,624	9,554	3,574	(3,017)	0	6,537
32530	B	542000	Printing	117,205	146,010	89,017	47,434	0	193,444
32530	B	553000	Office Equip & Furniture-Under	12,913	7,475	6,778	(3,730)	0	3,745
32530	B	561000	Utilities	534	802	276	(222)	0	580
32530	B	582000	Rentals/Leases - Bldg/Land	110,251	102,528	39,987	(15,591)	0	86,937
32530	B	591000	Repairs	1,187	4,024	1,895	391	0	4,415
32530	B	601000	IT - Data Processing	4,083	5,135	1,201	(1,108)	0	4,027
32530	B	602000	IT-Communications	12,201	15,898	6,294	(1,384)	0	14,514
32530	B	611000	Professional Development	34,380	34,820	12,562	19,523	0	54,343
32530	B	621000	Operating Fees and Services	9,160,819	9,534,420	4,657,449	704,756	0	10,239,176
			Subtotal:	9,593,957	10,092,283	4,882,080	742,270	0	10,834,553

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
ECONOMIC ASSISTANCE POLICY DIVISION
GRANTS SUMMARY 2009-2011 BIENNIUM

Description	Bgt_Acct_Desc	Current Budget 2007 - 2009	Cont Prgm Changes	Cost Changes	Caseload Changes	Executive Budget Recommendations	Total Budget Changes	2009-2011 "To House"
Child Care	Grants - General Fund			$75,789		$274,408	$350,197	$350,197
Child Care	Grants - Federal Funds	$14,504,629		$910,996	$330,651		$1,241,647	$15,746,276
Child Care	Grants - Other Funds	$5,225,819		$918,413	$119,129		$1,037,542	$6,263,361
Child Care	**Grants, Benefits & Claims**	**$19,730,448**		**$1,905,198**	**$449,780**	**$274,408**	**$2,629,386**	**$22,359,834**
Indian County Allocation	Grants - General Fund	$955,124	$454,479				$454,479	$1,409,603
Indian County Allocation	Grants - Other Funds	$1,964,607						$1,964,607
Indian County Allocation	**Grants, Benefits & Claims**	**$2,919,731**	**$454,479**				**$454,479**	**$3,374,210**
JOBS-Support Services	Grants - Federal Funds	$1,344,000		$276,258	($65,582)		$210,676	$1,554,676
JOBS-Support Services	**Grants, Benefits & Claims**	**$1,344,000**		**$276,258**	**($65,582)**		**$210,676**	**$1,554,676**
JOBS-Transportation	Grants - Federal Funds	$3,050,000		$750,000	($978,125)		($228,125)	$2,821,875
JOBS-Transportation	**Grants, Benefits & Claims**	**$3,050,000**		**$750,000**	**($978,125)**		**($228,125)**	**$2,821,875**
Kinship Care	Grants - Federal Funds	$420,000						$420,000
Kinship Care	**Grants, Benefits & Claims**	**$420,000**						**$420,000**
Low Inc Home Enrgy Assist Prgm	Grants - Federal Funds	$40,540,430		$12,022,292			$12,022,292	$52,562,722
Low Inc Home Enrgy Assist Prgm	**Grants, Benefits & Claims**	**$40,540,430**		**$12,022,292**			**$12,022,292**	**$52,562,722**
SNAP - Benefits	Grants - Federal Funds	$106,969,803		$29,515,631	$67,850,941		$97,366,572	$204,336,375
SNAP - Benefits	**Grants, Benefits & Claims**	**$106,969,803**		**$29,515,631**	**$67,850,941**		**$97,366,572**	**$204,336,375**
TANF Benefit	Grants - General Fund	$4,314,942		$1,941,059	($724,043)		$1,217,016	$5,531,958
TANF Benefit	Grants - Federal Funds	$9,766,881		($683,667)	($632,909)		($1,316,576)	$8,450,305
TANF Benefit	Grants - Other Funds	$11,303,716		$89,139	($1,897,196)		($1,808,057)	$9,495,659
TANF Benefit	**Grants, Benefits & Claims**	**$25,385,539**		**$1,346,531**	**($3,254,148)**		**($1,907,617)**	**$23,477,922**
SNAP - Nutrition Education Plan	Grants - Federal Funds	$3,344,838	$155,162				$155,162	$3,500,000
SNAP - Nutrition Education Plan	**Grants, Benefits & Claims**	**$3,344,838**	**$155,162**				**$155,162**	**$3,500,000**
Other Grants	Grants - General Fund		$16,080				$16,080	$16,080
Other Grants	Grants - Federal Funds	$38,040	($1,680)				($1,680)	$36,360
Other Grants	Grants - Other Funds	$8,040	($8,040)				($8,040)	
Other Grants	**Grants, Benefits & Claims**	**$46,080**	**$6,360**				**$6,360**	**$52,440**

Total Economic Assistance Policy Grants	**$203,750,869**	**$616,001**	**$45,815,910**	**$64,002,866**	**$274,408**	**$110,709,185**	**$314,460,054**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
ECONOMIC ASSISTANCE POLICY DIVISION CASELOAD COMPARISON
2009 - 2011 BIENNIUM

	2007-2009 Budgeted Avg Monthly		2009-2011 Budgeted Avg Monthly		Difference - Increase (Decrease)	
Description	Caseload	Cost Per Case	Caseload	Cost Per Case	Caseload	Cost Per Case
TANF	2,750	384.63	2,851	343.12	101	(41.51)
SNAP	20,600	216.37	30,786	276.56	10,186	60.19
Child Care	4,064	202.29	4,164	223.74	100	21.45
LIHEAP	6,218	229.00	6,218	296.49	-	67.49

A

Economic Assistance Grant Costs

Over the past ten years there have been new programs and services added and various changes made to existing programs. The Department does not know if the counties would have shared in the cost of these new programs and services, or if the counties were to share in the cost, what their share would have been, had the SWAP legislation not been approved. If required to make these assumptions, the Department requests your assistance. **Attachment C** lists the changes made since the implementation of the SWAP legislation which have a direct impact on the economic assistance grant costs.

Indian County Payments

Prior to the 1997-1999 biennium, the Department was appropriated $440,000 to be allocated to Benson, Sioux and Rolette counties for assistance in the cost of providing economic assistance programs due to the large amount of tax-exempt land in these counties. The 1997 Legislative Assembly added an additional $619,000 to the Indian County appropriation for assistance to these three counties. Beginning in 1999-2001 biennium the Indian County payments were based upon a specific formula outlined in Subsection 3 of section 50-01.2-03.2 of the NDCC. This section states that a county is eligible for Indian County payments if both of the following conditions are met:

- more than 20% of their Economic Assistance caseload is living on a federally recognized Indian Reservation or tribal trust land and;
- the administrative costs expressed in mills is greater than the statewide average administrative costs expressed in mills for all other counties.

ATTACHMENT D

North Dakota Department of Human Services
Indian County Payment Calculation
CY 2008

	All Counties			Counties that do not have 20% of the Economic Assistance caseload living on Reservation or Tribal Trust Land				
County	Total Economic Assistance Administrative Costs (July 2006 - June 2007) *	Value of a Mill June 2006	Economic Assistance Administrative Costs expressed in Mills	Total Economic Assistance Administrative Costs (July 2006 - June 2007) *	Value of a Mill June 2006	Economic Assistance Administrative Costs expressed in Mills	Individual County Variance From Statewide Average Mill	Indian County Allocation CY 2008
	A	B	C = A / B	D	E	F = D / E	G = F - 11.68	H = G X B
Adams	91,803.66	7,507.35	12.23	91,803.66	7,507.35	12.23	0.55	
Barnes	389,478.04	37,449.66	10.40	389,478.04	37,449.66	10.40	-1.28	
Benson	450,442.36	13,794.21	32.65	-------	-------	-------	20.97	289,265
Billings								
Bottineau	242,857.73	25,974.50	9.35	242,857.73	25,974.50	9.35	-2.33	
Bowman/Slope	181,540.80	15,171.49	11.97	181,540.80	15,171.49	11.97	0.29	
Burke	101,234.06	8,674.87	11.67	101,234.06	8,674.87	11.67	-0.01	
Burleigh	1,828,879.01	194,888.08	9.38	1,828,879.01	194,888.08	9.38	-2.30	
Cass	3,114,312.11	395,777.45	7.87	3,114,312.11	395,777.45	7.87	-3.81	
Cavalier	268,360.65	21,350.84	12.57	268,360.65	21,350.84	12.57	0.89	
Dakota Central	693,809.00	59,895.86	11.58	693,809.00	59,895.86	11.58	-0.10	
Dickey	261,472.81	17,463.21	14.97	261,472.81	17,463.21	14.97	3.29	
Divide	95,264.43	9,636.72	9.89	95,264.43	9,636.72	9.89	-1.79	
Dunn	221,760.51	12,876.60	17.22	-------	-------	-------	5.54	71,336
Eddy	115,205.92	6,481.23	17.78	115,205.92	6,481.23	17.78	6.10	
Emmons	170,973.20	14,303.61	11.95	170,973.20	14,303.61	11.95	0.27	
Foster	103,917.37	12,872.67	8.07	103,917.37	12,872.67	8.07	-3.61	
G. Valley/Billings	104,103.65	10,740.84	9.69	104,103.65	10,740.84	9.69	-1.99	
G. Forks	1,847,736.81	161,756.08	11.42	1,847,736.81	161,756.08	11.42	-0.26	
Grant	117,803.41	8,921.51	13.20	117,803.41	8,921.51	13.20	1.52	
Griggs	137,165.81	9,379.93	14.62	137,165.81	9,379.93	14.62	2.94	
Hettinger	127,632.83	9,812.88	13.01	127,632.83	9,812.88	13.01	1.33	
Kidder	104,708.30	10,223.05	10.24	104,708.30	10,223.05	10.24	-1.44	
LaMoure	135,102.23	18,657.11	7.24	135,102.23	18,657.11	7.24	-4.44	
Logan	94,188.58	7,120.07	13.23	94,188.58	7,120.07	13.23	1.55	
McHenry	164,529.55	22,827.00	7.21	164,529.55	22,827.00	7.21	-4.47	
McIntosh	168,646.56	10,182.45	16.56	168,646.56	10,182.45	16.56	4.88	
McKenzie	275,289.44	17,230.41	15.98	-------	-------	-------	4.30	74,091
McLean								
Mercer								
Morton	981,575.22	61,505.20	15.96	981,575.22	61,505.20	15.96	4.28	
Mountrail	390,760.94	16,308.80	23.96	-------	-------	-------	12.28	200,272
Nelson	154,740.43	11,233.88	13.77	154,740.43	11,233.88	13.77	2.09	
Oliver								
Pembina	327,724.98	31,175.62	10.51	327,724.98	31,175.62	10.51	-1.17	
Pierce	142,432.09	14,505.87	9.82	142,432.09	14,505.87	9.82	-1.86	
Ramsey	457,238.94	26,566.00	17.21	457,238.94	26,566.00	17.21	5.53	
Ransom	141,922.95	16,977.38	8.36	141,922.95	16,977.38	8.36	-3.32	
Renville	92,873.42	10,369.90	8.96	92,873.42	10,369.90	8.96	-2.72	
Richland	352,580.16	51,433.58	6.86	352,580.16	51,433.58	6.86	-4.82	
Rolette	729,798.86	10,208.57	71.49	-------	-------	-------	59.81	610,575
Sargent	123,452.40	15,915.73	7.76	123,452.40	15,915.73	7.76	-3.92	
Sheridan								
Sioux	309,029.55	2,056.53	150.27	-------	-------	-------	138.59	285,015
Slope								
Stark	907,742.24	44,563.70	20.37	907,742.24	44,563.70	20.37	8.69	
Steele	129,148.49	11,066.75	11.67	129,148.49	11,066.75	11.67	-0.01	
Stutsman	649,519.07	53,706.58	12.09	649,519.07	53,706.58	12.09	0.41	
Towner	68,529.71	11,608.24	5.90	68,529.71	11,608.24	5.90	-5.78	
Traill	298,874.49	26,942.09	11.09	298,874.49	26,942.09	11.09	-0.59	
Walsh	359,174.72	32,636.56	11.01	359,174.72	32,636.56	11.01	-0.67	
Ward	1,531,357.62	127,555.98	12.01	1,531,357.62	127,555.98	12.01	0.33	
Wells	220,398.08	18,849.95	11.69	220,398.08	18,849.95	11.69	0.01	
Williams	801,519.51	41,436.48	19.34	801,519.51	41,436.48	19.34	7.66	
Total:	**20,778,612.70**			**18,401,531.04**		**490.49**		**1,530,554**

Number of Counties 42
Statewide Avg Mill 11.68
(490.49 / 42 = 11.68)

Counties with more than 20% of Economic Assistance Caseload Living on Reservation or Tribal Trust Land	
County	SFY 2007
Benson	78.00%
Dunn	28.16%
McKenzie	48.73%
Mountrail	60.00%
Rolette	68.84%
Sioux	100.00%

* For purposes of calculating the CY 2008 Indian County Allocation, the Child Support costs are not included in the "Total Economic Assistance Administrative Costs for SFY 2007". Effective July 1, 2007 the state is responsible for the costs associated with the operation of the Child Support Program. (SB 2205)

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations Committee
Senator Holmberg, Chairman
March 3, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, I am Tove Mandigo, Economic Assistance Policy Division Director in the Department of Human Services. I am here today to provide you an overview of Economic Assistance Policy Division, for the Department of Human Services.

Programs

Economic Assistance Policy (EAP) is responsible for eligibility policy for Basic Care Assistance, and state administration of Child Care Assistance, the Low Income Home Energy Assistance Program (LIHEAP), the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF). This includes:

- Distribution of benefits to recipients and payments to providers;
- Direction, supervision, and training of county social service board administration of EAP programs;
- Implementation of applicable state and federal law;
- Operation of electronic eligibility determination and reporting systems; and
- Preparation of required state and federal reports.

Economic Assistance Policy also does Quality Control reviews of SNAP, Healthy Steps, Medicaid, TANF eligibility determinations, and estate recovery of Medicaid expenditures.

Caseload / Customer Base

EAP will direct and supervise county social services' determinations or redeterminations of eligibility for the following:

Basic Care Assistance: approximately 455 residents of licensed Basic Care facilities.

Child Care Assistance: approximately 4,164 children from 2,519 families each month, and will pay about 1,573 licensed, certified, or approved child care providers a total of $931,660 per month.

Supplemental Nutrition Assistance Program (SNAP formerly Food Stamps): 30,786 families each month, and will pay about 450 grocers in North Dakota a total of $8,514,016 in federal funds per month.

Low Income Heating and Energy Assistance Program: approximately 15,500 households each heating season, and will pay about 400 energy providers. About $26.3 million in federal funds is budgeted for heating assistance and weatherization for each year of the biennium.

Temporary Assistance for Needy Families (TANF): approximately 2,851 families with 4,828 children, providing an average monthly cash benefit of $343 for each family, while the Job Opportunities and Basic Skills (JOBS) program will work with 1,425 adult heads of households to find jobs and promote family self-sufficiency at an average cost of $210 per individual.

Kinship Care: will use TANF funds to provide an average monthly cash benefit of $350 for about 50 children who would otherwise be in foster care.

Program Trends / Major Program Changes

TANF:

North Dakota is one of only ten states meeting the federally required 50% work participation rate without the addition of the caseload reduction credit. In order to meet the federally required work participation rate, the Department contracted not only with Job Service North Dakota, but also Career Options. Career Options was in a position to give the kind of wrap-around services on a case-by-case basis necessary for challenging clients.

Diversion Assistance - Front-end

Diversion Assistance was designed to provide aid to families whose earned income has been reduced and who are in need of short-term assistance to provide for financial needs until self-sustaining income begins again. Diversion Assistance is designed to be an alternative to receiving ongoing TANF cash assistance. Due to receipt of federal guidelines on Diversion Assistance that became effective October 1, 2008, the effectiveness of the program is minimal. Therefore, pay after performance is being developed.

Pay After Performance

The pay after performance program has an anticipated implementation date of April 2009. Work-eligible individuals will be required to meet work requirements before their needs will be met. This means a child only payment will be made, and, if the work-eligible individual meets the

work requirements, unless there is good cause, a supplemental payment will be made to meet their needs. If the work-eligible individual does not meet the work requirements, a sanction will be imposed. Pay after performance will be effective for the first four months of an application.

Benefits

- System will process cases according to policy without case closure
- Work-eligible individuals will participate in required hours before receiving a benefit
- Anticipate increase work participation rate

LIHEAP: The LIHEAP caseload has remained fairly stable, but the fuel costs have steadily increased. This is a totally federally funded program. The federal government recently funded an additional $5.1 billion nationwide, so states could meet the fiscal demands of increasing fuel costs. With this additional funding, trends indicate that North Dakota will meet the needs of the LIHEAP clients in the 2009-2011 biennium.

SNAP: There has been a sharp increase in the number of clients seeking food assistance during the 2007-2009 biennium. This appears to be the result of an outreach effort on the part of the federal government, coupled with the implementation of simplified reporting and the 2008 Farm Bill. Simplified reporting allows a client to report earnings on a semi-annual basis as opposed to monthly.

Child Care Assistance: The Department implemented a certificate program to meet federal regulations that identifies a constant amount to be paid for three to six months, depending on the family circumstances. This resulted in higher average monthly caseload and cost per case.

Prior to the certification program, each family's payment had to be calculated monthly.

Overview of Budget Changes:

Description	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget	House Changes	To Senate
Salary and Wages	4,568,776	741,307	5,310,083	(147,588)	5,162,495
Operating	10,092,283	742,270	10,834,553	-	10,834,553
Capital Assets	205	-205	0	-	0
Grants	203,750,869	110,709,185	314,460,054	-	314,460,054
Total	218,412,133	112,192,557	330,604,690	(147,588)	330,457,102
General Funds	7,784,373	2,041,903	9,826,276	(48,462)	9,777,814
Federal Funds	191,369,536	111,369,897	302,739,433	(99,126)	302,640,307
Other Funds	19,258,224	(1,219,243)	18,038,981	-	18,038,981
Total	218,412,133	112,192,557	330,604,690	(147,588)	330,457,102

FTE	39.80	-	39.80	-	39.80

Budget Changes from Current Budget to Executive Budget:

The Salary and Wages line item increased by $741,307 and can be mainly attributed to the following:

- The salary and health insurance package that adds $475,306 in total funds of which $212,910 is general funds;
- $75,703 in total funds is for the continuation of the year two 4% increase of which $38,261 is general funds;
- An increase of $79,682 to cover an underfunding of salaries from the 2007-2009 budget; and

- The remaining $110,616 increase is a combination of increases and decreases needed to sustain the salary of the 39.8 FTEs in this area of the budget.

The Operating line item increased by $742,270, and is a combination of the increases and decreases expected next biennium. Some of the significant changes are noted below:

- $1,565,878 increase to the JOBS program due to the need for increased client services, as a large portion of the individuals remaining on TANF are challenging clients;
- $464,144 increase in Parental Responsibility Initiative for the Development of Employment (PRIDE) to provide for a statewide program;
- $188,308 increase to provide for federally required estate collection activities;
- $1,016,486 decrease to SNAP EBT (Electronic Benefit Transfer) provider payments due to the completion of the EBT reprocurement process, and the resulting decrease in the monthly cost per case of $1.91; and
- $502,969 decrease in the Payment Error Rate Measurement contract due to the cyclical nature of the three-year federal eligibility review requirements.

The Grants line item increased by $110,709,185, and is a combination of the increases and decreases expected next biennium. Some of the significant changes are noted below:

- $97,366,572 increase in SNAP benefits, all federal funds, based upon federal outreach, implementation of simplified reporting, and the 2008 Farm Bill;

- $12,022,292 increase in LIHEAP benefits, all federal funds, based upon increasing heating costs and available federal funds;
- $454,479 increase in Indian County Allocation, all general funds, based upon the statutory funding formula;
- $1,907,617 decrease in TANF grants, mainly due to the decrease in the number of clients, and consists of a $1,217,016 increase in general funds, a $1,316,576 decrease in federal funds, and a $1,808,057 decrease in other funds or Child Support collections;
- $2,629,386 increase in Child Care Assistance grants, consisting of a $350,197 increase in general funds, of which $274,408 was included in the Executive Budget to increase provider rates for centers and group facilities; and
- $155,162 increase in the Supplemental Nutrition Assistance Program Education Plan, all federal funds, based upon NDSU budget projections.

House Changes:

The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $48,462 – general fund and $99,126 – federal funds for a total of $147,588.

This concludes my testimony on the 2009 – 2011 budget request for the Economic Assistance Policy area of the Department. I would be happy to answer any questions.

A

TANF Block Grant

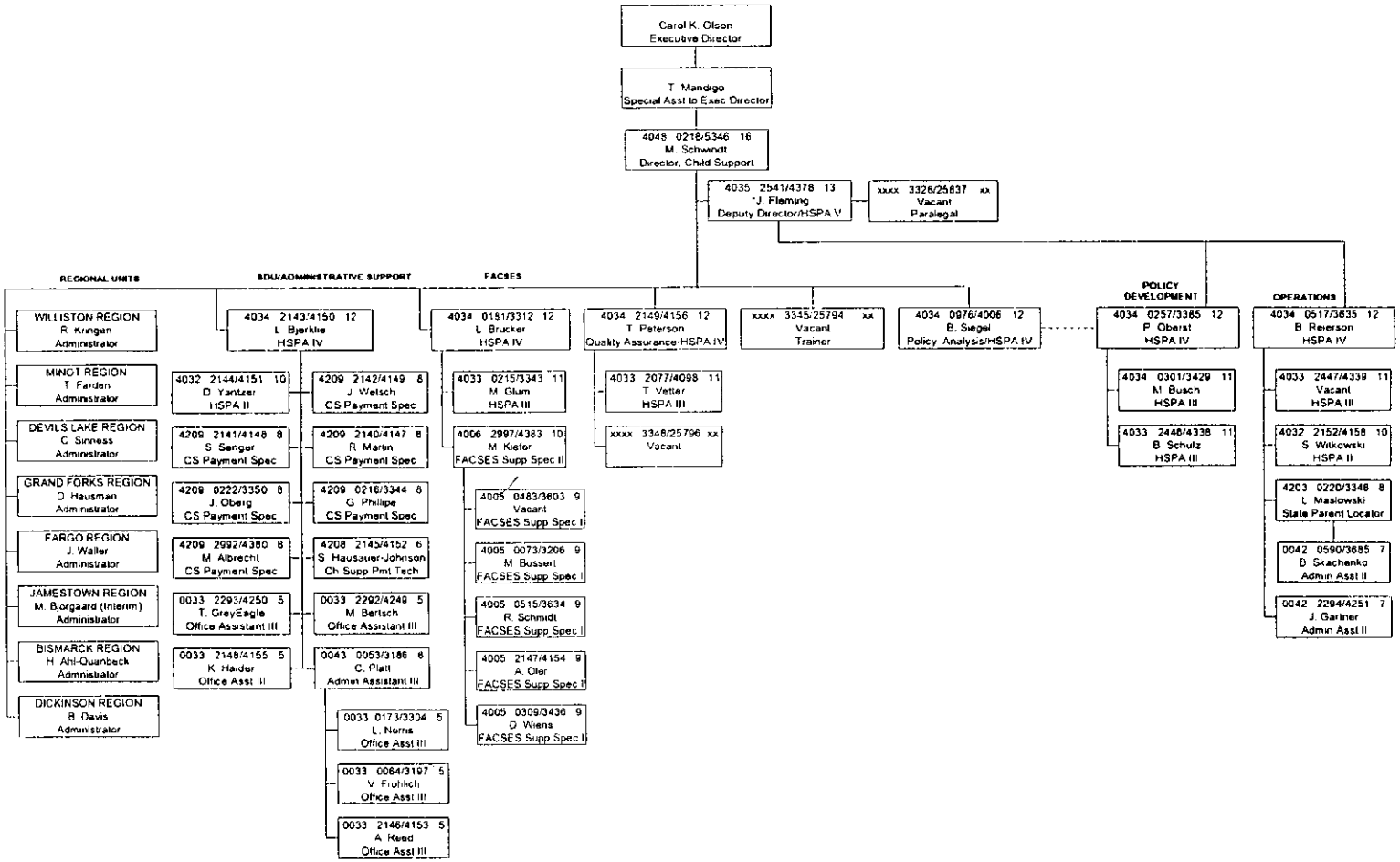
Revenue / Estimated Expenditures

2009-2011

	TANF Block Grant	Estimated Expenditures 2009-2011	Estimated CarryForward to 2011-2013
REVENUE			
FY 2009	18,244,674	18,244,674	
FY 2010	26,399,809	26,399,809	
FY 2011	19,799,856	18,777,170	1,022,686
Transfer to CCDBG	(500,000)	(500,000)	
Total Est Expenditures & Transfers	**63,944,339**	**62,921,653**	**1,022,686**

	Total	Federal	General	Other
ESTIMATED EXPENDITURES				
Assistance to Needy Families				
TANF Benefit	22,605,502	7,577,885	5,531,958	9,495,659
TANF Kinship Care	420,000	420,000		
TANF Transition Child Care	892,700	892,700		
Subtotal	23,918,202	8,890,585	5,531,958	9,495,659
Job Preparation				
TANF Work Activity - Sp Pymts	909,242	909,242		
JOBS - Transportation	2,821,875	2,821,875		
JOBS - Client Services	6,418,568	6,418,568		
JOBS - Support Services	1,554,676	1,554,676		
Subtotal	11,704,361	11,704,361		
Formation & Maintenance of Families				
Wraparound Case Management	3,399,433	2,322,550		1,076,883
Parent Aid	1,083,350	1,083,350		
Intensive In-Home Services	470,513	470,513		
Child Abuse & Neglect Investigations	4,747,706	4,747,706		
Foster Care	21,772,753	21,772,753		
Subtotal	31,473,755	30,396,872		1,076,883
Other				
Systems Maint. & Operations	1,524,589	1,524,589		
Alternatives to Abortion	400,000	400,000		
County:				
Emergency Assistance - Case Mgmt.	1,646,587	1,646,587		
TANF Assessments	607,143	607,143		
Subtotal	4,178,319	4,178,319		
Administration				
JOBS Contract Administration	752,510	752,510		
State Office Administration	2,994,497	2,994,497		
County Administration	3,252,426	3,252,426		
Human Service Center Administration	752,083	752,083		
Subtotal	7,751,516	7,751,516		
Child Care MOE	2,034,072			2,034,072
Subtotal	2,034,072			2,034,072
Total Estimated Expenditures	**81,060,225**	**62,921,653**	**5,531,958**	**12,606,614**

North Dakota Department of Human Services
Child Support Division



*Legal work of RCSEUs is supervised by Jim Fleming

2007 - 2009 Budget:
172.2 FTEs

Revised 1/5/09

E

Testimony
House Bill 1012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
January 12, 2009

Chairman Pollert, members of the House Appropriations Human Resources Division, I am Mike Schwindt, Child Support Enforcement director. I am here to provide an overview of the award-winning Child Support Enforcement (CSE) program for the Department of Human Services.

Programs

The CSE program is designed to enhance the well-being of children and reduce the demands on public treasuries by securing child support and medical support from legally responsible parents and by encouraging positive relationships between children and their parents.

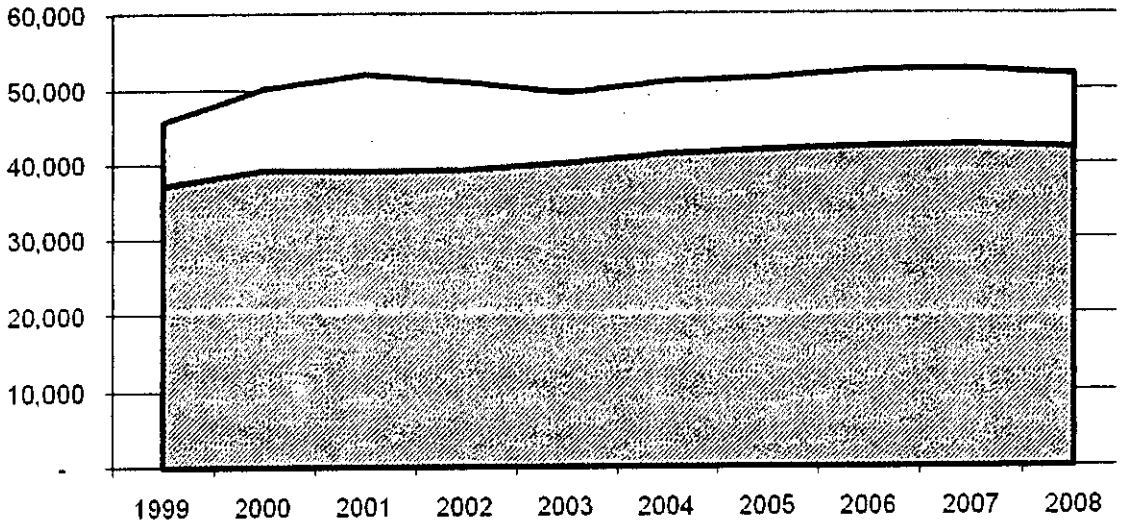
This budget includes, for the first time, the staff and operating costs of the eight regional child support enforcement units (RCSEUs) transferred from county to state responsibility with the enactment of SB 2205 last session.

Caseload / Customer Base

The total IV-D caseload was at 42,108 in December 2008. The nonIV-D portion of the caseload added 9,971 more cases.

- These cases include about 66,000 children and 79,600 parents.
- Within the IV-D portion of the program, about 4,700 cases are awaiting court orders, the key to getting funds to the children.
- Our caseload is distributed among the 54 states and territories plus a number of Indian tribes and foreign countries.

Department of Human Services
Open Child Support Cases
December 1999 through December 2008



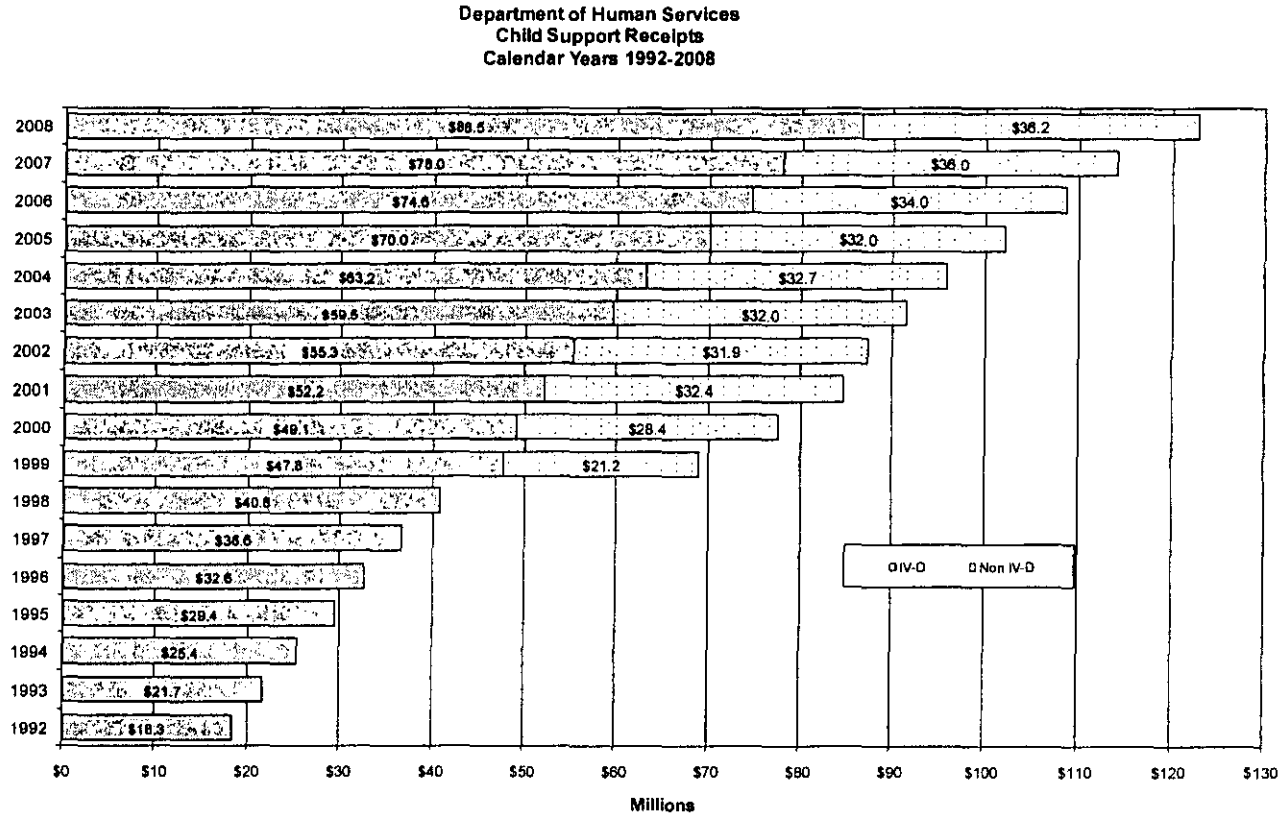
	Dec-99	Dec-00	Dec-01	Dec-02	Dec-03	Dec-04	Dec-05	Dec-06	Dec-07	Dec-08
Non IV-D Cases	8,591	11,071	13,131	11,872	9,474	9,802	9,771	10,314	10,161	9,971
IV-D Cases	37,161	39,244	39,047	39,236	40,180	41,385	41,886	42,323	42,540	42,108

Major Trends, Issues and Program Changes

Collections. Total collections continue to increase. We initially passed the $100 million threshold in annual collections in December 2005. For calendar year 2008, total collections reached $122.7 million, a 7.6% increase over 2007. Within the IV-D program, collections increased 10.9% to $86.5 million while the nonIV-D portion increased only a half percent to $36.2 million. Despite these increased collections, our total receivables continue to climb, reaching $279.7 million as of the end of December 2008.

Of the estimated $250 million we expect to collect next biennium, about 90% will be sent directly to the families, 5% will be sent to another state

for further distribution and the balance will be retained to reimburse taxpayers including about $7 million used to fund our TANF and foster care programs.



Fees. A recent federal mandate requires us to charge an annual $25 service fee on nonassistance cases included in the IV-D caseload. We implemented the fee in October 2007 by charging:

- the $25 fee on select IV-D cases after $500 has been received and paid to the family, and
- a monthly $2.10 fee whenever collections are received on nonIV-D cases.

Fees received are shared with our federal partners as revenue where they are entitled to a piece of the collection. The state share of all fees is projected to be $263,938 and is included in this budget.

Performance. I'm pleased to report that we – the CSE program, the courts, and the clerks of court - continue to rank as one of the best programs nationally. Additionally, our program performance has been recognized by a number of organizations including:

- Western Interstate Child Support Enforcement Council's **Outstanding State Program** in November 2006.
- The Council of State Government' 2007 **regional and national Innovation Awards** for our PRIDE (Parental Responsibility in the Development of Employment) program which relies heavily on TANF, Job Service North Dakota and the Courts.
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- The CSE director was also recognized in August, receiving the National Child Support Enforcement Association's 2008 **Outstanding Manager** award along with the OCSE Commissioner's award for **Exemplary Leadership**.

While we have made steady improvements over the years, we still have a long way to go. Using comparative federal fiscal year measures:

- Percent of children in IV-D cases born out of wedlock with paternity established or acknowledged.
    - In 2007 we were at 105%, moving to 104% in 2008.
    - Using same year data, for 2007 we were at 98.2%, moving to 99.7% in 2008.

- Percent of cases with court orders for child support.
    - In 2007 we were at 87% and remained unchanged for 2008. Since a court order is essential to moving forward with the case, we are focusing our efforts on this and the following measure to improve overall performance. The improvement target is 2% per year until we are in the top five in the country. In the latest ranking we were 9th in the country for this measure.

- Percent of current support owed on IV-D cases that is collected.
    - In 2007 we were at 74.2%, moving to 75.85% in 2008. Our improvement target is collecting an additional 2% per year until we collect 90% of support that is due each month. In the latest ranking we were 2nd in the country.

- Amount collected for each $1 spent.
    - In 2007 we were at $5.59, inching to $5.81 in 2008.
    - Overall, we collect about $32 for every $1 in state general funds used.

- Medical Support is the newest performance measure coming on line. This measurement continues under development at the national level.

Benefits. This program also results in measurable savings to taxpayers. In addition to the millions we recover each year to offset the TANF, Foster Care and Medicaid programs, there is another, more difficult to measure component – that being cost avoidance. While this measurement process can use some refinement, applying the federal data to our collections shows that our efforts result in about $22 million in additional savings to the Medicaid, Food Stamps, Housing, SSI and TANF programs each year.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / (Decrease)
Salary and Wages	16,879,193	19,099,615	2,220,422
Operating	4,160,835	4,144,458	(16,377)
Equipment		13,000	13,000
Grants	462,946	200,000	(262,946)
Total	21,502,974	23,457,073	1,954,099
General Funds	491,698	6,365,045	5,873,347
Federal Funds	15,571,363	14,303,519	(1,267,844)
Other Funds	5,439,913	2,788,509	(2,651,404)
Total	21,502,974	23,457,073	1,954,099
FTE	172.20	164.70	(7.50)

Salaries. The salaries line changed by $2,220,422 primarily because of

- the $1,790,188 needed for the Governor's salary and health package. This was funded with $578,186 in general funds, $1,131,349 of federal and $80,653 of other funds.

- the reduction of $621,970 for the 7.5 FTEs extracted consisting of $264,174 in general funds, and $357,796 of federal funds along with
- a $16,250 reduction for temporary salaries, (general funds share of $4,289).
- $182,933 is needed to sustain the 4 & 4% salary increase for the current biennium, (general funds share of $63,747).
- most of the balance is needed to address underbudgeted RCSEU salaries as part of the transfer to state administration as well as maintain salary adjustments occurring during the current biennium.

Operating. The $4.1 million operating line has a net decrease of $16,377.

- The single largest item is the $2 million in operating fees and services, which has a $79,931 increase. This item includes
  - $1,148,778 of federal funds for the Supreme Court, an increase of $98,778.
  - Genetic testing fees and related costs of $135,000.
  - $200,000 for a receivables study.
- Rent for our RCSEUs and the central office increased by $114,128 to $1,054,565. We have moved or anticipate moving the RCSEUs in Williston, Devils Lake, and Fargo because either the host county wanted the space or our lease expired.
- All other items were conservatively budgeted at anticipated usage.

Equipment. There is $13,000 included for copiers at the Dickinson and Williston RCSEUs.

Grants. The grants line shows a net decrease of $262,946, resulting in a $200,000 request which will cover the expected access and visitation federal funding.

Revenues. The CSE program is now state administered. Funding for the program is primarily federal in that eligible expenditures are matched with 66% federal funds and 34% state funds. A recent federal law change prohibits using incentive funds as match for other federal funds. The Other Funds category includes fees of $263,938 and $2.5 million of federal incentive funds which must be reinvested in the program. You will note the reduction of $3.2 million in county funds in the appropriation.

This concludes my testimony on the 2009 – 2011 budget request for the Child Support program. I would be happy to answer any questions.

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
March 3, 2009

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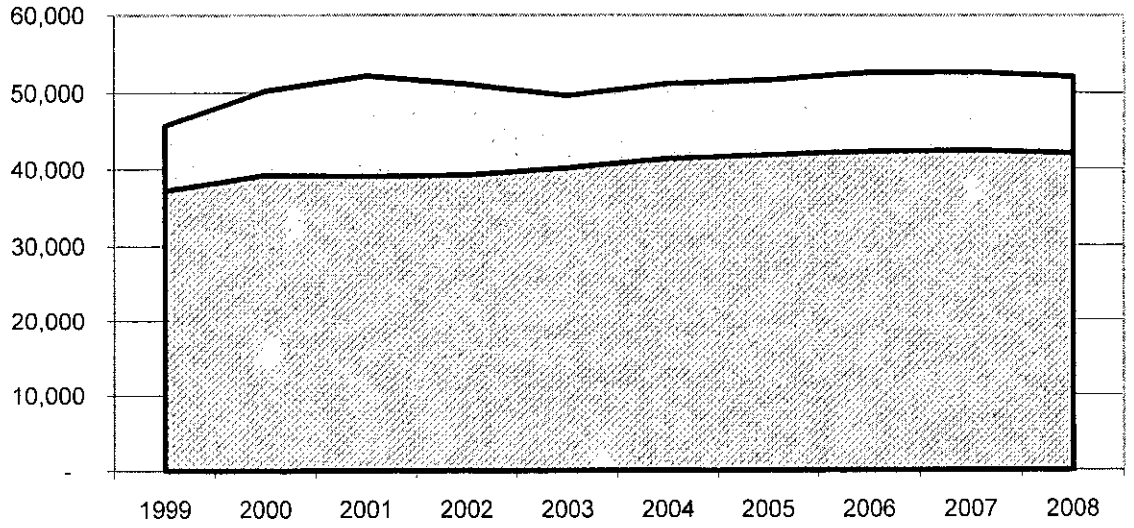

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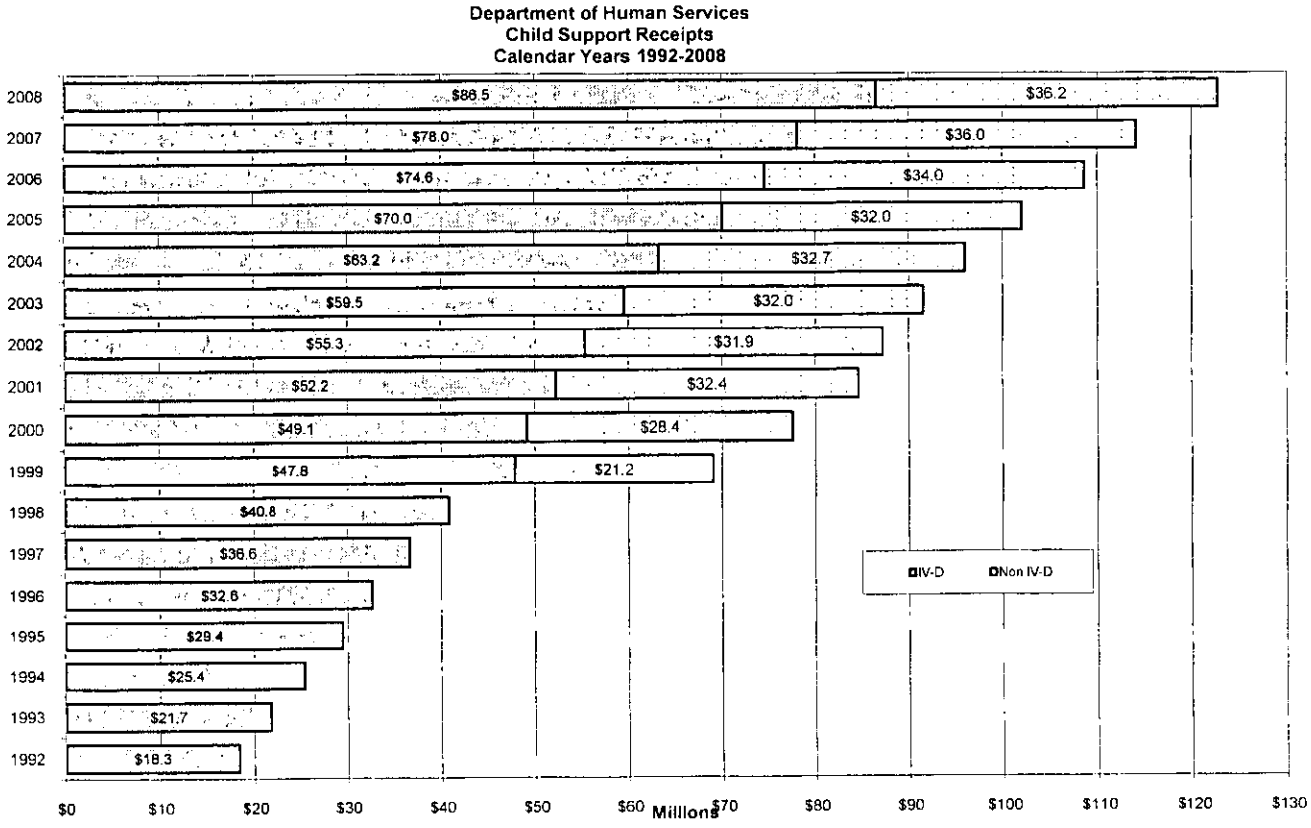

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    - Using same year data, for 2007 we were at 98.2%, moving to 99.7% in 2008.

- Percent of cases with court orders for child support.
    - In 2007 we were at 87% and remained unchanged for 2008. Since a court order is essential to moving forward with the case, we are focusing our efforts on this and the following measure to improve overall performance. The improvement target is 2% per year until we are in the top five in the country. In the latest ranking we were 9th in the country for this measure.

- Percent of current support owed on IV-D cases that is collected.
    - In 2007 we were at 74.2%, moving to 75.85% in 2008. Our improvement target is collecting an additional 2% per year until we collect 90% of support that is due each month. In the latest ranking we were 2nd in the country.

- Amount collected for each $1 spent.
    - In 2007 we were at $5.59, inching to $5.81 in 2008.
    - Overall, we collect about $32 for every $1 in state general funds used.

- Medical Support is the newest performance measure coming on line. This measurement continues under development at the national level.

Benefits. This program also results in measurable savings to taxpayers. In addition to the millions we recover each year to offset the TANF, Foster Care and Medicaid programs, there is another, more difficult to measure component – that being cost avoidance. While this measurement process can use some refinement, applying the federal data to our collections shows that our efforts result in about $22 million in additional savings to the Medicaid, Food Stamps, Housing, SSI and TANF programs each year.

OVERVIEW OF BUDGET CHANGES

Description	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget	House Changes	To Senate
Salary and Wages	16,879,193	2,220,422	19,099,615	(209,487)	18,890,128
Operating	4,160,835	(16,377)	4,144,458		4,144,458
Equipment		13,000	13,000		13,000
Grants	462,946	(262,946)	200,000		200,000
Total	21,502,974	1,954,099	23,457,073	(209,487)	23,247,586
General Funds	491,698	5,873,347	6,365,045	(68,787)	6,296,258
Federal Funds	15,571,363	(1,267,844)	14,303,519	(99,733)	14,203,786
Other Funds	5,439,913	(2,651,404)	2,788,509	(40,967)	2,747,542
Total	21,502,974	1,954,099	23,457,073	(209,487)	23,247,586
FTE	172.20	(7.5)	164.70		164.70

Budget Changes from Current Budget to Executive Budget:

Salaries. The salaries line changed by $2,220,422 primarily because of

- the $1,790,188 needed for the Governor's salary and health package. This was funded with $578,186 in general funds, $1,131,349 of federal and $80,653 of other funds.
- the reduction of $621,970 for the 7.5 FTEs extracted consisting of $264,174 in general funds, and $357,796 of federal funds along with
- a $16,250 reduction for temporary salaries, (general funds share of $4,289).
- $182,933 is needed to sustain the 4 & 4% salary increase for the current biennium, (general funds share of $63,747).
- most of the balance is needed to address underbudgeted RCSEU salaries as part of the transfer to state administration as well as maintain salary adjustments occurring during the current biennium.

Operating. The $4.1 million operating line has a net decrease of $16,377.

- The single largest item is the $2 million in operating fees and services, which has a $79,931 increase. This item includes
    - $1,148,778 of federal funds for the Supreme Court, an increase of $98,778.
    - Genetic testing fees and related costs of $135,000.
    - $200,000 for a receivables study.
- Rent for our RCSEUs and the central office increased by $114,128 to $1,054,565. We have moved the RCSEUs in Williston, Devils Lake, and Fargo because either the host county wanted the space or our lease expired.
- All other items were conservatively budgeted at anticipated usage.

Equipment. There is $13,000 included for copiers at the Dickinson and Williston RCSEUs.

Grants. The grants line shows a net decrease of $262,946, resulting in a $200,000 request which will cover the expected access and visitation federal funding.

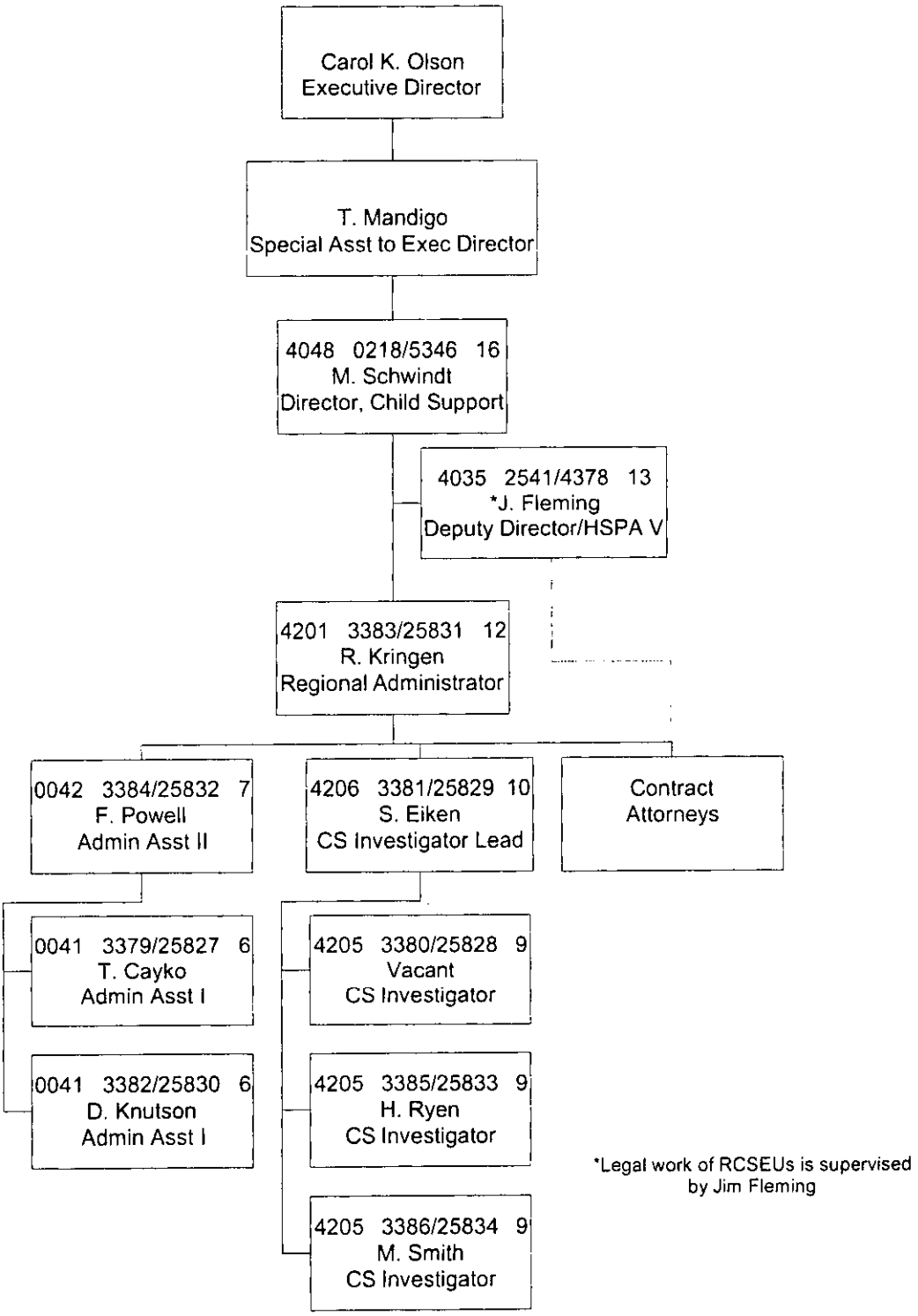
Revenues. The CSE program is now state administered. Funding for the program is primarily federal in that eligible expenditures are matched with 66% federal funds and 34% state funds.

The Other Funds category includes fees of $263,938 and $2.5 million of federal incentive funds which must be reinvested in the program. You will note the reduction of $3.2 million in county funds in the appropriation.

House Changes: The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $68,787 - general funds, $99,733 - federal funds, and $40,967 of other funds for at total of $209,487.

This concludes my testimony on the 2009 – 2011 budget request for the Child Support program. I would be happy to answer any questions.

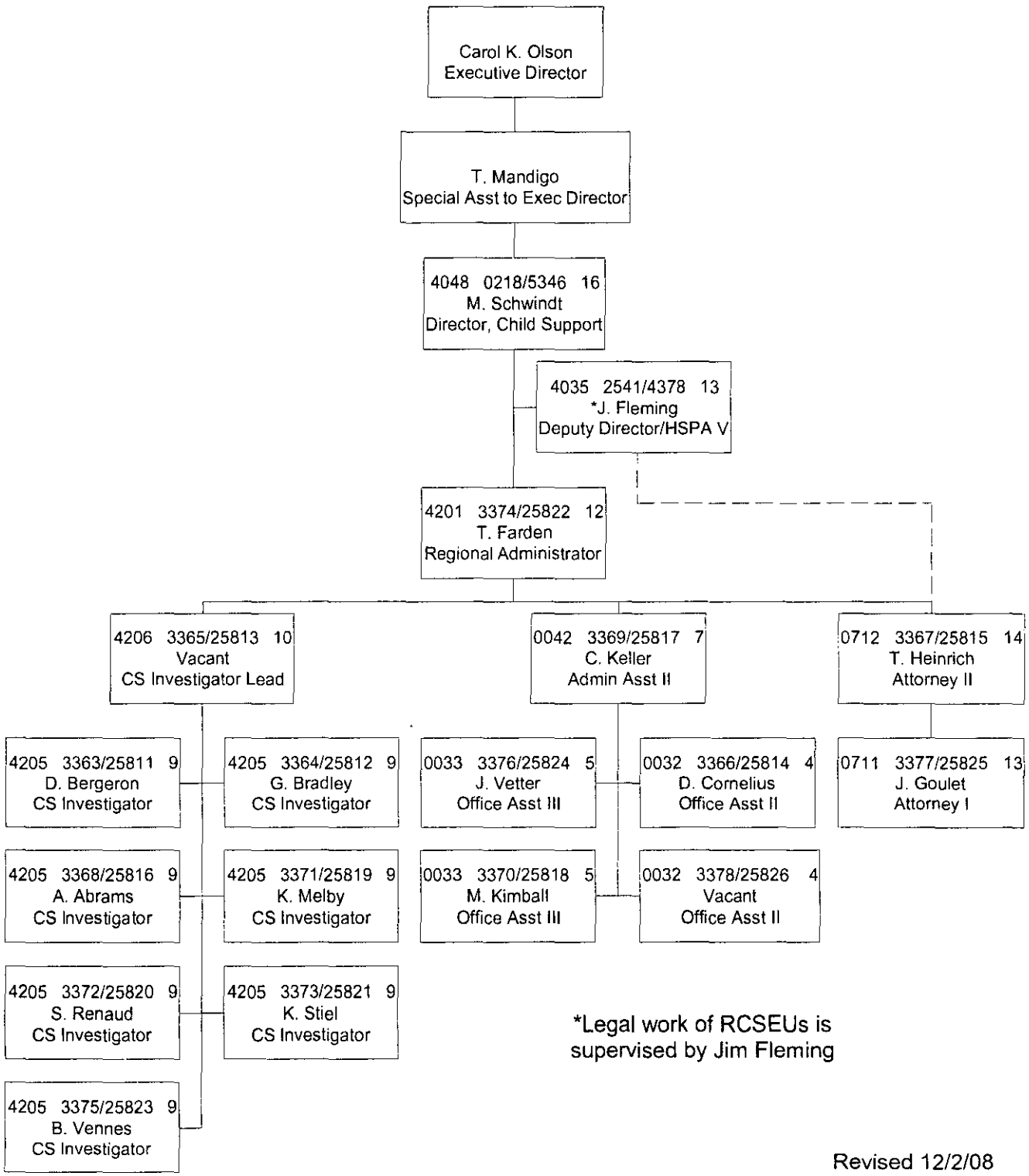
North Dakota Department of Human Services
Child Support Division
Williston Region



*Legal work of RCSEUs is supervised by Jim Fleming

Revised 12/2/08

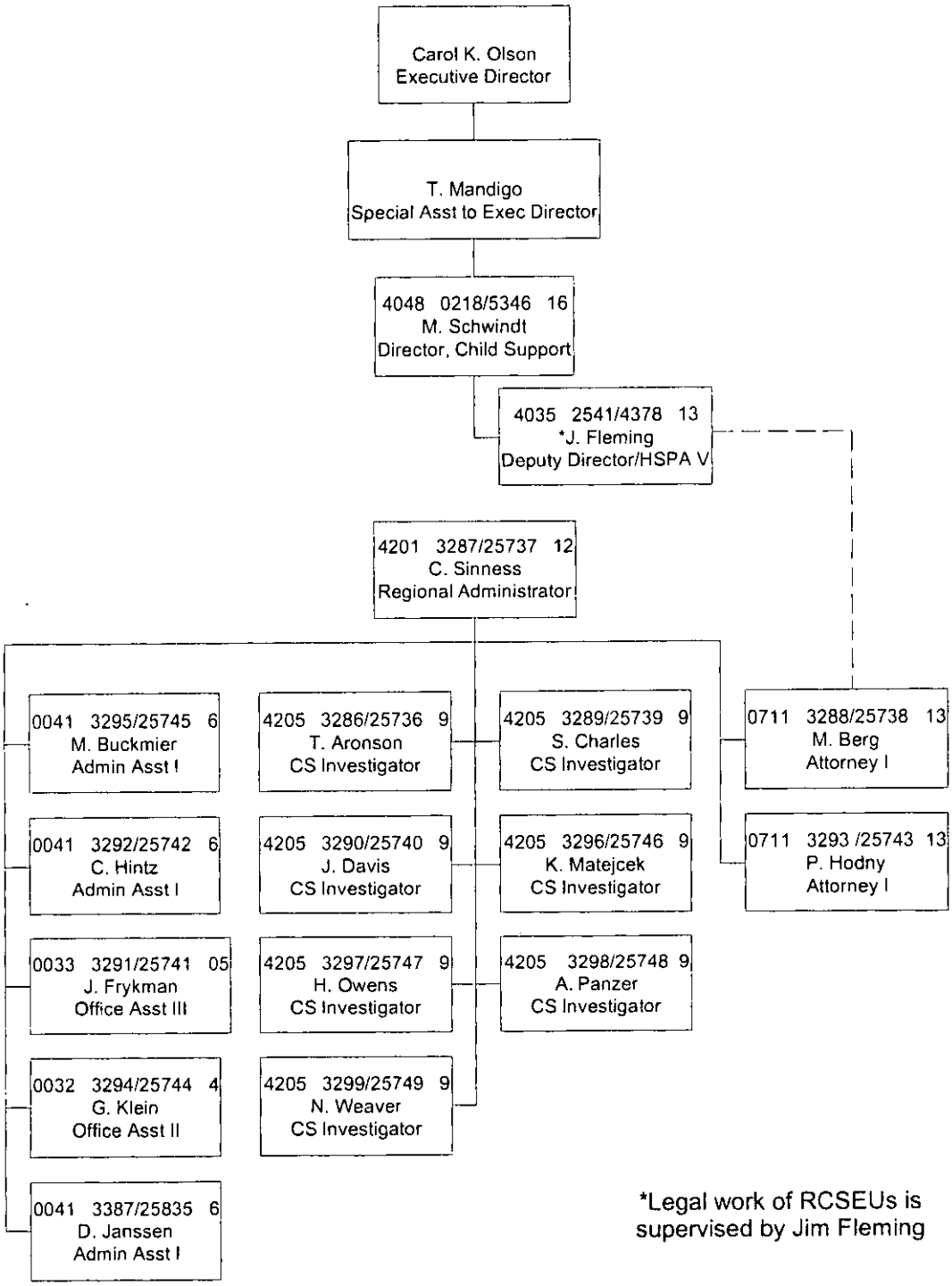
North Dakota Department of Human Services
Child Support Division
Minot Region



*Legal work of RCSEUs is supervised by Jim Fleming

Revised 12/2/08

North Dakota Department of Human Services
Child Support Division
Devils Lake Region



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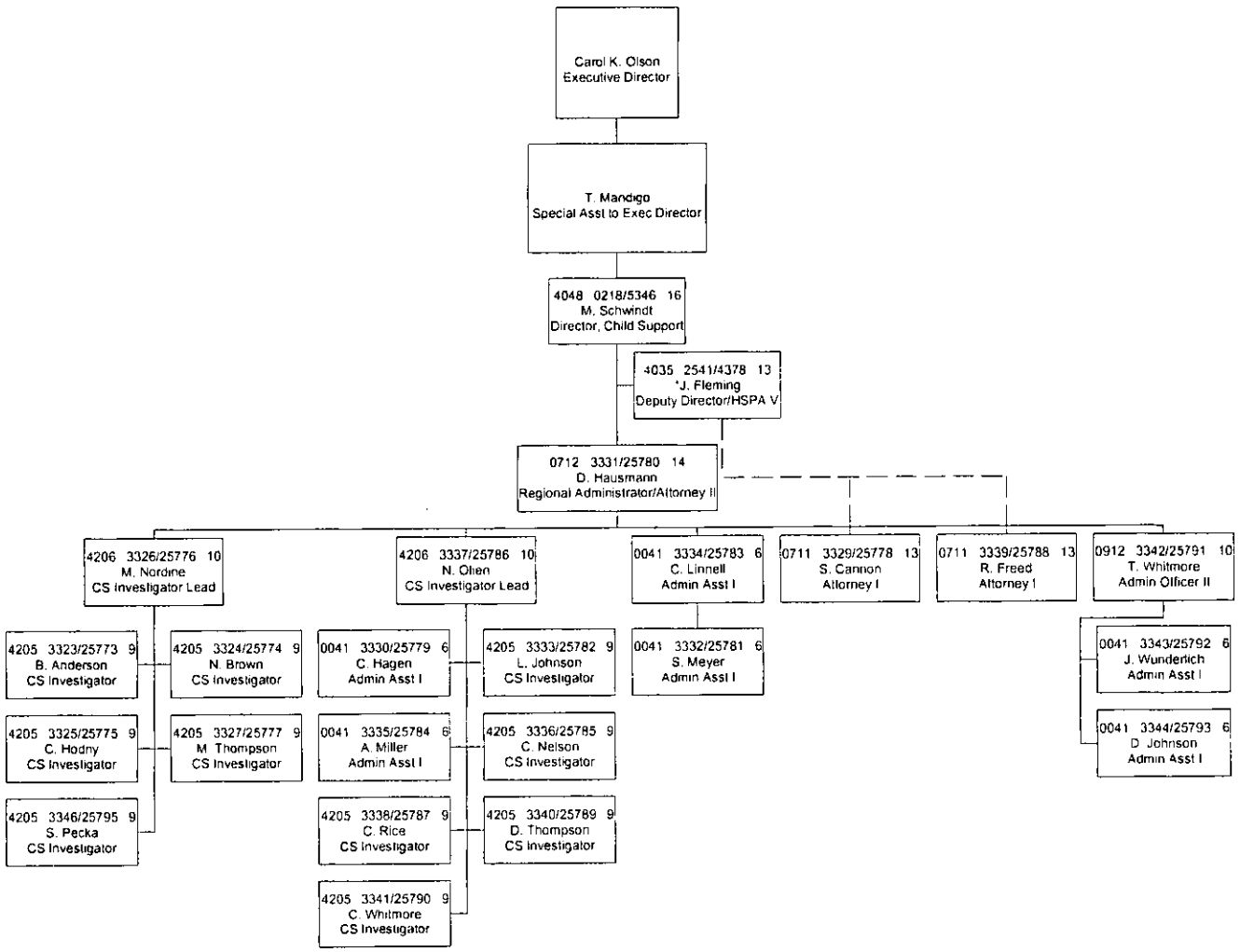
Revised 1/5/09

North Dakota Department of Human Services
Child Support Division
Grand Forks Region



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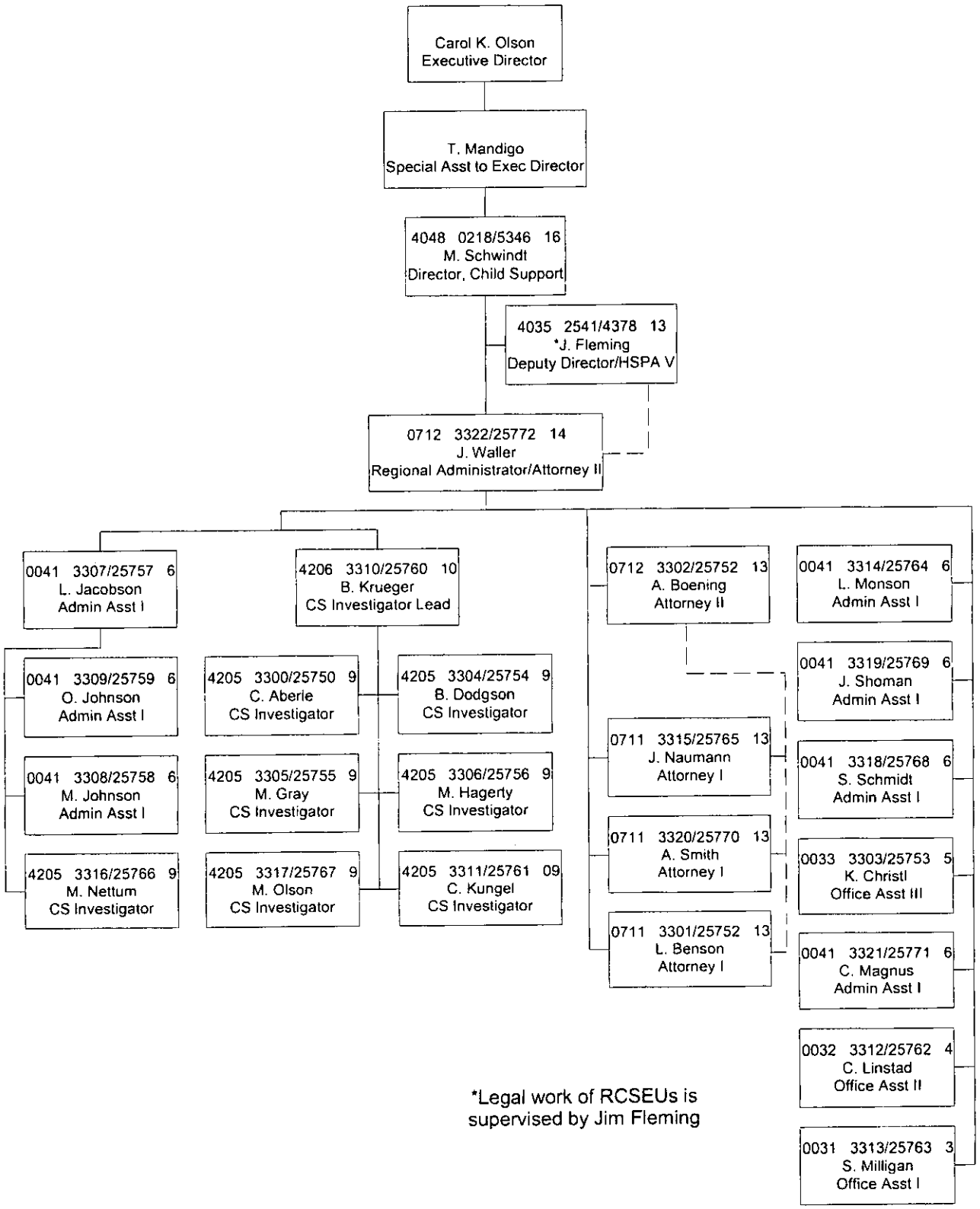
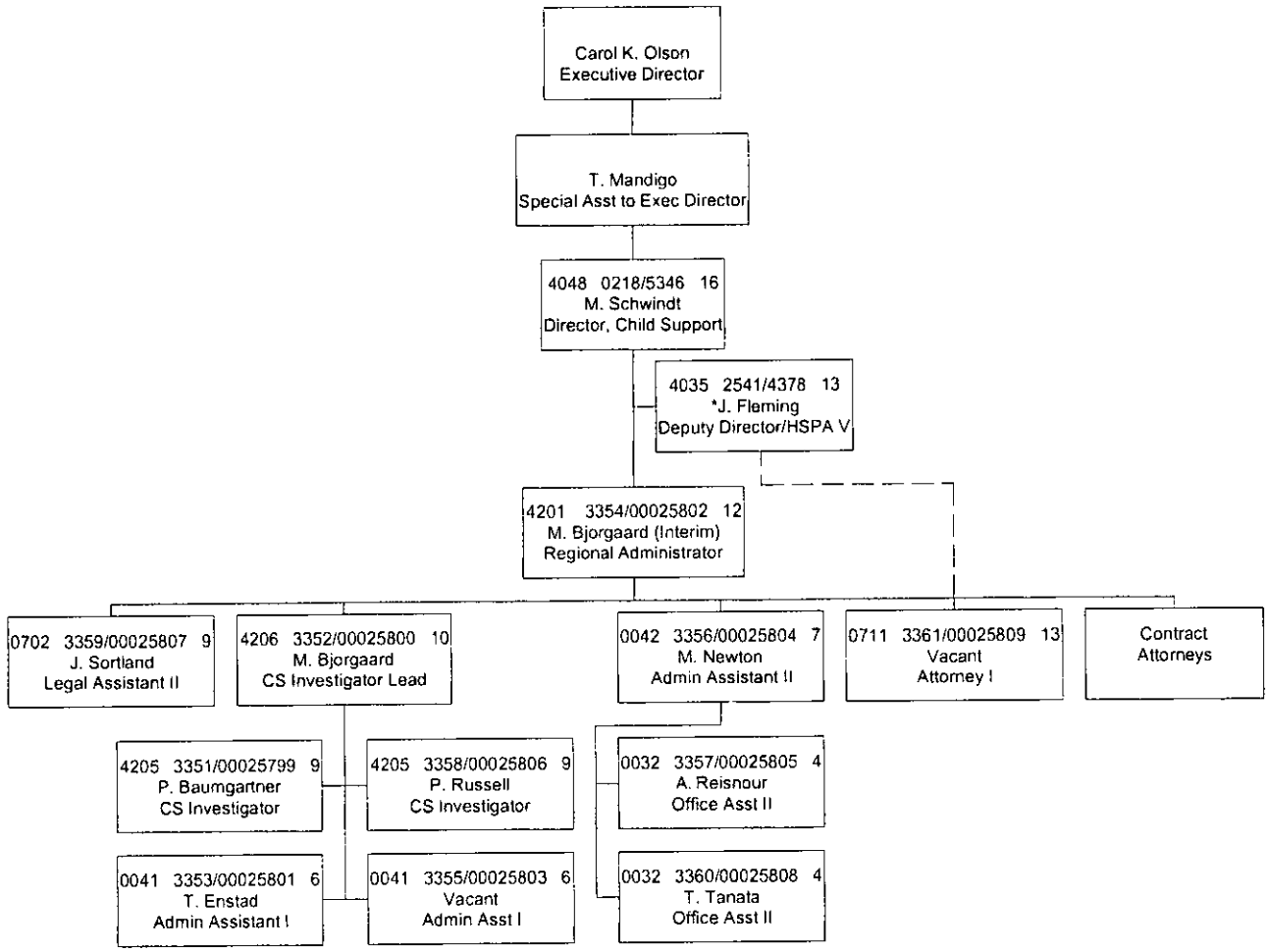
North Dakota Department of Human Services
Child Support Division
Fargo Region



*Legal work of RCSEUs is supervised by Jim Fleming

Revised 12/2/08

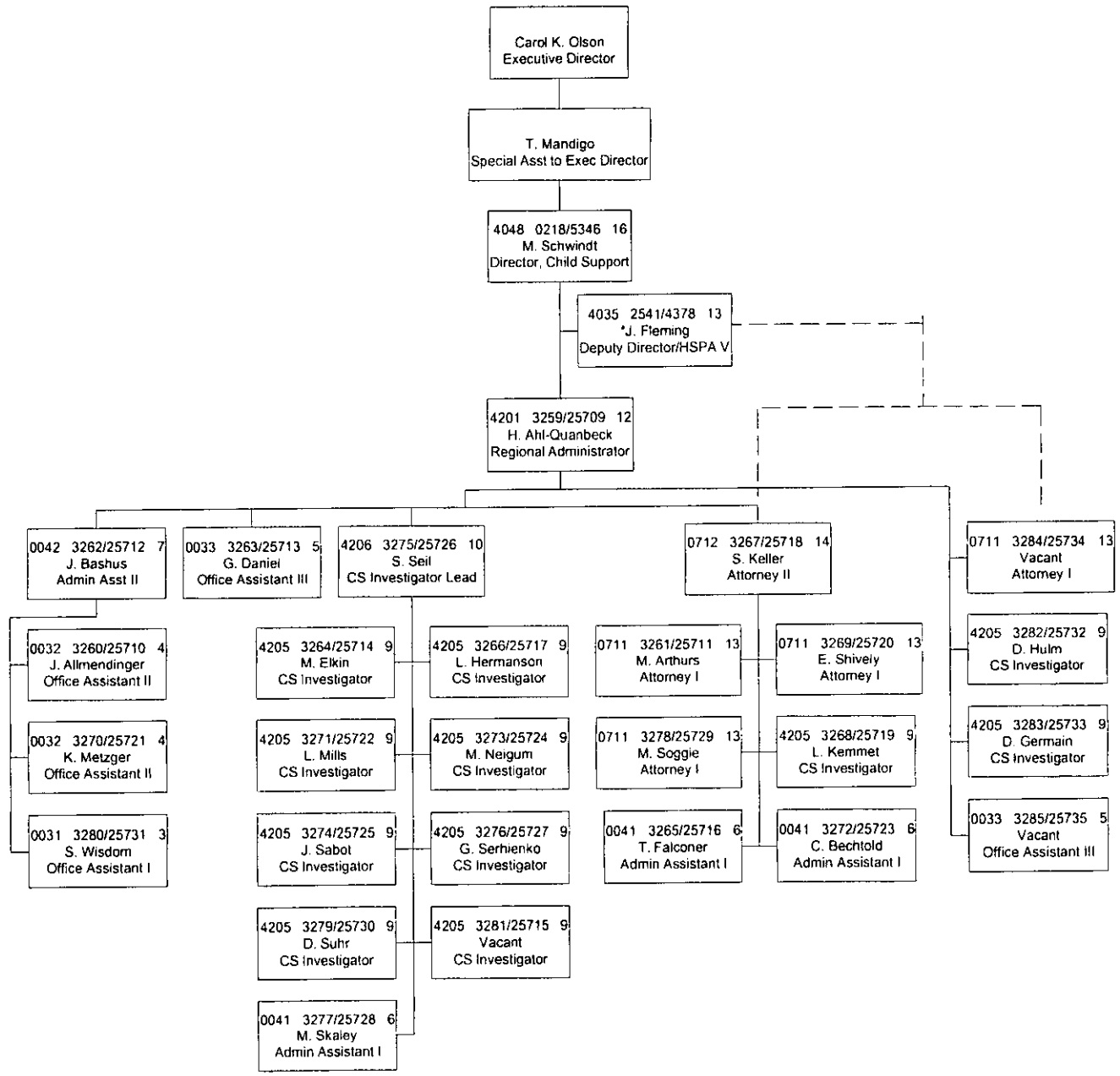
North Dakota Department of Human Services
Child Support Division
Jamestown Region



*Legal work of RCSEUs is supervised by Jim Fleming

Revised 9/2/08

North Dakota Department of Human Services
Child Support Division
Bismarck Region



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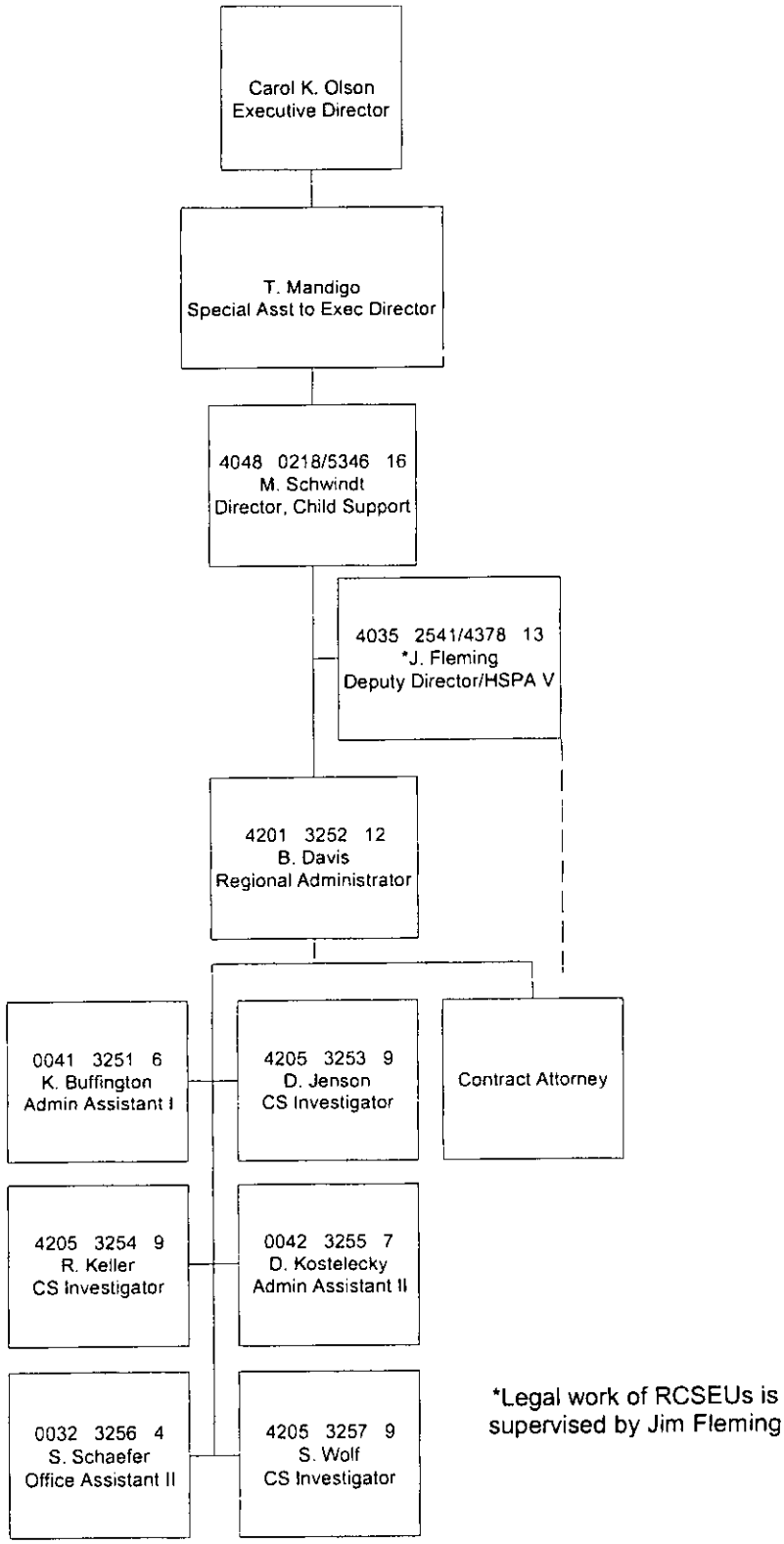
Revised 1/5/09

North Dakota Department of Human Services
Child Support Division
Dickinson Region



*Legal work of RCSEUs is supervised by Jim Fleming

Revised 9/4/07

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code		Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-02 CHILD SUPPORT ENFORCEMENT									
		S101 FULL-TIME EQUIVALENTS (FTEs)		38.000	172.200	0.000	(7.500)	0.000	164.700
32510	B	511000 Salaries - Permanent		2,313,938	11,517,130	5,661,025	842,623	5	12,359,758
32510	B	513000 Temporary Salaries		31,720	125,642	24,899	(16,250)	0	109,392
32510	B	514000 Overtime		31,238	32,801	6,010	24,511	0	57,312
32510	B	516000 Fringe Benefits		877,097	5,203,620	2,135,569	(420,650)	675,688	5,458,658
32510	B	599110 Salary Increase		0	0	0	0	953,877	953,877
32510	B	599160 Benefit Increase		0	0	0	0	160,618	160,618
			Subtotal:	3,253,993	16,879,193	7,827,503	430,234	1,790,188	19,099,615
32510	F	F_1991 Salary - General Fund		574,963	407,358	372,108	4,648,835	578,186	5,634,379
32510	F	F_1992 Salary - Federal Funds		2,068,253	11,941,380	4,501,559	(1,793,216)	1,131,349	11,279,513
32510	F	F_1993 Salary - Other Funds		610,777	1,728,488	1,600,668	376,582	80,653	2,185,723
32510	F	F_1995 Salary - County Funds		0	2,801,967	1,353,168	(2,801,967)	0	0
			Subtotal:	3,253,993	16,879,193	7,827,503	430,234	1,790,188	19,099,615
32530	B	521000 Travel		20,212	173,972	28,380	(22,867)	0	151,105
32530	B	531000 Supplies - IT Software		15,270	62,600	28,428	(960)	0	61,640
32530	B	532000 Supply/Material-Professional		6,378	16,684	7,890	9,067	0	25,751
32530	B	535000 Miscellaneous Supplies		1,601	24,353	970	(24,353)	0	0
32530	B	536000 Office Supplies		10,212	143,337	31,704	(45,731)	0	97,606
32530	B	541000 Postage		2,519	313,986	123,753	(27,178)	0	286,808
32530	B	542000 Printing		19,146	69,452	38,898	52,149	0	121,601
32530	B	553000 Office Equip & Furniture-Under		6,194	108,365	15,920	(73,471)	0	34,894
32530	B	571000 Insurance		0	29,400	393	(28,352)	0	1,048
32530	B	581000 Rentals/Leases-Equip & Other		18,714	62,073	23,725	(20,026)	0	42,047
32530	B	582000 Rentals/Leases - Bldg/Land		194,184	940,437	465,480	114,128	0	1,054,565
32530	B	591000 Repairs		11,333	49,156	36,446	34,684	0	83,840
32530	B	601000 IT - Data Processing		3,851	42,363	20,237	4,609	0	46,972
32530	B	602000 IT-Communications		7,337	58,411	18,511	(51,235)	0	7,176
32530	B	603000 IT Contractual Services and Re		1,966	7,960	17	(7,960)	0	0
32530	B	611000 Professional Development		13,868	59,228	22,472	(8,012)	0	51,216

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code		Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-02 CHILD SUPPORT ENFORCEMENT									
32530	B	621000 Operating Fees and Services		1,712,728	1,995,758	804,677	79,931	0	2,075,689
32530	B	623000 Fees - Professional Services		88	3,300	60	(800)	0	2,500
			Subtotal:	2,045,601	4,160,835	1,667,961	(16,377)	0	4,144,458
32530	F	F_3991 Operating - General Fund		293,464	84,340	64,770	641,906	0	726,246
32530	F	F_3992 Operating - Federal Funds		1,673,019	3,167,037	1,198,192	(351,611)	0	2,815,426
32530	F	F_3993 Operating - Other Funds		79,118	473,353	209,382	129,433	0	602,786
32530	F	F_3995 Operating - County Funds		0	436,105	195,617	(436,105)	0	0
			Subtotal:	2,045,601	4,160,835	1,667,961	(16,377)	0	4,144,458
32550	B	691000 Equipment Over $5000		0	0	0	13,000	0	13,000
			Subtotal:	0	0	0	13,000	0	13,000
32550	F	F_5991 Land & Cptl Imprv - Gen Fund		0	0	0	4,420	0	4,420
32550	F	F_5992 Land & Cptl Imprv - Fed Funds		0	0	0	8,580	0	8,580
			Subtotal:	0	0	0	13,000	0	13,000
32560	B	712000 Grants, Benefits & Claims		2,071,326	462,946	52,662	(262,946)	0	200,000
			Subtotal:	2,071,326	462,946	52,662	(262,946)	0	200,000
32560	F	F_6991 Grants - General Fund		115	0	0	0	0	0
32560	F	F_6992 Grants - Federal Funds		407,555	462,946	52,662	(262,946)	0	200,000
32560	F	F_6993 Grants - Other Funds		1,663,656	0	0	0	0	0
			Subtotal:	2,071,326	462,946	52,662	(262,946)	0	200,000

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-02 CHILD SUPPORT ENFORCEMENT							
	Subdivision Budget Total:	7,370,920	21,502,974	9,548,126	163,911	1,790,188	23,457,073
	General Funds:	868,542	491,698	436,878	5,295,161	578,186	6,365,045
	Federal Funds:	4,148,827	15,571,363	5,752,413	(2,399,193)	1,131,349	14,303,519
300-02 CHILD SUPPORT ENFORCEMENT	**Other Funds:**	2,353,551	2,201,841	1,810,050	506,015	80,653	2,788,509
	SWAP Funds:	0	0	0	0	0	0
	County Funds:	0	3,238,072	1,548,785	(3,238,072)	0	0
	IGT Funds:	0	0	0	0	0	0
	Subdivision Funding Total:	7,370,920	21,502,974	9,548,126	163,911	1,790,188	23,457,073

Child Support

Detail of Budget Account Code 582000 - Rentals / Leases - Buildings / Land
For the 2009-11 Biennium

Rentals / Leases	Total	General	Federal / Other
Century Center ($13.50 / sq ft for office space & $5.00 / sq ft for storage space)	$ 201,489	$ 55,526	$ 145,963
Williston RCSEU ($12.00 / sq ft)	42,000	14,280	27,720
Minot RCSEU ($12.60 / sq ft)	105,840	19,737	86,103
Devils Lake RCSEU ($12.00 / sq ft)	102,000	34,680	67,320
Grand Forks RCSEU ($13.15 / sq ft)	120,737	41,051	79,686
Fargo RCSEU ($16.00 / sq ft)	164,352	55,880	108,472
Jamestown RCSEU ($6.22 / sq ft)	48,746	16,574	32,172
Bismarck RCSEU ($12.00 / sq ft and $12.50 effective June 2010)	179,007	60,862	118,145
Dickinson RCSEU ($10.08 / sq ft)	45,000	15,300	29,700
Outgoing Interstate Unit ($13.15 / sq ft)	31,896	10,845	21,051
High Intensity Enforcement Unit ($12.00 / sq ft and $12.50 effective June 2010)	13,498	4,589	8,909
Total Rentals / Leases	$ 1,054,565	$ 329,324	$ 725,241

Child Support

Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2009-11 Biennium Budget

Operating Fees & Services	Total	General	Federal / Other Funds
FIDM (Financial Institution Data Matching)	$ 86,106	$ 29,276	$ 56,830
CSLN (Child Support Lien Network-Matching)	24,000	8,160	15,840
Locate Tools	18,260	6,208	12,052
Health Management Systems (Health Insurance Matching)	120,000	40,800	79,200
Supreme Court	1,108,778	-	1,108,778
State's Attorneys-Criminal Prosecutions	40,000	-	40,000
Contract Attorney Services for Civil Litigation	61,450	20,893	40,557
Receivables Study	200,000	68,000	132,000
Policy Studies Inc. (Collaboration Grant Contract)	135,000	6,750	128,250
Sheriff / Private Firm Service Fees	106,817	36,318	70,499
Genetic Testing	135,460	46,056	89,404
CPA License, Attorney Bar Licenses, Notary Licenses	16,514	5,622	10,892
Years of Service Awards	8,300	2,822	5,478
Other Miscellaneous Fees & Services	15,004	5,101	9,903
Total Operating Fees & Services Budget Account Code	$ 2,075,689	$ 276,006	$ 1,799,683

Fact Sheet

Child Support Enforcement

e purpose of the Child Support Enforcement program is to enhance the well-being of children and reduce the demand on public treasuries by securing financial and medical support from legally responsible parents and encouraging positive relationships between children and their parents.

The Child Support Enforcement Division within the Department of Human Services works with two types of cases:

- **IV-D cases** which stem from referrals from public assistance programs (TANF, foster care and Medical Assistance) or from either custodial or noncustodial parents applying for IV-D services.
- **NonIV-D cases** which stem from court orders where there is no application or referral to the IV-D program or where people choose to close their IV-D case.

Services Provided -

By the eight Regional Child Support Enforcement Units (RCSEUs):

- IV-D cases: Paternity establishment, establishment and enforcement (including issuing income withholding orders and national medical support notices) of child support and medical support orders, review and adjustment of court orders, local locate when customers need to be found, and customer services.
- NonIV-D cases: None

By the Clerks of Court:

- IV-D and NonIV-D cases: Initiate contempt proceedings, enter civil file information into the automated system, and customer services.

By the Child Support Enforcement central office:

- IV-D cases: Manage a number of programs including Federal and State Tax Intercept, State Parent Locate Service, Credit Bureau Reporting, Financial Institution Data Match, Passport Denial, State Directory of New Hires, Central Registry, and Federal Case Registry. Also provide customer services and centralized receipting and distribution of payments including Electronic Funds Transfer (EFT).
- NonIV-D cases: Centralized receipting and distribution of payments, issuing income withholding orders, stomer services, and EFT.

The court order:

- Is issued by the district court. District court judges or judicial referees may conduct hearings.
- Establishes medical support and the amount of child support due based upon the child support guidelines and the unique fact situations of each case.
- May be amended at the request of either party either through private legal counsel or pro se (self representation).
- Will be reviewed by RCSEUs, in IV-D cases, generally no more frequently than 35 months since the order was entered or last reviewed.
- Is enforced by the courts. Requests for enforcement may come from Clerks of Court, private attorneys, either party or, in IV-D cases, the RCSEUs.
- Is also enforced, in IV-D cases, by the Child Support Enforcement program through a variety of administrative actions.
- Is also enforced, in nonIV-D cases, by the Child Support Enforcement program through administratively issued income withholding orders.

Contacts/Information:

Web site: http://www.childsupportnd.com

Customers:

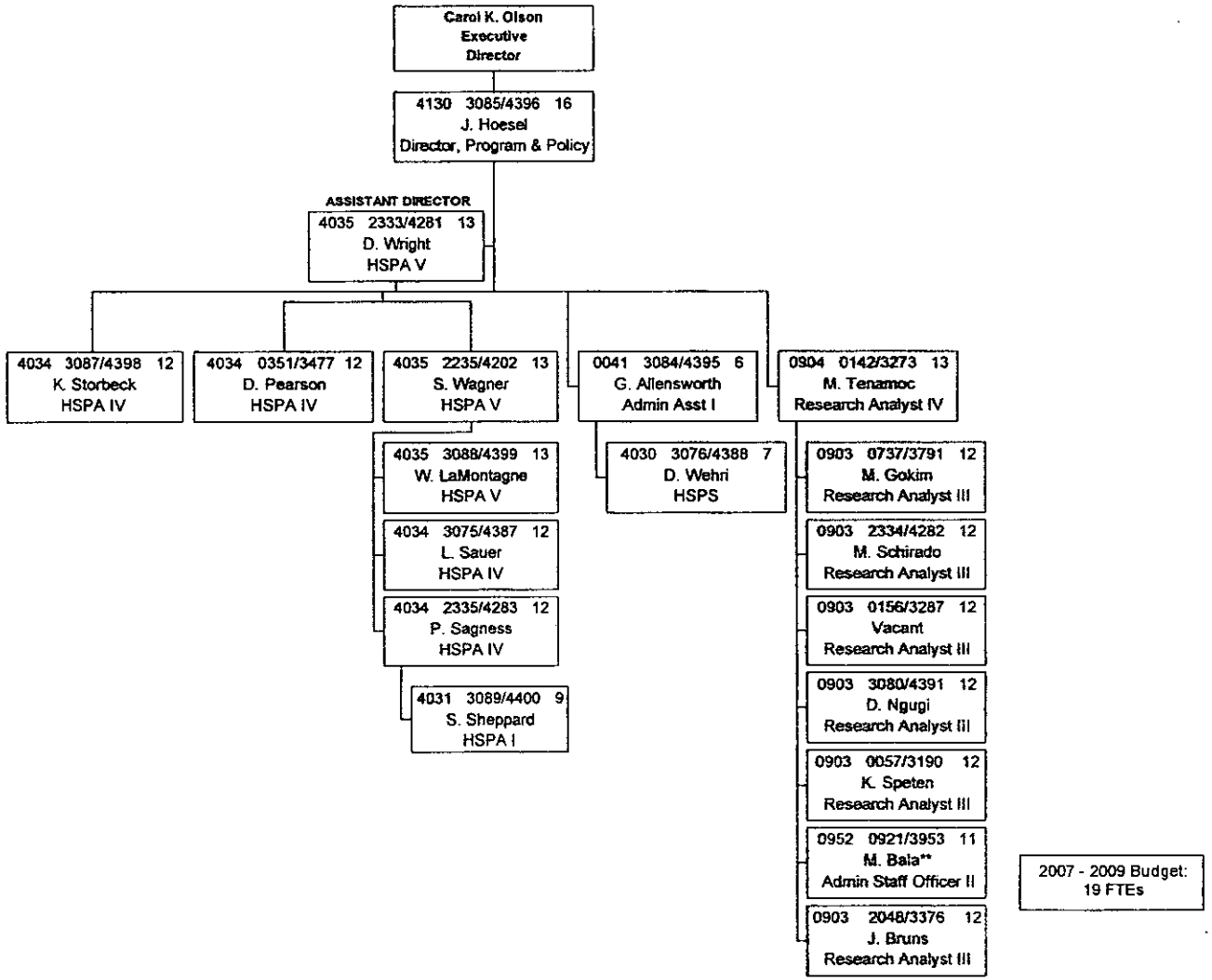
Customer Service Unit:
Email: centralofficecse@nd.gov
Ph: 800.231.4255 Local: 328.5440
Fax: 701.328.5425
Visit the Web site listed above for more information and for online services.

Employers:
Email: sohire@nd.gov
Ph: 800.755.8530 Local: 328.3582
Visit the Web site listed above for more information and for online services.

Mike Schwindt, Director
Email: mschwindt@nd.gov
Ph: 701.328.3582

Revised January 2009
North Dakota Department of Human Service
Child Support Enforcement Division
P.O. Box 7190, Bismarck ND 58507-7190
(701) 328-3582
toll free: (800) 755-8530, TTY: (800) 366-6888

North Dakota Department of Human Services
Mental Health/Substance Abuse Division



Revised 1/6/09

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Testimony
House Bill 1012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
January 13, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, I am JoAnne Hoesel of the Department of Human Services. I am here today to provide you an overview of the Division of Mental Health & Substance Abuse for the Department of Human Services.

Programs

The Division of Mental Health & Substance Abuse provides system-wide education, regulation, technical assistance, training for public and private service providers, federal and state reporting and department-wide research analysis and research/data support.

Service programs directly managed by the Division are Compulsive Gambling Treatment, Community-Based High-Risk Sex Offender Treatment, Regional Prevention Coordination and Model programs, and Methamphetamine Residential Treatment.

Customer Base

During SFY 2008 the public mental health system provided services to 17,388 children, youth, and adults. For the same time period, the public substance abuse system provided services to 6,290 adolescents and adults. The Division is responsible for licensure of 84 substance abuse

treatment programs, 38 DUI seminar providers, eight regional human service centers, and six psychiatric residential treatment facilities for children and adolescents. The Prevention Resource Center is a lending and resource library and distributes educational products annually in the areas of developmental disabilities, mental health, and substance abuse. The Division provided private and public workforce development training in the areas of substance abuse and mental health.

Program Trends / Major Program Changes

Recovery Model – Mental health – The Division continues its transition to a recovery approach in service delivery which shifts emphasis from 'symptom control' to prevention and recovery for those with mental illness. Person centered treatment planning, recovery model training, training of peers to support those in treatment, and integrated dual disorder treatment are just a few of the specific techniques in place, which give consumers primary control for their wellness. The result is significant life enhancement, gains in self-esteem, and self confidence as they become contributing members of the community. This approach is in contrast to traditional models of service delivery where consumers are instructed what to do or simply have things done for them. The Recovery Model's goal is that individuals with mental illness have greater control and choice in their treatment, which leads to their enhanced ability to take increased responsibility in their lives.

Substance Abuse services have enhanced their recovery approach by the continued use of the MATRIX model, which acknowledges the impact of methamphetamine and other drug use on the brain in its design. Two human service centers have recently achieved national certification in the MATRIX model through the University of California – Los Angeles. This certification means their programs maintain the model's approach and fidelity. Other centers are currently in the process of review for certification.

The Division recently began a telephone recovery program, which provides ongoing telephone support after completion of traditional treatment. This program is designed to provide support to those who may not have access to support groups or other community supports due to isolation and transportation problems at a critical time in their recovery.

Returning Veterans – North Dakota has the highest number of Army National Guard soldiers per 100,000. North Dakota's rate is 51.52 whereas, the national average of the 50 states is 11.46. In order to address the needs of returning veterans seeking service in the pubic sector, the Division participates in the Inter-service Family Assistance Committee (ISFAC), a collaborative effort with community agencies to assist in promoting quality of life for returning soldiers and their families. With Traumatic Brain Injury (TBI) being the signature injury sustained in the Iraq and Afghanistan wars, training through the Division's TBI grant is being provided to regional human service centers on screening techniques and other TBI treatment related changes. The

National Guard provided statewide training at the annual Clinical Forum conference and a TBI advisory committee was formed with representation from the Veterans Administration (VA). North Dakota has had 400 returning veterans' with positive first level TBI screens. The regional human service centers are reporting an increase in veterans seeking services.

At the regional human service centers in calendar year 2007, alcohol was the **primary substance** in 57% of admissions (2,252), marijuana was 25% of admissions (1,001), and methamphetamine was 12% of admissions (462).

Treatment admissions for those with primary methamphetamine dependence equaled 272 in 2002, 511 in 2005, and 462 in 2007. From 2005 to 2007 there was a decrease of 9.5% in the number of admissions for methamphetamine dependence. As a percent of total substance abuse admissions, methamphetamine admission trend was 9% in 2002; 13% in 2005; and 12% in 2007. At the same time, alcohol and marijuana trends as percents of total substance abuse admissions are as follows: Alcohol from 63% in 2002; 55% in 2005; 57% in 2007, and marijuana was 23% in 2002; 20% in 2005, and 25% in 2007. Abuse of prescription drugs appears to now be the current upward substance abuse trend.

Trauma Informed Systems – Unresolved trauma severely impacts a person's ability to maintain positive mental health and their ability to recovery from a psychiatric illness. Given the importance of addressing trauma, the Division has partnered with UND-Neuropsychiatric Research Institute (NRI) and is part

of their Treatment Collaborative for Traumatized Youth (TCTY) project. Each regional human service center plus additional private providers across the state have staff specially trained in evidence-based treatments to traumatized youth. In the first NRI TCTY report regarding DHS clients, 67 children completed the program and had a wide array of trauma experiences (physical neglect, sexual abuse, physical abuse, and domestic violence). Most children experienced multiple traumatic events with an average of six per child but over 10% of the children reported 10 or more traumatic incidents or types of trauma. Improvement in the children's psychological functioning was reported as outcomes in this initial report.

DD/MI – Individuals with both a developmental disability and a mental illness continue to challenge the system, especially adolescents and those in transition to adult services. Either the youth are too low functioning for the mental health system or too high functioning for the developmental disabilities system. The Department is currently studying options for integrating treatment services.

Community Readiness Survey – In the spring of 2008, the Division contracted with the Rural Crime and Justice Center at Minot State University to gauge the perceptions of alcohol and other drug use of North Dakota citizens. The survey results will be used by the Department's prevention coordinators, Division, and other agencies to target prevention strategies based on the

level of readiness of communities to address their underage drinking problem. 45.3 percent of community members perceived alcohol use by youth as a minor-moderate problem and 49.9 percent of community members believed that alcohol/drugs were only minor or moderate contributing factors in crashes or injuries. This illustrates the state's challenge that despite data showing persons aged 12 – 20 are ranked number two nationally in alcohol use in the past month (OAS, 2007) and from 1998 to 2006, a total of 971 persons died in 827 crashes, and 437 or 45 percent of these deaths were a result of alcohol-related crashes (NDDOT, 2007), there is a misperception of alcohol's impact.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase/ Decrease
Salary and Wages	2,305,342	2,586,907	281,565
Operating	5,988,903	8,620,910	2,632,007
Grants	4,256,644	1,599,006	(2,657,638)
Total	12,550,889	12,806,823	255,934
General Funds	5,700,420	5,950,416	249,996
Federal Funds	6,345,413	6,441,815	96,402
Other Funds	505,056	414,592	(90,464)
Total	12,550,889	12,806,823	255,934
FTE	19.00	19.00	0.00

The Salary and Wages line item increased by $281,565 and can be attributed to the following:

- $226,691 in total funds, of which $164,047 is general fund, for the Governor's salary package for state employees.
- The cost to continue the 4% salary increase for the last year of the 07-09 biennium is $37,474 of which $35,634 is general fund.
- The remaining $17,400, of which 1,812 is general fund, is a combination of increases and decreases needed to sustain the salary of the 19 FTE in this area of the budget.

The Operating line item shows a net increase of $2,632,007 for a variety of reasons:

- Increase in travel of $131,884 and the majority is reflected by an increase in substance abuse and mental health program licensing work, 29,705, increased traveling in the prevention programming, 45,208, travel for the Decision Support Services unit, 32,844, and State epidemiology outcome workgroup travel, 17,997.
- Increase in supply/material- professional of $8,204, all federal funds reflects work planned for the enforcing underage drinking laws grant.
- Increase of $20,040 in building rent due to a shift in cost allocation and an increase in rent.
- Increase of $4,794,599 in operating fees and services, this reflects $80,000 for the Governor's Prevention Advisory Council support, $300,000 general fund for an increase in

the Compulsive Gambling treatment program, $1,653,764 in federal dollars, moves the prevention coordinators contracts from grant line to operating fees and services, $82,990 for the Traumatic Brain Injury Grant, all federal, $220,922 in federal funds moves efforts with Enforcing Underage Drinking from grants to operating fees and services, $145,810 reflects the 7% inflationary increase in each year of the biennium for the Methamphetamine treatment program, $146,191 for mental health evidence-based treatment training, and $225,500 federal funds for the State Epidemiology Outcome Workgroup.

- Decrease of (12,245) for postage in the Prevention Resource Center
- Decrease of (37,807) in professional development
- Decrease of (17,500) in printing in PRC represents the Division spending plan and is 100% federal.
- Decrease of (911,507) for the sex offender treatment program reflecting projected numbers of offenders to be referred by the Department of Corrections and Rehabilitation and the State Hospital.

Grants resulted in a net decrease of (2,657,638) of which ($2,808,594) is federal funds and ($150,956) is general funds.

- Decrease of (807,174) of which ($260,834) reflects a decrease in federal funds and the remaining $546,340 is shifted to the operating fees and services line for the Safe and Drug Free Schools and Community Funds

- Increase of $200,000 for grants awarded from the Governor's Prevention Advisory Council.

This concludes my testimony on the 2009 – 2011 budget request for the Division of Mental Health & Substance Abuse. I would be happy to answer any questions.

Division of Mental Health & Substance Abuse

Detail Testimony

January 21, 2009

The Salary and Wages line item increased by $281,565 and can be attributed to the following:

- $**226,691** in total funds, of which $164,047 is general fund, for the Governor's salary package for state employees.
- The cost to continue the 4% salary increase for the last year of the 07-09 biennium is $**37,474** of which $35,634 is general fund.
- The remaining $**17,400**, of which $1,812 is general fund, is a combination of increases and decreases needed to sustain the salary of the 19 FTE in this area of the budget.

The Operating line item shows a net increase of $2,632,007 for a variety of reasons:

- Increase in travel of $**131,884**, of which $52,591 is general funds. The increases are as follows:
  - $29,705 increase in substance abuse and mental health program licensing, of which $21,609 are general funds;
  - $45,208 increase in the prevention programming, which is all federal funds;
  - $32,844 increase for the Decision Support Services unit, of which $29,206 are general funds;
  - $17,997 increase for the State epidemiology outcome workgroup, which is all federal funds
  - $6,130 increase for the sexual offender treatment program, the traumatic brain injury program and the compulsive gambling program, of which $1,776 are general funds.

- Increase in supply/material- professional of $**8,204**, all federal funds reflects work planned for the enforcing underage drinking laws grant.
- Increase in rent of $**20,040**, of which $19,614 is general funds. Increase in rent is due to staff that were relocated to Prairie Hills Plaza during the 2007-2009 biennium and a rate increase in rent.
- Increase of $**2,534,847** in operating fees and services and other fees, of which ($241,853) is a decrease in general funds. Increases and decreases are as follows:
    - $80,000 increase for Governor's Prevention Advisory Council support, which is all general funds;
    - $300,000 increase for the Compulsive Gambling treatment program, which is all general funds;
    - $1,634,410 increase due to transfer of the prevention coordinators contracts from the grants line to the operating line, which is all federal funds;
    - $546,340 increase due to transfer of the Safe and Drug Free Schools and Community programs from the grants line to the operating line, which is all federal funds;
    - $82,990 increase for the Traumatic Brain Injury grant, which is all federal;
    - $220,922 increase due to transfer of the Enforcing Underage Drinking Laws grant from the grants line to the operating line, which is all federal funds;
    - $145,810 increase reflects the 7% inflationary increase in each year of the biennium for the Methamphetamine treatment program, which is all general funds;
    - $146,191 increase for mental health evidence-based treatment training, of which $86,746 is general funds;

- $225,500 increase for the State Epidemiology Outcome Workgroup, which is all federal funds;
- $40,098 increase for training contract for Substance Abuse programs, which is all general funds;
- $24,093 increase in other programs, which is all federal funds;
- ($911,507) decrease for the sex offender treatment program, reflecting projected numbers of offenders to be referred by the Department of Corrections and Rehabilitation and the State Hospital, of which ($894,507) is general funds.

- Decrease of ($12,245) for postage in the Prevention Resource Center, which is all federal funds.
- Decrease of ($37,807) in professional development, of which $5,800 is general funds.
- Decrease of ($12,916) in other operating costs, of which $61,395 is an increase in general funds due to a funding source change.

Grants resulted in a net decrease of ($**2,657,638**) of which ($2,808,594) is federal funds and $150,956 is general funds.

- ($807,174) decrease, of which ($260,834) reflects a decrease in federal funds and the remaining ($546,340) is shifted to the operating fees and services line for the Safe and Drug Free Schools and Community Funds.
- ($272,000) decrease due to transfer of Enforcing Underage Drinking Laws program grant from the grants line to the operating line, which is all federal funds.
- ($125,000) decrease due to transfer of Mental Health contracts from the grants line to the operating line, of which ($32,291) are general funds.

- ($1,634,410) decrease due to transfer of prevention coordinators contracts from the grants line to the operation line, which is all federal funds.
- ($19,354) decrease due to transfer of prevention funds from the grants line to the operating line for travel and supplies, of which ($17,000) are general funds.
- $200,000 increase for grants awarded from the Governor's Prevention Advisory Council.
- $300 increase for miscellaneous grants, of which $247 are general funds.

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code		Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-47 MENTAL HEALTH AND SUBSTANCE ABUSE									
		S101 FULL-TIME EQUIVALENTS (FTEs)		17.000	19.000	0.000	0.000	0.000	19.000
32510	B	511000 Salaries - Permanent		1,346,699	1,708,543	795,286	54,113	1	1,762,657
32510	B	513000 Temporary Salaries		28,909	23,720	14,176	(2,528)	0	21,192
32510	B	516000 Fringe Benefits		414,666	573,079	258,410	3,289	69,562	645,930
32510	B	599110 Salary Increase		0	0	0	0	134,401	134,401
32510	B	599160 Benefit Increase		0	0	0	0	22,727	22,727
			Subtotal:	1,790,274	2,305,342	1,067,872	54,874	226,691	2,586,907
32510	F	F_1991 Salary - General Fund		395,120	832,672	366,093	37,446	164,047	1,034,165
32510	F	F_1992 Salary - Federal Funds		1,338,638	1,384,435	684,519	95,985	62,452	1,542,872
32510	F	F_1993 Salary - Other Funds		56,516	88,235	17,260	(78,557)	192	9,870
			Subtotal:	1,790,274	2,305,342	1,067,872	54,874	226,691	2,586,907
32530	B	521000 Travel		103,005	98,395	80,187	131,884	0	230,279
32530	B	531000 Supplies - IT Software		2,189	3,300	867	(3,300)	0	0
32530	B	532000 Supply/Material-Professional		167,787	176,166	93,135	8,204	0	184,370
32530	B	534000 Bldg, Grounds, Vehicle Supply		25	0	0	0	0	0
32530	B	535000 Miscellaneous Supplies		3,174	3,100	569	5,419	0	8,519
32530	B	536000 Office Supplies		6,019	5,500	2,826	(1,800)	0	3,700
32530	B	541000 Postage		5,449	16,245	557	(12,245)	0	4,000
32530	B	542000 Printing		2,703	22,800	22,790	(6,200)	0	16,600
32530	B	551000 IT Equip under $5,000		112	1,000	810	(1,000)	0	0
32530	B	553000 Office Equip & Furniture-Under		914	4,155	4,131	(1,705)	0	2,450
32530	B	561000 Utilities		75	0	0	0	0	0
32530	B	582000 Rentals/Leases - Bldg/Land		156,853	147,781	88,629	20,040	0	167,821
32530	B	591000 Repairs		1,976	950	0	(880)	0	70
32530	B	601000 IT - Data Processing		1,721	1,800	1,333	(1,800)	0	0
32530	B	602000 IT-Communications		1,407	2,450	701	(1,450)	0	1,000
32530	B	603000 IT Contractual Services and Re		2,026	200	160	(200)	0	0
32530	B	611000 Professional Development		149,956	140,015	74,564	(37,807)	0	102,208
32530	B	621000 Operating Fees and Services		1,655,905	2,659,484	2,658,746	5,240,409	0	7,899,893

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code		Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-47 MENTAL HEALTH AND SUBSTANCE ABUSE									
32530	B	632000	Other Expenses	0	2,705,562	0	(2,705,562)	0	0
32530	B	683000	Other Capital Payments	381	0	0	0	0	0
32530	B	712000	Grants, Benefits & Claims	39,905	0	0	0	0	0
32530	B	722000	Transfers Out	27,174	0	0	0	0	0
			Subtotal:	2,328,756	5,988,903	3,030,005	2,632,007	0	8,620,910
32530	F	F_3991	Operating - General Fund	769,612	4,132,394	1,190,988	(102,453)	0	4,029,941
32530	F	F_3992	Operating - Federal Funds	1,448,482	1,773,688	1,773,328	2,746,559	0	4,520,247
32530	F	F_3993	Operating - Other Funds	110,662	82,821	65,689	(12,099)	0	70,722
			Subtotal:	2,328,756	5,988,903	3,030,005	2,632,007	0	8,620,910
32560	B	621000	Operating Fees and Services	35,371	0	0	0	0	0
32560	B	712000	Grants, Benefits & Claims	3,847,786	4,256,644	747,280	(2,657,638)	0	1,599,006
32560	B	722000	Transfers Out	145,967	0	0	0	0	0
			Subtotal:	4,029,124	4,256,644	747,280	(2,657,638)	0	1,599,006
32560	F	F_6991	Grants - General Fund	731,455	735,354	380,982	150,956	0	886,310
32560	F	F_6992	Grants - Federal Funds	2,997,931	3,187,290	218,910	(2,808,594)	0	378,696
32560	F	F_6993	Grants - Other Funds	299,738	334,000	147,388	0	0	334,000
			Subtotal:	4,029,124	4,256,644	747,280	(2,657,638)	0	1,599,006
			Subdivision Budget Total:	8,148,154	12,550,889	4,845,157	29,243	226,691	12,806,823
			General Funds:	1,896,187	5,700,420	1,938,063	85,949	164,047	5,950,416
			Federal Funds:	5,785,051	6,345,413	2,676,757	33,950	62,452	6,441,815
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE			**Other Funds:**	466,916	505,056	230,337	(90,656)	192	414,592
			SWAP Funds:	0	0	0	0	0	0
			County Funds:	0	0	0	0	0	0
			IGT Funds:	0	0	0	0	0	0
			Subdivision Funding Total:	8,148,154	12,550,889	4,845,157	29,243	226,691	12,806,823

Mental Health and Substance Abuse

Detail of Budget Account Code 621000 - Operating Fees & Services

Operating Fees & Services	Amount	General	Federal/Other
Sex offender advocate contracts	400,075	400,075	0
Sex offender treatment contract	1,462,980	1,462,980	0
Gambling awareness campaign	60,000	0	60,000
Gambling treatment	300,000	300,000	0
MATRIX, ASAM & other AOD training	62,000	10,473	51,527
Recovery support contract	109,958	0	109,958
Contingency management	20,000	0	20,000
SYNAR contracts	30,000	0	30,000
Prevention coordinators (regional and tribal)	1,634,410	0	1,634,410
Support of Governor's Council on Prevention	80,000	80,000	0
AOD Summit	170,200	44,250	125,950
Share House meth treatment contract	1,502,810	1,502,810	0
Community Prevention contracts	496,340	0	496,340
Evidence based program development	15,000	0	15,000
Enforcing Underage Drinking laws contracts	550,000	0	550,000
Roughrider Conference	116,242	0	116,242
SEOW contracts	225,500	0	225,500
MH training contracts	179,542	15,532	164,010
Licensing visits	100,000	25,598	74,402
Clinical Forum conference	90,000	15,195	74,805
Supported Employment	15,000	2,532	12,468
Mental Health Recovery	25,000	4,221	20,779
IDDT	25,000	4,221	20,779
MH Consumer and Family Network contract	60,000	10,130	49,870
Underwriting conferences	5,000	1,636	3,364
AOD Peer support	50,000	16,365	33,635
Freight	29,000	0	29,000
TBI Contracts	82,990	0	82,990
Miscellaneous fees and services	2,846	783	2,063
Total Operating Fees & Services Budget Account Code	7,899,893	3,896,801	4,003,092

Mental Health and Substance Abuse

Detail of Budget Account Code 582000 - Rentals/Leases

Rentals & Leases	Amount	General	Federal/Other
Staff located at Prairie Hills Plaza - $14.05 per sq foot	153,421	42,532	110,889
Rent of CD halfway house in Minot - flat monthly rate of $1,200 (funded for only the first year of the biennium)	14,400	0	14,400
Total Rentals & Leases Budget Account Code	167,821	42,532	125,289

Department of Human Services
HB1012
Travel Increase - Mental Health and Substance Abuse

Department Wide Travel Rates used in Budget Preparation

Budgeted Travel Rates				
In-State Travel	07-09 Biennium	09-11 Biennium	Difference	% Difference
Meals	25	25	0	
IRS Meals Taxable	10	10	0	
Lodging (Includes Taxes)	55	61	6	9.84%
Mileage (Non-State Employee or Personal Vehicle)	0.375	0.45	0.075	16.67%
Motor Pool Mileage	0.37	0.40	0.03	7.50%
Out of State Travel				
Meals	64	64	0	
Lodging (Includes Taxes)	140	140	0	
Mileage	0.375	0.45	0.075	16.67%
Airfare	600	800	200	25.00%
Other Transportation (Taxi, parking, etc.)	60	60	0	

	07-09		09-11		Breakdown of Rate Increases			Rate	Utilization	Total
	Trips	Budget	Trips	Budget	Lodging	Mileage	Airfare	Increase	Increase*	
Total Non-Employee Trips	36	$ 6,752	417	$ 63,687	$ 144	$ 630		$ 774	$ 56,161	$ 56,935
Total In-State Trips	383	$ 31,411	525	$ 59,583	$ 1,122			$ 1,122	$ 27,050	$ 28,172
Total Out-of-State Trips	46	$ 60,232	71	$ 107,009			$ 9,200	$ 9,200	$ 37,577	$ 46,777
Total		$ 98,395		$ 230,279	$ 1,122	$ 630	$ 9,200	$ 11,096	$ 120,788	$ 131,884

*Explanation of usage increases:

Non-Employee Trips increased due to new or addtional meetings with consumers for their input into programs or for consumer training opportunities. New and existing groups and committees have quarterly and/or annual meetings across the state. These new and existing committees/groups include: Youth Advisory Council, Gambling Advisory Council, State Epidemiological Outcomes Workgroup (SEOW), Peer Support groups, Mental Health Planning Council and TBI Implementation. Also, private professionals and consumers have been added to the teams that do the department's licensing.

In-State Trips increased due to research team trips for training and data research and increased trips by the state Prevention Coordinator due to changes in the oversight of the prevention program. Increase in licensing trips due to more programs to license, more required revisits and more complaints received.

Out-of-State Trips increased due to research team trips for conferences and training to help meet various federal reporting requirements. There are additional conferences tied to the Peer Support program, TBI Implementation and the SEOW group. Increased trips include required trips for Block Grant reviews, SEOW and TBI meetings and other SAMHSA required meetings.

Appendix D: Click here to view full document.

Executive Summary

Use of alcohol, tobacco, and illicit drugs exacts a heavy toll on the lives and families of North Dakotans and the economy of the state. North Dakota's culture lends itself to the use and abuse of substances, namely alcohol, cigarettes, and smokeless tobacco. Compared to the nation and other U.S. states, alcohol use and abuse is the biggest substance-related problem that faces the state (NSDUH, 2004; BRFSS, 2005). North Dakota has among the highest rates in the nation in recent alcohol use and binge drinking, regardless of age group. For example, among North Dakotans aged 12 to 20 years, 42.7 percent consumed alcohol in the past 30 days and 32.3 percent engaged in binge alcohol use in the past 30 days (NSDUH, 2004). Both of these figures are the highest across all 50 states. North Dakota ranks near the bottom among U.S. states regarding the percentage of persons who perceive great harm associated with drinking five or more drinks at a time on two or more occasions in the past month (NSDUH, 2004). This finding assists in understanding why binge drinking rates are so high in North Dakota: many perceive little or no physical, mental, or societal harm associated with this behavior.

There is evidence that alcohol use and abuse is generational in North Dakota. Children and young adults are following the example of the state's adults who use and abuse alcohol at the highest rate in the country. North Dakota children and young adults who are not of legal drinking age are also rated number one in the nation for recent alcohol use and binging (NSDUH, 2004). Further, North Dakota students grades 9-12 are substantially more likely than their U.S. counterparts to have recently driven a vehicle after consuming alcohol (BRFSS, 2005). Among DUI arrests in the state, persons aged 21-24 are the most frequent offenders and their arrest rate has substantially increased in recent years (ND Office of the Attorney General, 2006).

North Dakota adults and children smoke cigarettes at rates that are comparable to the U.S. American Indians, who smoke cigarettes at twice the rate of whites (48.4 percent vs. 20.7 percent) in the state (BRFSS, 1996-2005). Use of smokeless tobacco in North Dakota appears somewhat higher than the U.S. American Indians, who are more likely than whites to be current users of this form of tobacco (BRFSS, 1996-2005).

Among illicit drugs, methamphetamines are a growing problem, both in use and manufacturing. In 2004, there were 217 meth lab seizures in the state, which placed North Dakota in the top 20 percent of all states for meth lab offenses per capita (DEA, 2004). In addition, treatment admissions for meth use are on the upswing, similar to what is happening across the entire country. At present, marijuana is still the leading illicit drug used by persons entering treatment in North Dakota (TEDS, 2005). Marijuana and meth are the top two drugs among North Dakota's drug-related arrests, with meth use increasing at higher rates in recent years (ND Office of the Attorney General, 2006).

Appendix E: Click here to view full document.

Executive Summary

The following is a summary of the key findings from the study. All population densities (Urban, Rural, and Frontier) are combined in this section to represent statewide perceptions and opinions, whereas the ***Community Member*** respondents and ***Key Informant*** respondents are identified separately. The acknowledged points of interest might be important to consider for further interpretations.

Adult Use of Alcohol [see Table 2.1.1]

- When the ***Community Members*** were asked to rank the seriousness of adult use of alcohol, 65.2 percent indicated this to be a minor-moderate problem in their community, 23.2 percent felt this was a serious problem, and 5.4 percent indicated this was not a problem in the community.

- Similarly, 58 percent of the ***Key Informants*** felt this was a minor-moderate problem in their community, 39.8 percent responded this was a serious problem, and only .5 percent indicated this was not a problem in the community.

Youth Use of Alcohol [see Table 2.1.1]

- Alcohol use by youth was considered to be more of a problem within the selected communities, while 45.3 percent of the ***Community Members*** perceived this as a minor-moderate problem and 41.3 percent felt this was a serious problem within their community.

- The majority of the ***Key Informants*** (62.2%) felt that alcohol use by youth was a serious problem, whereas 35.4 percent indicated this to be a minor-moderate problem.

Adult Use of Methamphetamine [see Table 2.1.6]

- Regarding the use of methamphetamine by adults, 32.9 percent of the ***Community Members*** reported this to be a minor-moderate problem, 24.4 percent felt this was a serious problem, and 31.1 percent indicated that they do not know the extent of the problem.

- According to the ***Key Informants***, 46.5 percent believed that methamphetamine use by adults was a minor-moderate problem, 42.8 percent indicated this to be a serious problem and only 7.6 percent reported that they do not know the extent of the problem.

Youth Use of Methamphetamine [see Table 2.1.6]

- In reference to the use of methamphetamine by youth, 33 percent of the ***Community Members*** believed that this was a minor-moderate problem, 22.8 percent reported this to be a serious problem, and 32.5 percent did not know the extent of the problem within their community.

- Of the ***Key Informants***, 50.3 percent believed that methamphetamine use by youth was a minor-moderate problem, 28.5 percent indicated this was a serious problem, and 13.8 percent did not know the extent of the problem within their community.

Contribution of Drug and Alcohol Use to Crashes or Injuries [see Table 2.2.1]

- When respondents were asked to indicate their beliefs regarding the contribution of drugs/alcohol to injuries, 49.9 percent of the ***Community Members*** believed that this was a minor-moderate problem, while 34.7 percent felt this was a serious problem within their community.

- Approximately 38 percent of the ***Key Informants*** indicated this to be a minor-moderate problem, while the majority (58.3%) considered this to be a serious problem.

Community Acceptance of Underage Drinking [see Table 3.1]

- In terms of community acceptance of underage drinking, 68.4 percent of the ***Community Members*** disagreed-strongly disagreed that this behavior was accepted within the community, while 30.7 percent of respondents agreed-strongly agreed that underage drinking is tolerated.

- Perceptions from the ***Key Informants*** indicated more of a split decision, in that 51.8 percent disagreed-strongly disagreed, and 47.9 percent agreed-strongly agreed that this behavior is accepted within the community.

Support for Increasing Taxes on Alcohol [see Table 4.1]

- When respondents were asked to indicate the extent to which they either agree or disagree with increasing alcohol taxes, 41.8 percent of the ***Community Members*** disagreed-strongly disagreed, while 57.1 percent agreed-strongly agreed in support of increasing alcohol taxes.

- Results of the ***Key Informants*** also produced differing opinions, in that 35.4 percent disagreed-strongly disagreed, and 63.6 percent agreed-strongly agreed.

Laws Prohibiting Giving Alcohol to Your Own Children [see Table 4.2]

- There was a disparity in beliefs regarding support for laws in terms of providing alcohol to "your own" children. Nearly 67 percent of the ***Community Members*** supported this law and 31.8 percent were not in favor of this type of law.

- Results from the ***Key Informants*** indicated less of a difference in opinions, in which 75 percent responded "Yes" they would be in support of this law and 23.8 percent reported that "No" they would not be in favor of this law.

Support for Advertising Liquor/Beer/Wine Ads on Television/Billboards [see Table 4.3]

- For this series of three questions, the results were very similar. Over 60 percent of the ***Community Members*** were in support of banning alcohol advertisements on either television or billboards and over 30 percent were not in support of banning this type of advertising.

- Outcomes for the ***Key Informants*** were comparable to the Community Members, in that over 67 percent of respondents supported banning this form of advertisement while more than 29 percent of respondents did not support banning the ads.

Youth Accessibility to Alcohol [see Table 5.1]

- When the ***Community Members*** were asked "how difficult is it for youth to get an older person to buy alcohol for them," 48.7 percent believed that it is slightly/somewhat difficult, 40.1 percent indicated it was not at all difficult, and only 7.6 percent believed this be quite/extremely difficult.

- In reference to the question above, 50.6 percent of the ***Key Informants*** felt this was not at all difficult, 44.9 percent responded as slightly/somewhat difficult and only 2.9 percent believed this to be quite/extremely difficult.

- When the ***Community Members*** were asked "how difficult is it for youth to sneak alcohol from their home or a friend's home," 51.7 percent reported that this was not at all difficult and 39.7 percent perceived this to be slightly/somewhat difficult.

- Regarding the question above, 68.8 percent of the ***Key Informants*** specified that this was not at all difficult and 29.3 percent thought this was slightly/somewhat difficult.

Adult/Youth Access to Marijuana/Methamphetamine [see Table 5.2]

- The ***Community Member*** respondents perceived access to **marijuana** as; 33.3 percent responded this was not at all difficult for adults/youth to obtain in their community, 45.3 percent felt access was slightly/somewhat difficult, and only 12 percent perceived this to be quite/extremely difficult.

- Among the ***Key Informants***, almost half (49.9%) perceived **marijuana** was not at all difficult for adults/youth to access, while 43.7 percent felt accessing marijuana was slightly/somewhat difficult.

- The ***Community Member*** respondents perceived access to **methamphetamine** as; 24.1 percent indicated that methamphetamine was not at all difficult to access, 48.7 percent believed that access was slightly/somewhat difficult, and 16.4 percent specified that methamphetamine was quite/extremely difficult to access.

- Among the ***Key Informants***, 30.5 percent believed that **methamphetamine** was not at all difficult to access, over half (58.3%) believed that access was slightly/somewhat difficult and only 8.1 percent responded that methamphetamine was quite/extremely difficult to access.

Presence of Community Action Plan [see Table 6.2]

- For the ***Community Members***, 22.1 percent responded that "Yes" they do have a community action plan in place, 15.4 percent specified that "No" there was not a plan in place, and 60.1 percent of respondents "Did Not Know" if their community had any action plan in place.

- For the ***Key Informants***, 35.9% answered that "Yes" their community does have an action plan to deal with alcohol/substance abuse issues, 19.4% indicated that "No" the community has no plan in place, and 43.3% "Did Not Know" whether there was an action plan in their community.

Sources of Information Regarding Crime [see Table 6.3]

- The leading source of information about crime for the ***Community Members*** was "Television" (38%). "Newspapers" was the second most common (25.8%) and the least common among the three was "Other" (such as internet) (19.9%). Eight percent of the population sampled in this group did not answer this question.

- Outcomes for the ***Key Informants*** were similar to those of the Community Members as follows: "Television" (43.3%), "Newspapers" (28%), and "Other" (such as internet) (16.7%). Of the population sampled in this group, 5.9 percent did not answer this question.

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
March 4, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, I am JoAnne Hoesel, a Division Director, for the Department of Human Services. I am here today to provide you with an overview of the Mental Health & Substance Abuse area.

Programs

The Division of Mental Health & Substance Abuse provides education, regulation, technical assistance, training for public and private service providers, federal and state reporting and department-wide data analysis and research support.

Service programs directly managed by the Division are compulsive gambling treatment, community-based high-risk sex offender treatment, regional prevention coordination, and long-term methamphetamine residential treatment.

Customer Base

During SFY 2008 the public mental health system provided services to 17,388 children, youth, and adults and the public substance abuse system provided services to 6,290 adolescents and adults. The Division licenses 84 substance abuse treatment programs, 38 DUI seminar providers, eight regional human service centers, and six psychiatric residential treatment facilities for children and adolescents. The Prevention Resource Center is a lending and resource library located in the Division that distributes educational products covering developmental

disabilities, mental health, and substance abuse. The Division also provides private and public system workforce training.

Program Trends / Major Program Changes

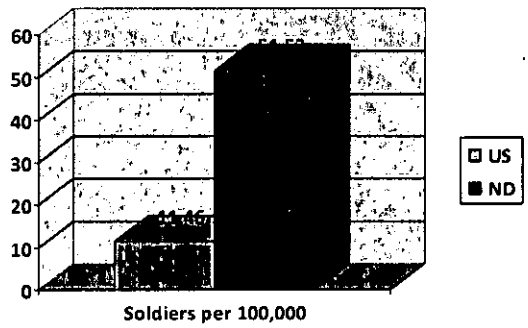
Recovery Model – Mental health – The public mental health system continues its transition to a recovery approach which shifts emphasis from 'symptom control' to that of prevention and recovery. Person-centered treatment planning, recovery model training, training of peers support workers, and integrated dual disorder treatment are a few techniques implemented. The **Recovery Model's** goal is that individuals with mental illness have greater control and choice in their treatment, leading to increased personal responsibility and better outcomes in school, home, work, and community.

The public substance abuse system offers a full array of services from outpatient to residential. Included in the offerings is the use of the **MATRIX** model. This is a method effective with those who have brain damage from meth or other drug use. Those with meth dependence can benefit from treatment and in ND do everyday. Two human service centers have achieved national certification in this MATRIX model through the UCLA -University of California – Los Angeles. This certification means their MATRIX program meets the standards to be listed as an official MATRIX program. The remaining human service centers are in the process of review for certification.

The Division contracts with a private agency to provide a **telephone recovery program**. Transportation can make a difference between sobriety and continued drug use. Isolation often leads to relapses. This telephone recovery program provides telephone support to those

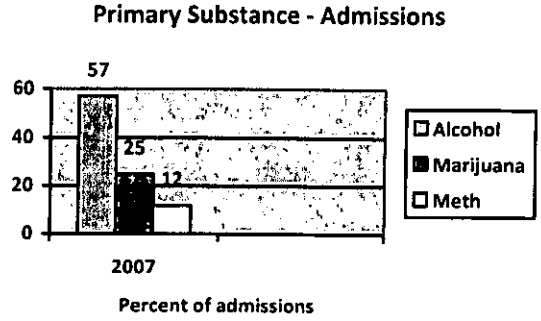
who do not have access to support groups or other community supports.

Returning Veterans – North Dakota has the highest number of Army National Guard soldiers per 100,000. The national average is 11.46; North Dakota's rate is 51.52.

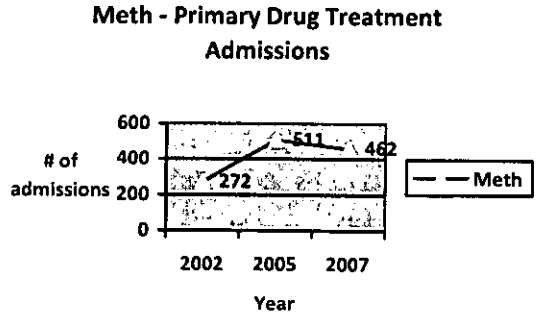


Veterans are returning from the Iraq and Afghanistan wars with **traumatic head injury (TBI)**. This is the 'signature' injury sustained. North Dakota has had over 400 returning veterans' with positive first level TBI screens. The Division participates in the Inter-Service Family Assistance Committee (ISFAC), a collaborative effort with community agencies to address quality of life issues for returning soldiers and their families. The Division's TBI grant provides training to regional human service center staff. Staff learn how to screen for this disorder as TBI is often unknown or not disclosed. TBI can affect the effectiveness of treatment unless treatment methods are adjusted. The National Guard provided training at the Division's annual mental health conference and a TBI advisory committee is in place with representation from the Veterans Administration (VA). The regional human service centers are reporting an increase in veterans seeking services.

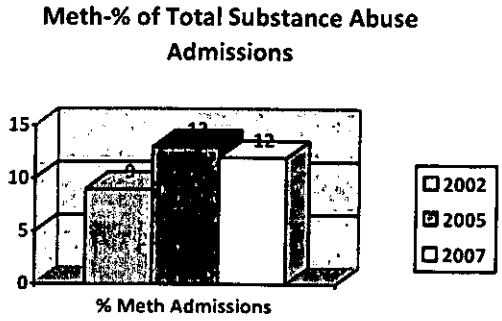
In the public substance abuse system in calendar year 2007, alcohol was the **primary substance** with 57% of admissions (2,252), marijuana was 25% of admissions (1,001), and methamphetamine was 12% of admissions (462) to treatment.



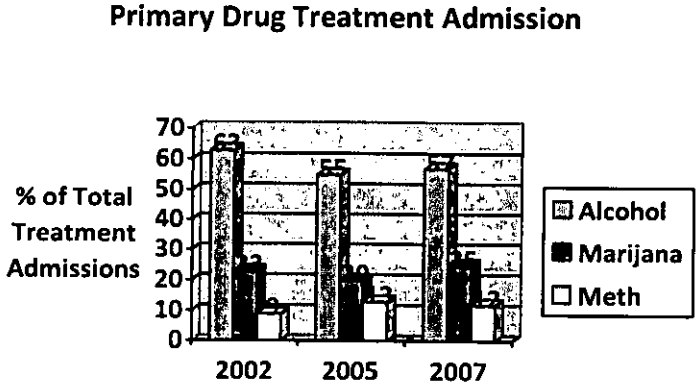
Treatment admissions for those with primary methamphetamine dependence equaled 272 in 2002, 511 in 2005, and 462 in 2007. From 2005 to 2007 there was a decrease of 9.5% in the number of admissions for methamphetamine dependence.



As a percent of total substance abuse admissions, methamphetamine admission trend was 9% in 2002; 13% in 2005; and 12% in 2007.



At the same time, alcohol and marijuana trends as percents of total substance abuse admissions are as follows: Alcohol from 63% in 2002; 55% in 2005; 57% in 2007, and marijuana was 23% in 2002; 20% in 2005, and 25% in 2007. Abuse of prescription drugs appears to now be the current upward substance abuse trend.



Trauma – Trauma comes in many forms (physical neglect, sexual abuse, physical abuse, and domestic violence) and if unresolved can severely impact a person's ability to recover from a psychiatric illness or a substance abuse disorder. The Division is working with UND-Neuropsychiatric Research Institute (NRI) and is part of the Treatment Collaborative for Traumatized Youth (TCTY) project. Each regional human service center plus private providers have specially trained

staff in treatments proven effective for traumatized youth. In the first project outcome report on DHS clients, the majority of children experienced multiple traumatic events with an average of six (6) events per child. But 10% of the group of these North Dakota children experienced ten (10) or more traumatic incidents or types of trauma. The outcome for the first year showed improvements for the children and their psychological functioning. This means they did better in school, home, and/or community places.

Prevention - The Division worked with the Rural Crime and Justice Center at Minot State University to learn how people in North Dakota, in every region, view alcohol and other drug use by youth. The result is a **community readiness survey** completed in the fall of 2008. This survey helps regional prevention coordinators, community leaders, concerned parents, and agencies choose the best prevention methods to match their area of the state. The community readiness survey showed that 45.3 percent of community members view alcohol use by youth as a minor-moderate problem and 49.9 percent of community members believed that alcohol/drugs were only minor or moderate contributing factors in crashes or injuries. In reality, individuals who are between the ages of 12 – 20 are ranked number two nationally in the number that used alcohol in the past month (OAS, 2007) and from 1998 to 2006, a total of 971 persons died in 827 crashes, and 437 or 45 percent of these deaths were a result of alcohol-related crashes (NDDOT, 2007). There is a misperception of alcohol's impact. This example of the survey results show how big of a challenge prevention work is for North Dakota.

The **Epidemiology Work Group** brings all agencies with data related to alcohol or other drug use together and with the help of UND and

NDSU puts North Dakota's data about alcohol use and its consequences into one place – the Epi Profile. The **Governor's Prevention Advisory Council**, formed by the 2007 Legislative session, used this information to target its appropriation toward six local programs. North Dakota's data shows youth using at younger ages. As a result the Council targeted the funded programs toward youth in first through fifth grades along with their parents. In its firt official year, this Council developed a road map for North Dakota prevention efforts, a prevention service gap analysis, plus a funding matrix of prevention programs across state agencies.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase/ Decrease	2009 - 2011 Budget	House Changes	To Senate
Salary and Wages	2,305,342	281,565	2,586,907	(24,181)	2,562,726
Operating	5,988,903	2,632,007	8,620,910	(232,794)	8,388,116
Grants	4,256,644	(2,657,638)	1,599,006	(200,000)	1,399,006
Total	12,550,889	255,934	12,806,823	(456,975)	12,349,848
General Funds	5,700,420	249,996	5,950,416	(395,019)	5,555,397
Federal Funds	6,345,413	96,402	6,441,815	(51,768)	6,390,047
Other Funds	505,056	(90,464)	414,592	(10,188)	404,404
Total	12,550,889	255,934	12,806,823	(456,975)	12,349,848
FTE	19.00	0.00	19.00	0.00	19.00

Budget Changes from Current Budget to Executive Budget:

The Salary and Wages line item increased by $281,565 and can be attributed to the following:

- $226,691 in total funds, of which $164,047 is general fund, for the Governor's salary package for state employees.
- The cost to continue the 4% salary increase for the last year of the 07-09 biennium is $37,474 of which $35,634 is general fund.

- The remaining $17,400, of which $1,812 is general fund, is a combination of increases and decreases needed to sustain the salary of the 19 FTE in this area of the budget.

The Operating line item shows a net increase of $2,632,007 for a variety of reasons:

- Increase in travel of $131,884, of which $52,591 is general funds. The increases are as follows:
    - $29,705 increase in substance abuse and mental health program licensing, of which $21,609 are general funds;
    - $45,208 increase in the prevention programming, which is all federal funds;
    - $32,844 increase for the Decision Support Services unit, of which $29,206 are general funds;
    - $17,997 increase for the State epidemiology outcome workgroup, which is all federal funds
    - $6,130 increase for the sexual offender treatment program, the traumatic brain injury program and the compulsive gambling program, of which $1,776 are general funds.
- Increase in supply/material- professional of $8,204, all federal funds reflects work planned for the enforcing underage drinking laws grant.
- Increase in rent of $20,040, of which $19,614 is general funds. Increase in rent is due to staff that were relocated to Prairie Hills Plaza during the 2007-2009 biennium and a rate increase in rent.

- Increase of $2,534,847 in operating fees and services and other fees, of which ($241,853) is a decrease in general funds. Increases and decreases are as follows:
  - $80,000 increase for Governor's Prevention Advisory Council support, which is all general funds;
  - $300,000 increase for the Compulsive Gambling treatment program, which is all general funds;
  - $1,634,410 increase due to transfer of the prevention coordinators contracts from the grants line to the operating line, which is all federal funds;
  - $546,340 increase due to transfer of the Safe and Drug Free Schools and Community programs from the grants line to the operating line, which is all federal funds;
  - $82,990 increase for the Traumatic Brain Injury grant, which is all federal;
  - $220,922 increase due to transfer of the Enforcing Underage Drinking Laws grant from the grants line to the operating line, which is all federal funds;
  - $145,810 increase reflects the 7% inflationary increase in each year of the biennium for the Methamphetamine treatment program, which is all general funds;
  - $146,191 increase for mental health evidence-based treatment training, of which $86,746 is general funds;
  - $225,500 increase for the State Epidemiology Outcome Workgroup, which is all federal funds;
  - $40,098 increase for training contract for Substance Abuse programs, which is all general funds;
  - $24,093 increase in other programs, which is all federal funds;

- ($911,507) decrease for the sex offender treatment program, reflecting projected numbers of offenders to be referred by the Department of Corrections and Rehabilitation and the State Hospital, of which ($894,507) is general funds.

- Decrease of ($12,245) for postage in the Prevention Resource Center, which is all federal funds.
- Decrease of ($37,807) in professional development, of which $5,800 is general funds.
- Decrease of ($12,916) in other operating costs, of which $61,395 is an increase in general funds due to a funding source change.

Grants resulted in a net decrease of ($2,657,638) of which ($2,808,594) is federal funds and $150,956 is general funds.

- ($807,174) decrease, of which ($260,834) reflects a decrease in federal funds and the remaining ($546,340) is shifted to the operating fees and services line for the Safe and Drug Free Schools and Community Funds.
- ($272,000) decrease due to transfer of Enforcing Underage Drinking Laws program grant from the grants line to the operating line, which is all federal funds.
- ($125,000) decrease due to transfer of Mental Health contracts from the grants line to the operating line, of which ($32,291) are general funds.
- ($1,634,410) decrease due to transfer of prevention coordinators contracts from the grants line to the operation line, which is all federal funds.

- ($19,354) decrease due to transfer of prevention funds from the grants line to the operating line for travel and supplies, of which ($17,000) are general funds.
- $200,000 increase for grants awarded from the Governor's Prevention Advisory Council.
- $300 increase for miscellaneous grants, of which $247 are general funds.

House Changes:

The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $7,940 - general fund and $16,241 - federal and other funds for at total of $24,181.

The House reduced 50% of the department-wide travel increase. Mental Health & Substance Abuse Divisions' share of this decrease is $61,557 total funds; $15,842 – general fund.

In Operating Fees and Services, the inflationary increase for the contract with ShareHouse-Robinson Recovery Center was reduced from the 7% & 7% increase to 6% & 6% resulting in a decrease of $21,237. $150,000 was reduced from the Compulsive Gambling Treatment Program. Both reductions are general fund decreases.

In the grants line, all funding for the Governor's Prevention Advisory Council was removed resulting in a general fund decrease of $200,000.

This concludes my testimony on the 2009 – 2011 budget request for Mental Health & Substance Abuse Division of the Department. I would be happy to answer any questions.

F

Department of Human Services

Public Testimony Presenter Information

Partial List – Tied to MH/SA and DD

Agency	DHS Funded?	Role
Mental Health America	No	Advocate
Protection & Advocacy	No	Advocate
North Dakota Association Of Community Facilities (NDACF)	No	Advocate for DD providers
North Dakota Advocacy Consortium	Yes – State Council on Developmental Disabilities	
Mental Health Infrastructure	No	Grant with Minot State
Dave Zentner	No	Lobbyist
Family Voices	No	advocate for children with disabilities
Healthy Families	Yes	provider of this program
Federation of Families	Yes	reimbursed for parent to parent service Other role is advocacy

H

House Human Services Committee

Support for the Peer Support Program OAR

Representative Pollert, Chairman

January 14, 2009

Chairman Pollert and members of the House Human Services Committee, thank you for inviting public comment. My name is Sara Highum from Minot. I am a Peer Support Specialist, as well as a lead for the Consumer and Family Network, and a past member of the Mental Health Planning Council. I wanted to take a few moments to tell you about our Program.

Currently I am working with one individual and leading twice weekly support group a the Harmony Center. The person I work with is seeing an improved quality of life. He is getting out of the house more. It has given me back my self-worth by showing me that I can still be a contributing member of soceity, even with my new limitations. The employment also allows me to participate in the local economy of Minot.

I can say that without this program, I would have been close to requiring hospitalization over the holiday season. I didn't though because people were depending on me and there were also people who would understand. I had a safe, supportive environment to go to. My therapist is leaving for two weeks and this time, she didn't think she needed to have me see anyone in her absence.

The gains I have seen in the people who come to the support is incredible. One member spoke that because of the peer support she was able to keep her sobriety and this was the first holiday in many years that she didn't require

hospitalization. She counts the peer support as a key component of her sobriety. Another gentleman is currently residing in the Transitional Living home and has been for many years. He would sit and not say much about goals and was quite content with his life. Now he participates, visiting with fellow members and has decided to begin the process of thinking about living independently.

Peer support also teaches us how to become active participants in our care and life planning, as opposed to a recipient. We talk about many needs to assist in our recovery, including how to cope with the side effects of the medication and how to talk to your doctor. This helps with keeping us on our medications when otherwise we might have stopped and ended up in the hospital because of a relapse. Relapse prevention or at least controlling the length of it is cost-effective to the community because sadly with relapses, the more we have, the longer it takes to recover. That includes the use of intensive services, both on an inpatient and outpatient basis. It creates a vicious cycle dragging us down deeper and deeper.

We build support systems both using public and private mental health services. More importantly though, we build it with each other. We support each other and some of us are able to return to employment. Even those that can't feel better about ourselves and are contributing back to soceity. We would appreciate any support you can offer us in this endeavor.

Thank you very much for your time and consideration.

House Human Services Committee

Support for the Peer Support Program OAR

Representative Pollert, Chairman

January 14, 2009

Chairman Pollert and members of the House Human Services Committee, I am Janice Ray, a member of Progress Community Center in Jamestown, and a group facilitator for our local Peer Support Program.

Five years ago I was living a secluded life not even liking to go out to get groceries. I was afraid of people and would avoid any situation where I would have to talk to others. Coming to the Community Center and participating in peer support has changed my life. My self-esteem has returned and I am now able to go where I want and have even gotten to the point where I can be an advocate for others. During peer support training, I was shown the tools so that I can be a leader and the skills to become a group facilitator. Peer support is about people helping other people who have been through similar trauma or challenges. My motto is: When you need someone to lay your head upon I will be there, everyone try to be there for each other.

House Human Services Committee

Support for the Peer Support Program OAR

Representative Pollert, Chairman

January 14, 2009

Chairman Pollert and members of the House Human Services Committee, I am David M. Oxtra from Jamestown. I grew up in a dysfunctional family, with an abusive alcoholic father. I hated him for this. As I grew into adulthood I turned out to be just like him for many years.

Since I became acquainted with the Human Service Center and Progress Community Center, I have turned my life around. These facilities should be praised for the programs they offer such as the peer support group free of charge. I am in recovery now and have had my downfalls, but thanks to these wonderful people who take care in what they do and are willing to listen, I can get back on my feet again.

House Human Services Committee

Support for the Peer Support Program OAR

Representative Pollert, Chairman

January 14, 2009

Chairman Pollert and members of the House Human Services Committee, I am Holly K. Nicholson, a member of Progress Community Center. I have been a member of the Peer Support Group in Jamestown since it began. I attended the Peer Support Specialist Training that they had in Minot. It is important that we get funding for Peer Support because it has helped me to be a more confident individual. I am more driven in purpose and it has helped me from having as many problems.

Peer Support has been a Godsend to me because it gives me a reason to be happy and fulfilled. I feel great about it because I can help others through Peer Support. Helping fellow human beings is very rewarding to me.

House Human Services Committee

Support of Peer Support Program OAR

Representative Pollert, Chairman

January 15, 2009

Chairman Pollert and members of the House Human Services Committee, my name is Jennifer Bartsch and I am the Director of the Harmony Center. The Harmony Center is a Psychosocial Center for adults 18 and older who have been diagnosed with a severe and persistent mental illness.

I am writing in support of the Peer Support Program OAR. Currently there is a Peer Support Program based out of the Harmony Center. I have seen first hand how the members who are involved with this program and attend the support group meetings seem to be more confident, self assured, and more involved with their treatment and their journey on the road to Recovery.

The Peer Support Program is a way for people with mental illnesses to be involved/employed in a program that helps them feel good about themselves by giving back and being supportive of others who are struggling with mental illness. People who feel good about themselves and have a support system in place are more likely to need less of other costlier services to maintain living in the community of their choice. Who better knows the roadblocks to Recovery than those who have gone before?

Thank you for your time and consideration

Testimony

House Human Services Committee

Support for the Peer Support Program OAR

Representative Pollert, Chairman

January 14, 2009

Chairman Pollert and members of the House Human Services Committee, I am interested in becoming a mentor, coach and role model. Peer support is helping me achieve these goals. I am learning that I have the tools to help other people with their lives. I have suffered so much in the past. I can help people who are living difficult lives similar to the difficult life I once lived. I do not want people to suffer. I can help people stop suffering just by being there to help and support a friend. Peer support is teaching me to be a friend to someone in need. Whether I can help one person or if I can help one hundred people, I can help someone if I can just have a chance to help. There are so many people out there simply wanting someone to listen to them and understand what they are going through. I have two ears and one mouth. I love to listen to people. I think about dedicating so much of my life to helping others. Peer support is teaching me how to help others. If I can help three people live better lives, those three people can also each help three people and before you know it, there could be a lot of people helping a lot of people. People need peer support because it is good for your health.

House Human Service Committee

Support for the Peer Support Program Oar

Representative Pollert, Chairman

January 15, 2009

Chairman Pollert and member of the House Human Services Committee, I am, Sean Hoaglund a lead for the Consumer & Family Network in Grand Forks. It's a consumer group that promotes recovery based upon the concept.

I support the Peer Support Program for two reasons the first is because it will bring new jobs to North Dakota that consumer can and will help out the economy of the state. Plus they will get the satisfaction that they are supporting North Dakota economy.

The other reason is that this is a program that will promote good working skills for the consumers that are higher functioning to help with the high traffic of consumers that needs help to reach their recovery goals.

Testimony

House Human Services Committee

Support for the Peer Support Program Oar

Representative Pollert, Chairman

January 14, 2009

Chairman Pollert and members of the House Human Services Committee, I am Charlotte Gregerson, Director of Mountainbrooke, Psychosocial Rehabilitation Center In Grand Forks. Our mission is: To promote mental health through education, advocacy, understanding and access to quality care for all individuals.

Mountainbrooke supports the peer support program. The Peer support program is a consumer driven program. The program promotes recovery and resiliency. Individuals learn how to manage their symptoms and deal with their mental illness. Through Peer Support consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

House Human Services Committee

Support for the Peer Support Program OAR

Representative Pollert, Chairman

January 14, 2009

Chairman Pollert and members of the House Human Services Committee, I am Allen R. Falk, Director, Progress Community Center the Psycho-social Rehabilitation Center in Jamestown.

We serve approximately 300 members with a daily attendance of 75 - 95 members. We have had an active peer support group in Jamestown for the past six months. There are approximately 20 individuals involved at this time, with everyone participating on a volunteer basis. The benefits of this program are noticeable to me with fewer hospital admittances. I have seen situations where hospitalization has been avoided completely because of having an improved ability to cope with a crisis due to the ability to talk to education peers about their illness and being able to discuss shared experiences. As their self confidence grows we have seen members take increased leadership roles. They are helping themselves and each other and achieving more than they had previously thought they could.

Testimony

House Human Services Committee

Support for the Peer Support Program Oar

Representative Pollert, Chairman

January 15, 2009

Chairman Pollert and members of the House Human Services Committee, I am Mary Otteson, Director's Assistant Mountainbrooke.

I support the Peer Support Program. With the Peer Support Program individuals are able to learn how to cope and manage their Mental Health in ways that they have never been able to do before. With people having the Peer Support Program they learn together how to share insight of their illness and begin to share openly with one another. They then become encouraged with one another, feeling safe not rejected. With building one another up they begin a sense of belonging.

House Human Services Committee

Support for the Peer Support Program OAR

Representative Pollert, Chairman

January 14, 2009

Chairman Pollert and members of the House Human Services Committee, I am Tammy J. Falk, Peer Support Coordinator for the Jamestown area. Peer support has been active in Jamestown for the past 6 months on a volunteer basis. In January 2009 we received funds through the Department of Human Services to run our program through June 2009.

In June 2008 four of our members and myself volunteered our time to go to Peer Support Specialist training. After training they have returned to Jamestown and began holding weekly peer support meetings with the desire to bring hope and encouragement to their fellow members. The change in both the volunteer specialists and the group members has been wonderful to see. Both have grown in the areas of self reliance, self confidence motivation to be more involved. They are looking beyond themselves and their illness and reaching out and help others who are struggling and encourage them to continue to strive for recovery and to keep pushing to achieve more. They are learning about the choices they have and that they need to be a part of the decision making in their recovery process. Everyone who comes to the meetings has an opportunity to share their experiences which empowers other group members.

House Human Services Committee

Support for the Peer Support Program OAR

Representative Pollert, Chairman

January 14, 2009

Chairman Pollert and members of the House Human Services Committee, my name is Mary Thomason and I am the Peer Support services coordinator for the Minot Area. When I was offered the job of Peer Specialist Coordinator, I was still grieving for the loss of our son. I had fallen into a deep depression and life was pretty unbearable. I took this position because I had some experience supervising a program similar to this one in that I worked with people who had mental health illnesses. Also I was hoping the job would get me out of the house and give me something worth while to do.

The longer I am involved with the Peer Specialists and the Peer Support groups, the better I feel. Instead of just existing, I've begun to feel life is worth living again. This job has given me much more then I ever hoped it would, but even better is what it's doing for others. The support groups have fostered a greater acceptance of each individuals worth and has given them a true sense of belonging. Several of the people have mentioned to me how much they look forward to meeting together each week and how helpful it is to their well-being.

I'm especially proud of Minot's three Peer Specialists and the work they are doing with the eight folks with whom they are matched. These three have their own mental health issues to deal with and yet they are always there for their

matches to serve as role models, provide social and recreational links to the community, but most importantly support their friends on the road to recovery.

I could go on and on about how wonderful and cost effective the Peer Specialist program is, but I know your time is valuable. I hope you feel this program is important enough to fund.

House Human Services Committee

Support for the Peer Support Program OAR

Representative Pollert, Chairman

January 14, 2009

Representative Pollert and members of the Human Services Committee, my name is Colleen Miller and I am a Peer Support Specialist from Minot. The Peer Support Program has been a blessing for me, by aiding me in my recovery process. Not only does it build more friendships, but it helps me to know others have similar experiences with mental illness to which I can relate. At times I have doubts about my abilities to perform the job, but my co-workers and supervisor reassure me and build my confidence to stick with it.

One of my matches takes responsibility to pay off child support for three children and pay off debt by working more hours, despite her dual diagnosis. Even though she has made part mistakes, she is making great progress. She is living with the consequences and striving to live a better future.

My other match has inspired me not to take things for granted. With her new love for life and spirituality, she is striving to build better relations with her once distant parents, and now lives life to the fullest by spending more quality time with friends and family, especially her daughter.

I am so proud of my third match – how she has blossomed with the peer support program. For years she had wanted to volunteer at a local thrift store, but has been limited in this because of her paranoia, She now has been more

enthusiastic in working there that she suggests it on a regular basis. We talk quite a bit while working; and this helps her open up, expressing herself, and has kept her paranoia away thus far. I'd like to see her not be afraid of "being overheard", as she has put it, when she speaks; but instead to be heard and recognized. She is growing more social and less timid, and is feeling more comfortable in her expression. Seeing this is most rewarding.

This program has been a godsend for all of us.

Testimony

House Human Service Committee

Support for the Peer Support Program Oar

Representative Pollert, Chairman

January 15, 2009

Chairman Pollert and members of the House Human Services Committee, my name is Marcus Jensen from Jamestown and I have a mental illness. I have chronic depression which is well controlled with medication. Because of the medication, I live and work in my community. In the last few months, I have been involved with a project called "Peer Support" which is peers helping peers.

Individuals who have a mental illness have a little different outlook on life and we need to talk to people who understand what we are experiencing. This is where Peer Support steps in. Many of us are still working and living the way we used to. Being able to sit down with peers in a safe environment and discuss our situations and life experiences is extremely helpful in being able to function day to day.

As stated before, my illness is quite well controlled however; there are times when I need to talk to someone who understands. Psychologists and psychiatrists are very helpful, in their place, but on a day to day basis they still don't feel or experience what we do and having someone who has been

there, or perhaps, is there, to turn to is very supportive. That is what Peer Support is all about.

I encourage your support in putting the Peer Support program into the budget to help many North Dakotans.

Testimony

House Human Service Committee

Support for the Peer Support Program Oar

Representative Pollert, Chairman

January 15, 2009

Chairman Pollert and members of the House Human Services Committee, I am Loretta Cannon, a member of Mountainbooke in Grand Forks.

The peer support group is greatly needed for us as a person with mental illness. Just like AA and other support groups, this is needed to help us to help each other. We need this program to know we're not alone and that we can fit in with society. We need to help each other to keep ourselves functional and safe. Knowing that there are others out there with the same problems helps us to know we can be understood and we are not different.

House Human Services Committee

Support for the Peer Support Program OAR

Representative Pollert, Chairman

January 14, 2009

Chairman Pollert and members of the House Human Services Committee, my name is Robin Ault from Jamestown. I am a member of Progress Community Center and a member of their Peer Support Group. I like going to group because I learn a lot of things I did not know. I like being with people and talking with them. I learn what people are going through. I also have learned how to do things for myself.

I

House Human Services Committee

Support for the Peer Support Program OAR

Representative Pollert, Chairman

January 26, 2009

Chairman Pollert and members of the Human Services Committee, my name is Steve McWilliams from Minot. I am a peer support person and currently work with four matches. This program has done so much for my feelings of self-worth. When they are having a bad day, I am able to lift their spirits and they are able to lift mine. My first match is a young man that has surpassed any expectations that I had for him. He is living in an apartment, transfering into living independently. He is now using the library and other activities. A moving moment for me was when I attended an open house where he is living. He came and sat next to me, beaming like this was the first time he had someone visiting for him. He turned and told me that I was an inspiration to him.

Another of my matches is back to working. He is also setting goals and working on them, even if it means overcoming obstacles. He is working on earning his drivers license. My third match is beginning to go out in public more. He also has said how much it means to him to have someone to talk to besides his mother. I am also working out with another match periodically at the local communicity center. During the summer, we also went out to the park for both exercise and recreation.

This program is important. We are helping each other on our road to recovery.

J

Testimony

House Human Services Committee

Support for the Peer Support Program Oar

Representative Pollert, Chairman

January 15, 2009

Chairman Pollert and members of the committee, my name is Amber Hammer I am the Peer Support Coordinator for Western Sunrise Inc. in Williston, North Dakota.

In the beginning, I thought I was all alone; I was the only person who had a mental illness and has had difficult issues to face. After time went by I was introduced to the Peer Support program. I was then matched up with a peer support specialist, one who has experienced some of the things I had. I had pseudo seizures. Once at group I ended up having one. They called my doctor to see what to do. While they were waiting to hear from my doctor, my peer support specialist was making sure that I didn't hurt myself, was at my side calming me down, making sure I aware of my surroundings, and comforting me. She had never seen me have one before but was able to bring me back. It was something that just happened and she knew what to do at that time. I was alert of what happened before the doctor got to the phone. She taught me some more coping skills that she had used before and worked for her. She pushed me to do challenging things that I would have never dreamed of doing. This is a goal that specialist encourages their matches to do. With out her challenging me I wouldn't be where I am to day speaking to you. She gave me HOPE to keep working on my

recovery process and that things will get better. She was proof. I then became a peer support specialist. I too wanted to help others like she did me. I have graduated with my associate's degree. Today as I introduced myself I said I was the Peer Support coordinator one who leads the group.

Thanks for you time

K

Testimony
House Appropriations Committee
Human Resources Division
Support for Peer Support Services Initiative
Representative Pollert, Chairman

January 27, 2009

Chairman Pollert and members of the Appropriations Committee, Human Resources Division, my name is Todd Christlieb. I am mental health consumer and a member of the Mental Health America of North Dakota/Social Club at the Myrt Armstrong Center in Fargo, North Dakota.

I am a strong supporter of the Peer Support Services Program. As a member of the Myrt Armstrong Center, I interact with other members on a daily basis. We provide support to each other on an informal basis. I am a Program Coordinator for the Consumer and Family Network. Our main focus is to encourage peer support and recovery, also the primary elements of the Peer Support Services Program.

I have witnessed, through my job, what peer to peer support can do. A member is now working because of this support. I can only imagine what could happen with trained people.

Thank you.

L

Testimony
House Appropriations Committee Human Resources Division
Support for Peer Support Services Initiative
Representative Pollert, Chairman

January 27, 2009

Chairman Pollert and members of the Appropriations Committee, Human Resources Division, I am Susan Rae Helgeland, Executive Director of Mental Health America of North Dakota (MHAND). I am here to support an Optional Adjustment Request (OAR) to the Governor's Budget to fund a state-wide ND Peer Support Services Initiative.

MHAND's Mission *to promote mental health through education, advocacy, understanding and access to quality care for all individuals* is descriptive of the Peer Support Services program. Peer Support Services provide much needed and desired employment opportunities for people with mental illness while contributing to recovery for people with mental illness. In addition, the Peer Support Services program enhances existing case management services and can assist mental health providers.

Peer Support Specialists can work in multiple settings such as medical, corrections, employment and housing as well as other areas where people with mental health needs receive services. ND's human service system deserves a Peer Support Services program. It is cost efficient and contributes to recovery.

Funding is vital for our program so we can reach all the individuals who would like to participate. Our goal for this year is to expand our program to include meetings at the North Dakota State Hospital and to have individual one-on-one peer support. We have started to make plans for this, but need to know that all our work will not come to an end in June when our funds run out.

House Appropriations – Human Resources Division
Tom Alexander – Testimony
North Dakota Medicaid Infrastructure Grant (ND MIG),
North Dakota Center for Persons with Disabilities (NDCPD)
at Minot State University
House Bill 1012

Chairman Pollert and members of the committee, my name is Tom Alexander. I am the Project Director for the ND Medicaid Infrastructure Grant (NDMIG) with the North Dakota Center for Person with Disabilities at Minot State University. I greatly appreciate the opportunity to present testimony on HB 1012.

To begin, I would like to express my support for the proposed 7% & 7% increase for Qualified Service Providers (QSPs) and other providers as recommended in the Governor's budget; funding for the development and implementation of an Aging and Disability Resource Center (ADRC); and support for increased home and community based services (HCBS) for the elderly and people with disabilities of North Dakota. In addition I would like to urge you to reinstate the DHS's OAR for the Peer Support Program into the Human Services Budget. The following information will briefly explain the Peer Support Program and Services.

Peer Support Services refer to support provided *by* people with mental illness *to* others with mental illness. They are consumer-centered services with a rehabilitation and recovery focus. They are designed to promote skills for managing and coping with symptoms while facilitating the use of natural resources and the enhancement of community living skills. *Peer Support Services* are provided by a person who has progressed in their own mental health recovery

and is working to assist other people with mental health issues. These individuals are called *Peer Support Specialists*. Because of their life experiences, *Peer Support Specialists* have expertise that professional training cannot replicate. Peer Support Services are an integral piece of current state-wide efforts to create a Recovery-oriented, evidence based, consumer-driven Mental Health system of care.

Peer Support Specialists provide specific interventions including support and assistance with:

- Identifying individual strengths, resources, preferences, and choices;
- Identifying existing natural supports for development of a natural support team;
- Developing crisis management plans;
- Identifying risk factors related to relapse & development relapse prevention plans & strategies;
- Promoting self-advocacy & participation in decision-making, treatment, & treatment planning;
- Building a natural support team for treatment and recovery; and
- Developing functional, interpersonal, coping, and community living skills that are negatively impacted by the person's mental illness.

In the fall of 2007 NDDHS submitted a proposal to the Substance Abuse and Mental Health Services Administration (SAMHSA) titled, "Transformation Transfer Initiative (TTI)." ND was fortunate enough to be one of ten states selected to be funded for the initiative. The TTI project supported new and expanded efforts to improve the capacity and effectiveness of mental health systems that foster recovery and meet the multiple needs of consumers.

A variety of consumers, stakeholders and professionals were invited in January 2008 to be a part of the TTI – Peer Support Initiative. The purpose of the initial work group was to meet, provide an overview and a timeline for the initiative, form sub-groups, schedule meetings, and complete the Project Management Plan.

The main goal of the Project Management Plan *is "Initiative will prepare people with mental illness to become Peer Support Specialists, using their shared experience to guide others toward recovery."* The management plan also has eleven objectives to accomplish the goal and they include:

1. Develop a Peer Support Initiative Work Group (a.k.a. Stakeholder Committee and/or Steering Committee) and Sub Groups which included:
   - Technical Support and Research
   - Stakeholder
   - Stakeholder-System Partner Training/Peer Support Specialist Training
   - Psychosocial Rehab Centers
   - Peer Support Curriculum
   - 1915i Amendment
2. Conduct Stakeholder Input Meetings
3. Complete an initial Project Management Plan, and update as necessary until project is completed.
4. Design the Research and Outcomes Plan
5. Design Technical Support Plan
6. Develop Peer Support Certification Curriculum
7. Provide Training to Stakeholders within the Mental Health System to educate, inform, and increase readiness for peer involvement in the formal service delivery process.
8. Define the Recovery Principles Approach within the 8 Regional Psychosocial Rehabilitation Centers
9. Complete and submit the 1915i Amendment & Explore Options for Additional Funding
10. Evaluate Project and Submit the Final Report
11. Develop a Training & Employment Plan for Peer Support Specialists.

The management plan was submitted SAMHSA in September of 2008 with all objectives complete. It is important to note that this plan would provide peer support services to Medicaid eligible and non-Medicaid eligible individuals.

Currently, Northwest Human Services Center (Williston) and North Central Human Service Center has a very successful peer support specialist projects funded through the human service center at approximately $65,000. South Central Human Service Center has received $25,000 to begin a Peer Support Specialist program. The $25,000 is a good start but will not sustain the program.

Western Sunrise, Inc., a consumer-run, nonprofit organization in Williston, N.D., is an example of a successful consumer-directed peer support model currently operating in North Dakota. Outcome data for the *Peer Support Program* is extremely favorable. Outcome measures indicate: 50% decrease in hospitalization rates; 50% of consumers gained employment; volunteerism rates increased; and 94% of consumers indicated that their quality of life improved. Many of the consumers in the program began to rely less on other more expensive services.

The existing *Peer Support Programs* are funded through the Human Service Centers. There are options for federal dollars as well. Through an amendment to the State Plan, Medicaid can become a partner in funding *Peer Support Services*. More North Dakotans with a mental illness can benefit from *Peer Support Services* by making the program available state-wide. No one has to live feeling recovery is impossible; *Peer Support Services* makes recovery a reality. Other states have

experienced great successes by employing *Peer Support Specialists* to work in multiple settings such as medical, corrections, employment, and housing, as well as other areas where people with mental health needs receive services.

As part of the management plan the ND Department of Human Services submitted an OAR which did not make Governor Hoeven's proposed budget to the assembly.

The DHS, consumers, stakeholders and mental health professionals completed a great deal of work to develop the Peer Support Services Project Management Plan. This work should not go unrecognized. Therefore, I would like to recommend a two-step process to fund this initiative. The first step would include adding an additional $600,000 for the biennium into the 8 regional human service centers budgets, which would provide $75,000 per human service centers for the biennium to provide peer support services to individuals who are not Medicaid eligible. The second step would include the NDDHS to submit a revised state plan amendment to CMS under the Rehab Option and 1915 (b)4 Waiver. This would allow the management plan to be implemented and allow the peer support program to blossom prior to CMS's approval for a state plan amendment.

This is a project that needs to be funded for many reasons which were stated earlier. The bottom line is Peer Support Projects work. The current state projects and the national data indicates that as well. This is an opportunity that should not be missed! Thank you for your time and I would be happy to answer any questions that you may have.

March 9, 2009
HB 1012
Senate Appropriations

Same spoken to House

Chairman Pollert and members of the Committee, I am Randy Solem, Chair of the Mental Health Planning Council for the Department of Human Services. There is a Mental Health Planning Council in every State and U.S. Territory. Its focus is on mental health wellness and recovery that is consumer and family driven. On behalf of the Council, I would like to express support for the Governor's recommended budget for the Department of Human Services. I'd also like to encourage you to consider support for: 1) Crisis Intervention Team training and implementation; and 2) Peer Support Services.

The concept of a Crisis Intervention Team (CIT) was initially developed in Tennessee years ago as the result of a police shooting of a man with mental illness. It was recognized that law enforcement officers needed training on how to best work with people with mental illness. This program is highly acclaimed and has spread throughout the country.

The Minot Police Department is the first in North Dakota to use the CIT model. The Mental Health Planning Council heard first-hand about the intense training that six police officers received in Denver. Actors are used to portray real life situations and experiences of people with mental illness.

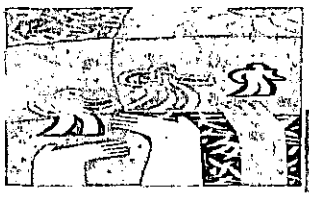
One of the most obvious benefits of the model is the focus on the safety of the person with a mental illness as well as law enforcement personnel. The police are trained to interact with the individual with a mental illness without the use of force unless there is absolutely no other option.

The Law Enforcement Academy in Bismarck and other police departments are also interested in this model. The Mental Health Planning Council encourages your support for funding the CIT model of training and implementation.

Our second area of emphasis is Peer Support Services, which are provided by specially trained individuals with a mental illness who relate to participants based on their experience in the recovery process. They teach social and coping skills essential to increasing resiliency and provide a model of recovery. These services are now being provided in the communities of Williston, Minot, and Jamestown.

Peer Support Specialists provide a diverse scope of tasks. These may include counseling, teaching, medication monitoring, benefits counseling, staffing crisis intervention and jail diversion programs, family and community education, and assistance in obtaining or using housing, transportation, and employment. Through studies conducted in 1998 and 2007, it has been found that people receiving peer support had fewer hospitalizations. This will mean a greater quality of life for program participants as well as a lower cost for treatment and services.

Thank you for your time and consideration.



Peer Support Services Intiative

Individuals with mental illness providing support to others with mental illness

What are Peer Support Services?

JANUARY 20, 2009

Peer Support Services refer to support provided by people with mental illness to other people with mental illness. They are consumer-centered with a rehabilitation and recovery focus. They are designed to promote skills for managing and coping with symptoms while facilitating the use of natural resources and the enhancement of community living skills. *Peer Support Services* are provided by a person who has progressed in their own mental health recovery and is working to assist other people with mental health issues. These individuals are called *Peer Support Specialists*. Because of their life experiences, *Peer Support Specialists* have expertise that professional training cannot replicate. Peer Support Services are an integral piece of current state-wide efforts to create a Recovery-oriented, evidence based, consumer-driven Mental Health system of care.

Peer Support Specialists **provide specific interventions including supporting and assisting with:**

- Identifying individual strengths, resources, preferences, and choices;
- Identifying existing natural supports for development of a natural support team;
- Developing crisis management plans;
- Identifying risk factors related to relapse & development relapse prevention plans & strategies;
- Promoting self-advocacy & participation in decision-making, treatment, & treatment planning;
- Building a natural support team for treatment & recovery; and
- Developing functional, interpersonal, coping, and community living skills that are negatively impacted by the person's mental illness.

How Will Peer Support Services Help?*

Jane is 32-years old and lives by herself in an efficiency apartment in a city of about 30,000 people. She has an Associate's Degree in occupational therapy. She doesn't work. Her minimal income is from public benefits. She rarely ventures out other than for occasional trips to the grocery store and infrequent visits to her doctor. She quit taking her prescription medications. She doesn't care. She doesn't like her life. She has a mental illness. She has severe depression.

While at the store, Jane ran into a friend, Mary, whom she hadn't seen for years. They talked a while in the frozen foods section. Mary convinced Jane to go to the local café for a cup of coffee. They talked more. Jane confessed that her days were long and empty. Mary told Jane about a new program in the community offering *Peer Support Services*. Mary, in fact, was a *Peer Support Specialist*. The two met several more times that week. They drank more coffee and shared more stories. Jane was eventually convinced that she should try the *Peer Support Program*.

There were ups and downs for Jane but after a month, she was again taking her medication as prescribed. After two months, she was volunteering three afternoons a week at the local hospital. She was starting to like her life again.

*The story of Jane is fictional but is based on situations that many North Dakotan's face and how they may benefit from Peer Support Services.

Peer Support Programs Working in North Dakota

Western Sunrise, Inc., a consumer-run, nonprofit organization in Williston, N.D., is an example of a successful consumer-directed peer support model currently operating in North Dakota.[1]

In 2002 Western Sunrise, Inc. embarked upon a strategic planning effort for their organization. The main area that consumers felt there was a gap in, was in the arena of *peer support*.

In response to this need, Western Sunrise, Inc. applied for and received a grant to provide *Peer Support Services* from the North Dakota Olmstead Commission in the fall of 2003. They have recently expanded their program to the Minot and Jamestown areas. They employ eight *Peer Support Specialists* who provide direct recovery-orientated services to consumers in the community.

Outcome data for the *Peer Support Program* is extremely favorable. Outcome measures indicate: 50% decrease in hospitalization rates; 50% of consumers gained employment; volunteerism rates increased; and 94% of consumers indicated that their quality of life improved. Many of the consumers in the program began to rely less on other more expensive services.

[1]*North Dakota Department of Human Services (2008-02-05).* N.D. Dept. of Human Services receives federal funding to establish peer support program. Press release. *http://www.nd.gov/dhs/info/news/2008/02-05-grant-for-peer-support-program.pdf Retrieved on 2009-01-15.*

How are Peer Support Services Funded?

The existing *Peer Support Programs* are funded through the Human Service Centers. There are options for federal dollars as well. Through an amendment to the State Plan, Medicaid can become a partner in funding *Peer Support Services*. It is estimated that seven to ten states already have Medicaid-funded *Peer Support Services* for individuals with mental illness including Georgia, Iowa, New Mexico, North Carolina, and Pennsylvania. States are only beginning to see the impact that *Peer Support Specialists* have in the lives of other peers.

What More Can We Do?

More North Dakotans with a mental illness can benefit from *Peer Support Services* by making the program available state-wide. No one has to live feeling recovery is impossible, *Peer Support Services* makes recovery a reality. Other states have experienced great successes by employing *Peer Support Specialists* to work in multiple settings such as medical, corrections, employment, and housing, as well as other areas where people with mental health needs receive services. The possibilities are endless.

P&A DISABILITY RIGHTS NORTH DAKOTA

CONSUMER & FAMILY H P O E NETWORK

NDCPD Minot State University Center of Excellence

For More Information Contact:

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Testimony
House Bill 1012 –Department of Human Services
Senate Appropriations Committee
Senator Ray Holmberg, Chairman
March 9, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, thank you for the opportunity to provide comments on HB 1012, particularly in the area of mental health/substance abuse services. I am Janet Sabol from Minot. I have volunteered for the National Alliance on Mental Illness (NAMI) in the local affiliate and statewide for over 10 years serving as the state coordinator, state president and current spokesperson.

The following areas are strongly supported to improve the health and quality of life for North Dakota's citizens who have mental illnesses:

*The Division of Mental Health/Substance Abuse (DMHSA) has been making steps in transition to a recovery approach for people with mental illnesses. This includes the implementation of Peer Support Specialist services available in the Williston and Minot regions. The Jamestown region has implemented support groups awaiting funds for individual Peer Support Specialists. Marilyn Rudolph, director of the Northwest and North Central Human Service Centers, reported the importance of these services in testimony the committee received March 4. This weekly support to peers has been proven

to be cost effective, a deterrent to hospitalization and a way to alleviate worsening of symptoms. Expansion of this program is requested at an estimated additional cost of $500,000.

*Supported housing: The DMHSA undertook a Continuum of Care Workgroup Project with the Executive Summary completed in April 2008. In that report housing and supervised housing options were rated as priority number one. Priority two was peer supports, one of which I just talked about and the third priority was enhanced community-based services. Supported housing and a variety of housing options is a great need throughout the state. Not only will people be able to remain in their community with the appropriate supervision for them, but it will greatly diminish the homeless population. The Minot YWCA executive director who works with homeless women has noted that 85% of these ladies have some type of mental health diagnosis.

*Diversity and expansion of community-based services: Enhanced residential services are needed in Minot, Grand Forks and Dickinson regions. There are no crisis beds in the Minot region which would help keep individuals from private or state hospitalization. Supported residential and detox services in the Grand Forks region, staffing needs in the Fargo and Jamestown region and residential services in Dickinson are all important to a diverse continuum

of services. The House removed funding for these services and there is a need to reinstate them. Cost: $3.5 million

*Crisis Intervention Team (CIT): The DMHSA and Mental Health Planning Council as well as the Governor's Commission on the Alternatives to Incarceration have verbally supported the implementation of Crisis Intervention Team training. Unfortunately, no monies were designated in the Governor's budget or Human Services budget. This evidence-based pre-booking jail diversion program involves 40 hour training for law enforcement and first responders designed to improve outcomes of interactions with people who have mental illnesses. (See Attachment A for a fact sheet.) The Ward County CIT Committee, with representatives of 24 agencies, has been meeting regularly since September 2007. The group obtained funding to send six (6) people to the 40 hour training and 8 hour Coaches' training in Colorado. The committee is now looking into offering the training in Minot later this fall. Police departments in Fargo and Bismarck have also indicated interest in this type of training. Increased safety of the officers, the person with a mental illness and the general public is a result of this program, but maybe more important is the individual's diversion from the criminal justice system to mental health treatment. Cost for the initial training is estimated at $25,000.

Annual trainings for 30 new officers and updates for CIT certified persons would improve outcomes across the state.

*Development of the Aging and Disability Resource Link model which is under Aging Services' budget and was removed by the House at a cost of $600,000. A person with a mental illness disability faces many challenges when seeking services that can involve going to 7 different agencies or more. Many times the illness causes a lack of focus, an inability to concentrate, an "overwhelming" feeling, and an overall inability to complete required applications necessary to receive services. Establishment of a "one stop shop" will improve access to services and includes follow-up with consumers, an essential component for persons with mental illness.

On Wednesday, March 11 NAMI will be releasing the 2nd Grading the States report of public mental health services. Information about North Dakota will be available at www.nami.org/grades09 . In March 2006 North Dakota was one of 8 states receiving an "F". The national grade was a "D" and there were no "A"s. I would encourage the subcommittee to take a look at the areas where improvements are needed and put financial resources into those services. In a time when the state has a budget surplus and federal economic stimulus monies

will be available, it's time to provide monies to the most vulnerable of our citizens—those who are young, elderly and coping with disabilities.

Thank you for your time and support of improved services in the Human Services budget. I would be willing to answer any questions you or the committee members may have.

NAMI
National Alliance on Mental Illness

Crisis Intervention Team Toolkit
CIT Facts

What is CIT?

Crisis Intervention Teams (CIT) are a pre-booking jail diversion program designed to improve the outcomes of police interactions with people with mental illnesses.

The first CIT was established in Memphis in 1988 after the tragic shooting by a police officer of a man with a serious mental illness. This tragedy stimulated a collaboration between the police, the Memphis chapter of the National Alliance on Mental Illness, the University of Tennessee Medical School and the University of Memphis to improve police training and procedures in response to mental illness. The Memphis CIT program has achieved remarkable success, in large part because it has remained a true community partnership. Today, the so-called "Memphis Model" has been adopted by hundreds of communities in more than 35 states, and is being implemented statewide in Ohio, Georgia, Florida, Utah, and Kentucky. To locate a CIT program near you, visit the University of Memphis website at: http://www.cit.memphis.edu/USA.htm.

The Memphis Model of CIT has several key components:

- A **community collaboration** between mental health providers, law enforcement, and family and consumer advocates. This group examines local systems to determine the community's needs, agrees on strategies for meeting those needs, and organizes police training. This coalition also determines the best way to transfer people with mental illness from police custody to the mental health system, and ensures that there are adequate facilities for mental health triage.

- A **40 hour training program** for law enforcement officers that includes basic information about mental illnesses and how to recognize them; information about the local mental health system and local laws; learning first-hand from consumers and family members about their experiences; verbal de-escalation training, and role-plays.

- **Consumer and family involvement** in decision-making, planning training sessions, and leading training sessions.

Why Do We Need CIT?

CIT equips police officers to interact with individuals experiencing a psychiatric crisis, by:

- **Providing specialized training.** Police officers report that they feel unprepared for "mental disturbance" calls and that they encounter barriers to getting people experiencing psychiatric symptoms quickly and safely transferred to mental health treatment. CIT addresses this need by providing officers with specialized training to respond safely, and quickly to people with serious mental illness in crisis. Officers learn to recognize the signs of psychiatric distress and how to de-escalate a crisis — avoiding officer injuries, consumer deaths and tragedy for the community. In addition, CIT officers learn how to link people with appropriate treatment, which has a positive impact on fostering recovery and reducing recidivism.

- **Creating a community collaboration.** Due to critical shortages in community mental health services, police officers have become first line responders to people with serious mental illness who are in a psychiatric crisis. When these crises occur, officers often have no options other than to arrest the individual, due to the lack of protocol or coordination between law enforcement and the mental health system. By creating relationships between law enforcement and mental health services, CIT can facilitate agreements that get people quickly transferred to mental health treatment, while reducing the burden on police and corrections. Speedy transfers to treatment save police time and money, and reduce the need for costly emergency psychiatric services.

CIT Works — for law enforcement, for consumers, and for the community.

CIT helps keep people with mental illnesses out of jail, and gets them into treatment.

- Studies show that police-based diversions, and CIT especially, significantly reduce arrests of people with serious mental illnesses.[1,2] Pre-booking diversion, including CIT, also reduced the number of re-arrests by 58%.[3]

- In a one-year study of pre-booking jail diversion, including CIT, participants in jail diversion programs spent on average two more months in the community than non-diverted individuals. Individuals diverted through CIT and other programs receive more counseling, medication and other forms of treatment than individuals who are not diverted.[3]

- CIT training reduces officer stigma and prejudice toward people with mental illness.[4]

- CIT officers do a good job of identifying individuals who need psychiatric care[5] and are 25% more likely to transport an individual to a psychiatric treatment facility than other officers.[6]

CIT reduces officer injuries, SWAT team emergencies, and the amount of time officers spend on the disposition of mental disturbance calls.

- After the introduction of CIT In Memphis, officer injuries sustained during responses to "mental disturbance" calls dropped 80%.[7]

- After the introduction of CIT in Albuquerque, the number of crisis intervention calls requiring SWAT team involvement declined by 58%.[8,9]

- In Albuquerque, police shootings in the community declined after the introduction of CIT. [9]

- Officers trained in CIT rate their program as more effective at meeting the needs of people with mental illness, minimizing the amount of time they spend on "mental disturbance" calls, and maintaining community safety, than officers who rely on a mobile crisis unit or in-house social worker for assistance with "mental disturbance" calls. [10]

CIT Works in Rural Communities: Many rural communities have created regional collaboratives for CIT. For example, successful rural CIT programs exist in the New River Valley in Virginia, and in Cambria County, Pennsylvania.

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Testimony
House Bill 1012
Senate Appropriations
Senator Ray Holmberg, Chairman
March 4, 2009

Chairman Holmberg and members of the Committee: my name is Carlotta McCleary. I am the Executive Director of ND Federation of Families for Children's Mental Health (NDFFCMH). NDFFCMH is a parent run advocacy organization that focuses on the needs of children and youth with emotional, behavioral and mental disorders and their families, from birth through transition to adulthood.

NDFFCMH supports increasing the net income eligibility from 150% to 200% of the poverty line for the state children's health insurance program. Expanding the net income eligibility allows more children to access mental health care. For many children, mental health care is a key component of the array of services needed for healthy childhood development.

Mental disorders affect about one in five American children and one in ten experience serious emotional disturbances that severely impair their functioning, according to the Surgeon General's comprehensive report on mental health. **Moreover, low-income children enrolled in Medicaid and SCHIP have the highest rates of mental health problems.**

Sadly, over two-thirds of children struggling with mental health disorders do not receive mental health care. The President's New Freedom Commission on Mental Health found that without early and effective identification and interventions, childhood mental disorders can lead to a downward spiral of school failure, poor employment opportunities, and poverty in adulthood. Untreated mental illness may also increase a child's risk of coming into contact with the juvenile justice system, and children with mental disorders are at a much higher risk for suicide.

NDFFCMH works with many families whose children have an Autism Spectrum Disorder. We support the Department of Human Services (DHS) budget that includes an autism waiver for children birth through five. Many of our children and adults do not currently meet the eligibility that ND DHS has set in its Developmental Disability Waiver.

We know that the needs go far beyond the current Autism Waiver proposal. Children and youth with autism spectrum disorder continue to have needs across their life span. Their needs do not stop at the age of five. Many of the transitioning age youth lack the adaptive skills necessary to become independent adults. There is a need for ongoing support for employment as well as supportive living arrangements. NDFFCMH would like to see an autism waiver expanded to include children as well as adults.

NDFFCMH supports increasing Family Foster Care payments to the nationally recommended level. We believe this will help recruit family foster homes.

Transition age youth with mental health disorders are not unique in experiencing difficulties as they transition to adulthood, they are more likely than their peers to experience poor outcomes, including areas of employment and education. Left without access to necessary services and supports, successful transitions to adulthood cannot be realized.

NDFFCMH supports the Department's budget which includes funding for youth facilities in Bismarck and Fargo, each providing eight residential beds for youth in transition. In addition to shelter, participating youth will have access to counseling, case management and other services through the regional human service centers.

NDFFCMH supports the development of a coordinated service delivery system to maximize continuity of care and access to services. Young adults who are transitioning to the adult mental health system should be able to benefit from the infrastructure that would be developed to access such services as peer support programs, independent living and life support skills as well as employment, housing and education supports.

NDFFCMH would like to see Peer-to-Peer Support Program enhanced to include funding for state-wide implementation. This is a very successful program.

Partnerships Program has been a very successful with positive outcomes for children and their families. NDFFCMH supports the increase of 1 FTE for Partnership Program at SEHSC.

Finally, NDFFCMH thanks you for your continued support for children with emotional, behavioral and mental disorders and their families.

Thank you for your time.

Carlotta McCleary, Executive Director
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Mental Health Extended Services in Relation to HB1012

January 27th, 2009

Human Resources Division of House Appropriations

~~Krystal Farmer~~

~~James Boomgaarden~~

~~Valerie~~

~~Taylor Lederman~~

~~Katie Storm~~

~~Paula Storm~~

Gail Eckstein

Mental Health Extended Services in Relation to HB1012
January 27th, 2009
Human Resources Division of House Appropriations

I. Background: Mental Health Extended Services is a program that assists people with serious mental illness find and maintain community-based employment. This service is an extension of Vocational Rehabilitation's Supported Employment Program. A person needs to meet certain criteria to be eligible for this program. This service provides supports such as job coaching to assist with skill training and development and other employment-related activities. This program is delivered in the same manner as Extended Services for individuals with Developmental Disabilities, but is funded through a different pool of money.

II. Issue: On October 24th, 2008, area agencies providing employment services were informed that Mental Health Extended Services was over budget by approximately 19%. The solution provided to this issue was to administer a new set of more restrictive guidelines that effectively eliminated at least six people from services—those with significant support needs who benefit most from the program. Over the course of the next two months, meetings were hastily arranged to let people know that their services would be ending on January 1st, 2009. No alternatives were provided beyond an invitation to join social therapy groups for people with mental illness. It was disclosed that the person had a right to appeal this decision, but no explanation was provided on that process, nor were any appeal forms provided to anyone until North Dakota Protection and Advocacy became involved. Beyond the six people who were immediately affected by this decision, many other people in the program may be in jeopardy of losing their services over the next three months if they are unable to adjust to the new highly restrictive guidelines. There is also a list consisting of nine people at present time who are waiting for Mental Health Extended Services and this list is expected to increase. Despite the current budget shortfall and the need for additional services as evidenced by the waiting list, there has been no request for any additional funding for the 2009-2011 biennium. There is also a discrepancy between the services available to those individuals with a developmental disability versus those with a mental health diagnoses in relation to the new guidelines. This has not been addressed.

- ***Friendship, Inc.***

- We were authorized 3520 units (intervention hours) @ $31.34 a unit = $110,316.80 for the 2009 Fiscal year

- July 1, 2008- December 31,2008 we were authorized $56,349.32; we used a total of $42,998.48 which is a savings of $13,350.84

- To continue to provided serves at this level January 1, 2009- June 30, 2009 we will need $42,998.48

- For the 2010-2011 biennium we are projecting $171,994 for the 24 month period with an addition of $66,190 to allow for new referrals

- ***Evaluation and Training Center (ETC)***

- We were authorized for $115,000 Fiscal year

- We were authorized $230,000 per this biennium

- To amend our current situation we would need $104,000

- With an addition of $50,000 for new referrals

- ***Community Living Services (CLS)***

- For the 2010-2011 biennium we are projecting we will need an additional $19,800

From: Terry Paulson - ETC

Mental Health Extended Services

I. Management of Fiscal Resources between the State Mental Health and Region V Mental Health in Fargo, do not appear to be managed very effectively. We were told on October 24th, 2008 that they had over spent their funds by approximately 19% and needed to make some changes. They told Providers at this meeting that they were looking at changing the criterion for being in the Extended Services program, and than proceeded to hand out a copy of the more restrictive guidelines. They went on to say that they would be meeting with each Provider and those consumers affected by these changes in the next month to decide on a course of action. They went on to discuss a pilot program that they were going to run to determine how the new criterion would work, and stated that a Request for Proposals would be issued in the near future for any Providers who would be interested in submitting a request. I am not sure where the funding for this pilot project would be coming from.

II. I felt that the handling of cutting off services to the six consumers that we serve could have been handled differently. They told each consumer that they had the right to appeal the decision, but did not fully explain the process, or provide them with the appeals form that was used by the Human Services Center. I felt that they did not allow for any flexibility to work towards meeting their new restrictive criteria, and were very arbitrary in just cutting them off from services with one months notice.

III. It is unusual for a State Agency to change it's criterion for services in the middle of the year, without first seeking input from the Organizations and people they serve. In discussing these changes with a Provider of Mental Health Services in the Bismarck area, they were unaware of any changes at all in their Region, and had not been contacted by anyone related to this issue.

IV. There are at least seven consumers that are being assisted by a client assistance attorney in our region in the filing of an appeal with the Human Service Center. I know that the State Protection and Advocacy Project is also involved in this process, and has similar concerns as

well. There are approximately eleven consumers impacted by these changes in our Region. We are continuing to meet with Mental Health officials and consumers that have been impacted to see if anything can be worked out.

V. Possible Solutions:

1. There needs to be an option/mechanism of transferring funds within the Mental Health Division, so that services to clients are not impacted. It was our understanding that they had monies in the caseworker side of the budget, but could not transfer to the Extended Services side.
2. Guidelines should be established that would require a period of public input/ comment, prior to changes in service eligibility criterion.
3. There needs to be a stronger system of fiscal management and coordination established between State Mental Health and the Regional Offices. There should be no excuse for over spending by 19% and having to change services on such short notice.
4. Allow the ten or eleven clients impacted, to remain in services, pending disposition of their appeals and resolution of the above issues.

IMPLEMENTATION OF EXTENDED SERVICES TO EMPLOYED INDIVIDUALS WITH SERIOUS MENTAL ILLNESSES

DIVISION OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

JULY 1998

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I. INTRODUCTION

History indicates that many individuals with serious mental illnesses have not been employed because of social stigma, the severity of their disease and/or a lack of the necessary supports to maintain them on the job. When an individual obtained a job, long-term employment was unlikely because the employer had no knowledge or training in working with the handicap, fellow employees were unsympathetic and/or no support system existed on or off the job site.

In order to assist these individuals, Vocational Rehabilitation developed a program called, "Supported Employment Program" (SEP). This program was started for individuals with mental retardation/developmental disabilities in 1986. Since that time, it has also been adapted to serve individuals with serious mental illnesses.

II. DEFINITIONS

The Supported Employment Program has been defined by Federal Regulations (34 CFR part 363) as competitive work in an integrated work setting with ongoing support services for individuals with severe disabilities for whom competitive employment:

--Has not traditionally occurred

--Has been interrupted or intermittent as a result of severe handicaps

The first phase of supported employment is called training and stabilization. This phase is provided by vocational rehabilitation. When the client has been stabilized on the job, he/she is then referred for extended services.

SEP includes a second phase, extended services, which is a system designed to provide necessary employment-related ongoing support and includes job development and replacement in the event job loss occurs.

On-going support service is continuous or periodic job skill training provided for individuals with serious mental illnesses throughout the term of employment to enable the individual to perform the work. It also includes services provided at or away from the work site such as personal care, counseling to family members and other employment-related activities.

In the case of job loss, those activities of replacement, retraining and restabilization will also be necessary to maintain an individual's employment status.

Direct Service means face-to-face contact by the job coach such as job development, job match, job placement and job skills training. Job skills training could include on or off the job site.

III. ELIGIBLE RECIPIENTS

Eligible recipients are North Dakota residents with serious mental illnesses. All recipients will have a SMI case manager who is employed at a regional human service center. (Include statement about need for on-going employment support).

IV. OUTCOMES

The success of extended services for individuals with serious mental illnesses can primarily be measured by the number of hours of work the person performs, the amount of wages a person receives, the length of time a person stays on the job and the degree of integration achieved within the work environment. The expected outcomes to be achieved for individuals in extended services are as follows:

Individual outcomes

--Work that is performed on a full-time or part-time basis averaging a minimum of 20 hours per week, unless the individuals's multi disciplinary team approves a lesser level of employment and it is documented in the client's record.

--Preferred compensation at a level of minimum wage and higher, if less, it must be in compliance with Section 14(C) of the Fair Labor Standards Act.

--Employment must be at an integrated work site as described in Service Chapter 720-01.

System Outcomes

The success of extended services can be gauged by statewide achievement of the above, as well as the responsiveness and flexibility with which the system can adjust to the changing intervention needs of individuals maintaining their employment. Specific outcome expectations are:

--The individualization of planning and reimbursement activities (based on specific intervention needs of the client).

--The establishment of an on-going support service structure to maintain job placement, training and stabilization efforts accomplished in obtaining work for individuals with serious mental illnesses.

--An emphasis on decision-making being accountable at local levels (multi-disciplinary teams, including SMI case management and extended service case management participation).

--Reimbursement to service providers which covers actual costs.

V. ROLE OF THE SMI CASE MANAGERS AND EXTENDED SERVICE CASE MANAGERS

Individuals with serious mental illnesses who are clients of a regional human service center must have a SMI case manager. When a multi disciplinary team has determined that an individual with serious mental illness could benefit from the supported employment program, the SMI case manager and/or the extended service case manager will refer him/her to Vocational Rehabilitation. If Vocational Rehabilitation also determines that the individual is eligible for the supported employment program, the SMI case manager and/or extended service case manager will work cooperatively with the Vocational Rehabilitation counselor. The Vocational Rehabilitation counselor will then make the necessary arrangements for referral to a local provider who will provide training and stabilization.

After the client has been stabilized on the job and the client no longer needs the services of Vocational Rehabilitation, he/she will enter the second phase which is extended services. The extended service case manager will then negotiate with the local provider to provide extended services. The

extended service case manager will negotiate an authorization for extended services based on the client's needs. If the client, after a period of time, requires additional job-related services including job development and placement on a different job, the extended service case manager will renegotiate an authorization.

The extended service case manager's role in coordination with the client's case manager, will be to provide support services to assist clients in maintaining their independence. Such activities may include assisting clients in accessing housing, therapy, medical treatment, SSI and other entitlement and/or any other supportive activities. The local provider will provide all extended service activities as they relate to the job. The provider will work with the employer and provide job coaches as needed to maintain the client on the job.

VI. CLIENT ENTRY INTO EXTENDED SERVICES

Individuals entering extended services will principally be referred from Vocational Rehabilitation having left that program with an:

--Intervention by a job coach being 20% less of an individual's work hours for two consecutive months, or

--Intervention being consistent at a level above 20% but less than 50% of work hours for four consecutive months.

Individuals may also enter extended services from other sources than Vocational Rehabilitation. Clients may already have a job, but need on-going support on or off the job site. Local providers may be contracted with to provide job coaching or some other support services to maintain the individual on the job.

VII. CLIENT EXIT FROM EXTENDED SERVICES

Individual's receipt of extended services may be discontinued for the following reasons:

--Retirement

--Death

--Paid intervention no longer necessary

--Intervention needs fall below minimum of twice monthly

—Individual choice (which may include job separation)

VIII. JOB LOSS

If job loss occurs under extended services and re-employment is to transpire, the provider, in conjunction with the extended service case manager, will develop a re-employment plan based on the individual's employment needs. This plan will outline the specific activities to be undertaken, as well as the magnitude and duration of efforts to get the individual's job (intervention needs) stabilized.

IX. REIMBURSEMENT

Reimbursement for extended services is intended to be client-centered, provider sensitive and in compliance with Federal Rules and Regulations.

A. Rate Setting

Individualized intervention rate setting is designed to accommodate provider's actual costs of extended services via an up front process. This rate setting process will include:

1. Direct service; and,

2. Administrative costs. Hourly rates of intervention will be set by the Developmental Disability Unit and communicated to regions for use in developing authorizations. The hourly rate will reflect the full cost of providing one hour of direct intervention to an individual.

B. Claims Processing

Extended service case managers will negotiate with the provider the number of intervention hours needed to maintain the individual on the job. She/he will then complete a rate form which will determine the amount the provider will receive. This will be the number of intervention hours times the rate which was established by the Department for the provider.

At the end of the month, the provider will submit a billing form to the extended service case manager who in turn will authorize the expenditure on the VRIS II System.

C. Audit

All providers are required to adopt an accounting system which allows for reporting of all costs to the Department of Human Services. The settlement of an audit to actual costs (which includes appropriate administrative cost allocation) will be made through a recoupment or refund to the Department of Human Services, Division of Mental Health and Substance Abuse Services for an overpayment, or an additional payment to the Provider for an underpayment.

X. EXTENDED SERVICE CASE MANAGER FUNCTIONS

A. Authorization

Extended service case managers will be responsible for documenting supported employment on the client's individual treatment plan (ITP).

B. Utilization Review

The conduct of utilization reviews will be a delicate matter for extended service case managers due to the sensitivity of on-site verifications of services being provided. Though such practice will not be prohibited, it is expected that utmost caution be exercised should on-site review take place. Otherwise, the collection of information from the individual served and the service provider should provide sufficient basis for the determination of the quality of service delivered.

XI. ROLE OF THE DIVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The role of the staff of the Division of Mental Health and Substance Abuse Services will be to monitor authorizations, maintain data on clients and provide quarterly audits of expenditures of money. The Division staff will make the necessary arrangements for the training of extended service case managers, local providers and others who may be involved in the provision of extended services.

"S" Drive/Jude: Extsers

New Guidelines

Serious Mental Illness Extended Services Consumer Continued Stay Criteria

Philosophy: The Extended Services program will assist consumers to maintain their substantial gainful community based employment achieved during their time spent under the Supported Employment Program. It is believed that with an appropriately matched job and on the job training and support a consumer will, over time, progress towards independence or a need for minimal interventions.

Goal: Assist consumers with disabilities to achieve and maintain community based employment in an integrated setting that includes the development of natural supports.

Criteria Points:

- Individual should be employed at least 50 hours per month
- The individual requires 20% or less intervention at the time of referral.
- It is expected that intervention will continue to decrease throughout the time on the program.
- The cost of job coaching interventions should not exceed the individual's monthly earnings.
- The individual earns at least minimum wage. No piece rate pay.
- An employer/employee relationship exists
- The employment relationship is not time limited
- The essential functions of the job must be performed by the individual
- The setting is not primarily a learning, evaluative, or experiential activity
- The setting is not a simulated segregated environment.
- The individual will develop an Individual Employment Plan with their job coaching service provider that targets issues/behaviors that are creating barriers to gaining independence on the job.
- The service provider will report monthly on progress made on the Individual Employment Plan and will attend quarterly meetings that will formally review progress towards achieving independence.
- Re-Employment activities need to be pre-authorized by the Extended Services Coordinator

Letters in Support of Increased Funding for Mental Health Extended Services

HB 1012
January 27th, 2009
Human Resources Division of House Appropriations

To Whom It May Concern:

My name is Glenn Erickson and I live in Fargo. I am 63 years old and have a long history of mental health issues, including major depression episodes were I have been hospitalized. I work at Hornbacher's at Osgood as a grocery bagger. They really like me there. I was just given another raise and now make $8.85 per hour. I love my job.
I receive services from Friendship through the Mental Health Extended Services program. My job coach helps me during my time in the drive-up and also to helps me remember things, like what items can go together and what can't. My supports help me from getting frustrated and going into a deep depression.
I get a lot of help from Hornbacher's and also from Friendship. They work together to make sure that I am doing what I need to do so I can keep my job and get raises. I really like my job coaches. They help me stay calm if I start to feel bad about myself and feel like the world would be better off without me. I can handle the little things better because of my supports.
I truly appreciate my services and want them to continue like they are now. My job gives me something to look forward to and to feel good about when everything else is going wrong.

Thank you,

Glenn Erickson
5300 12th Street S
Fargo, ND 58104

Glenn Erickson

HB 1012
January 27th, 2009
Human Resources Division of House Appropriations

To Whom It May Concern:

My name is Mary Reynolds. I am from District 21 in Fargo. I have been receiving services from Southeast Human Services and Friendship, Inc. since 2001. Since that time, I have worked a few different jobs. Now I have successfully settled in to two jobs that I love at 49 years old. In my younger years, I was a successful cosmetologist. Some circumstances came into my life and I began suffering from mental illness. The services I have received since then have helped me get back on my feet.

In the beginning, I had full supports and struggled. People have called me names at a job and I have been let go because of my illness. Friendship was able to help me pick up the pieces. Had I not had this support, I would not be so independent now.

I now work 58 hours a month and only have job coaching for a very minimal part of those hours. I was told I was going to lose my services because I did not meet the new requirement of working at least 50 hours a month. The things is, I had just gotten a new job doing home care for seniors and had not built up clients yet. The people at Southeast Human Services were not going to give me a chance to show that my hours were increasing until I got Protection and Advocacy involved. I cried and cried and had no clue as to what I was going to do. Fortunately in January, I did get clients and now I meet the new criteria. I found the way this whole thing was handled to be very inappropriate and hurtful. The director of Mental Health Extended Services has had me in going circles and has not followed through on the things we have discussed.

I still need to know that Friendship is backing me up. My self-esteem has grown, but I still have issues with my illness. I have been disabled since 1987. I am finally feeling like an "able" person. Please do not take these services away from us. There will be a lot of sick people if their work is taken from them. I hope you hear from other people in my same situation. I cannot be with you today because I have to work, but thank you for considering my story in your decisions.

Thank you for your time,

Mary Reynolds

Mary Reynolds
1545 4th Ave S
Fargo, ND 58103

Dear Mr. Chet Pollert, and members of the Committee:

Re: HB 1012 – Mental Extended Services

My name is Brenda Majerus, I am Director of Supported Employment / Extended Services at Friendship, Inc.

I am asking you to make additional dollars available for mental health extended services. This program provides funding for job coaching for people with severe mental health needs on community based jobs as well as re-employment dollars for those that have lost jobs. There are currently not enough dollars to fund this program. People with high job coaching needs or the job doesn't meet the criteria of the new program guidelines are being cut from the program or the job coaching needs will need to be cut to the lowest level possible which jeopardizes a person's employment. The goal according to the new guide lines would include the persons with severe mental health would eventually be able to leave the program leaving employers responsible for providing the job supports to individuals without taking into consideration that the persons mental illness is not going to go away and along with the mental illness the person may a have a cognitive disability, addition to drugs and alcohol or other conditions that may factor the need for on going support. As I understand it there are not enough dollars available for people who are receiving Vocational Rehabilitation Services that qualify for extended services to be referred for employment services because there are no extended service dollars available in mental health.

I feel that employment should be an option for every citizen that chooses to be employed in the job of his or her choice and that it is vital to a person's overall mental and physical health. When a person with a disability is earning a wage they feel better about themselves, they contribute to their community by earning a wage. SSI and SSDI payments are decreased, they are less dependent on food stamps and other government programs and are able to pay more of their rent. We see people employed taking their prescribed medications, which leads to better health, less hospitalizations, and fewer incarcerations, which saves taxpayer dollars.

I have worked in the human services field for a number of years. Because of the needs of people with a mental health diagnosis employers were not as willing to hire this population. Services providers have worked very hard to educate employers and create job opportunities for people with a mental health diagnosis. Please look at the benefits this program creates for Region V and the State of North Dakota and increase dollars so we can continue the provide people with quality job support services

Respectfully,

Brenda Majerus

Brenda Majerus, Director of Supported Employment / Extended Services

HB 1012
January 27th, 2009
Human Resources Division of House Appropriations

To Whom It May Concern:

My name is Suzanne Hanson. I live in District 21 in Fargo. I graduated with honors from North Dakota State University in 2007. I have a degree in political science and philosophy that I was planning on using to go to law school and most likely leave North Dakota. During college, I had been working as a job coach with Friendship, Inc. After graduation, I was offered a promotion and decided to stick with my current occupation. The pay is not what I might otherwise be making had I pursued my law degree, but the rewards are many. It is a wonderful experience to help someone in becoming gainfully employed. Work is such a defining and positive factor for many of us in our adult life, and persons with disabilities should have the same opportunity to have a positive community role.

Being born and raised in North Dakota, I know the value of good work ethics and self-sufficiency. I feel that those values and opportunities should be available to all. I find it very disheartening that a program that is in line with our state's values and gives people an opportunity to contribute is in jeopardy of being phased out for many people because of certain budget allocations.

I am encouraging you to ensure that the Department of Human Services has enough money for people with disabilities to receive Extended Services if they need them. This program is something that is positive for many parties—the person receiving supports, area businesses and our communities. We should not be cutting back this program, but finding ways to expand it to help people move from dependence to independence.

Thank you,

Suzanne Hanson

Suzanne Hanson
Employment Specialist
801 Page Drive
Fargo, ND 58103

HB 1012
January 27, 2009
Human Resources Division of House Appropriations

To Whom It May Concern:

My name is Jim Hoff. As a client of Friendship, I have been involved with the organization for roughly 6 & ½ years. I do lawn care and custodial work with very low intervention (job coaching). The rewards and support I receive have always matched my capabilities. Through my highs and lows, it's nice to know they are in my corner. It would be a shame to lose this footing or shake up the foundations of a good program through budget cuts.

Sincerely,
Jim Hoff

814 Oak Street #3
Fargo, ND 58102

January 22, 2009

RE: HB 1012 – Mental Health Extended Services

To Whom It May Concern,

My name is Matt Gregory and I am the Managing Partner of the Texas Roadhouse in Fargo, ND. I would like to encourage you to support additional funding for mental health extended services. This program provides job coaches to support people with severe mental health needs in community based jobs as well as re-employment dollars for those who have lost their jobs.

Our company has employed people with disabilities who receive supported employment services for the last 2 1/2 years. We feel that it has benefited our restaurant to have these employees work for us. They have proven to be reliable, trustworthy as well as friendly individuals.

Without supported employment services, it would be very difficult for our company to provide job supports at the level needed to help individuals with severe mental health needs be successful in their positions. The job coaches have helped them, not only to be on time, but to also understand their job requirements and to help enforce rules when necessary. They are trained well in how to deal with any issues that come up and to help the employee be happier in their job here as well.
I hope you will see the benefits of services that keep people successfully employed in their communities and support the additional funding needed for mental health extended services in HB 1012.

Respectfully,

Matt Gregory

Managing Partner
Texas Roadhouse
4971 13th Ave. S
Fargo, ND 58103
701-282-8290
FAX – 701-282-8591

January 23rd, 2009

RE: HB 1012 – Mental Health Extended Services

To Whom It May Concern:

My name is Bryce Weisser and I am the Manager at The Bottle Barn located at The Hub in Fargo. I would like to encourage you to support additional funding for Mental Health Extended Services. This program provides job coaches to support people with severe mental health needs in community based jobs as well as re-employment dollars for those who have lost their jobs.

Since my time as a manager at The Bottle Barn, I have employed two people who used the services at hand as cashiers and stockers. Although it has not always been perfect and sometimes I had to spend longer periods of time allowing for training, it has been a rewarding experience that I would encourage other employers to become involved in. I found my employees to be dedicated to their jobs and excited for the opportunity to work in a setting that was different than what they were used to.

Without supported employment services, it would have been difficult for our company to provide job supports at the level needed to help individuals with severe mental health needs be successful in their positions. It was helpful to have the job coaches be able to provide information and input to help our management team work better with our employees.
I hope you will see the benefits of services that keep people successfully employed in their communities and support the additional funding needed for mental health extended services in HB 1012.

Thank you,

Bryce Weisser
Manager
Bottle Barn Liquors
2525 9th Ave SW
Fargo, ND 58103
(701) 365-0840

HB 1012
January 27th, 2009
Human Resources Division of House Appropriations

To Whom It May Concern:

My name is Kim Fuss and I was the manager at Taco John's in Fargo for 23 years. During that time, I employed many individuals who had supports through Extended Services Mental Health. I found them to be very loyal employees who would suffer a great deal if they no longer had supports, such a job coaching. I feel to that if they were to lose their services, it would have a great impact on their self-confidence and ability to earn a paycheck for a job well done.

I would hate to see things go back to how they were in the past, when people with disabilities were shut out of society so no one could see them or hear them. For people to lose this progress and go back to wasting their skills and their life inside of four walls is not something we should ever see in North Dakota. I don't want to see that happen again—people deserve to be able to better themselves by working and earning paychecks in our communities.

It was wonderful to see the transformation of people who came to work for me who had disabilities. Often they were very shy and quiet when they first started and were able to become active and outgoing workers because of both their supports and our positive working environment. These are the opportunities we need to keep open for people. They are wonderful people to work with. I enjoyed it so much, that when I wanted a career change, I became a job coach myself.

I support making enough funds available to keep Mental Health Extended Services available to those people who need it.

Thank you for your time,

Kim Fuss

Kim Fuss
321 5th Ave W
West Fargo, ND 58078

January 22, 2009

RE: HB1012 – Mental Health Extended Services

To whom it may concern:

My name is Jason Westby I am the Manager of the Kelly Inn in Fargo, North Dakota. I would like to encourage you to support additional funding for mental health extended services. This program provides job coaches to support people with severe mental health needs in community based jobs as well as re-employment dollars for those who have lost their jobs.

Our company has employed people with disabilities who receive supported employment services for 14 years. We feel that this program is very important to the clients for their well being and to our company. They work very hard, do a great job, are very reliable, and our guests and employees enjoy their company as well. If there is a job that needs a lot of direction it is nice to know the job coaches are always there to help them along to make sure that we get a job well done.

Without supported employment services, it would be very difficult for our company to provide job supports at the level needed to help individuals with severe mental health needs to be successful in positions of employment. I feel job coaches are essential part of making work a success for individuals with mental health issues. For example Friendship has been employed with us for 14 years and it has been a great experience. I would hate to loose their services.

I hope you will see the benefits of services that keep people successfully employed in their communities and support the additional funding needed for mental health extended in HB – 1012.

Respectfully,

Jason Westby

Kelly Inn Main

January 22, 2009

RE: HB1012 – Mental Health Extended Services

To whom it may concern:

My name is Karan Devereaux and I am the Manager of the housekeeping department of The Kelly Inn in Fargo, North Dakota. I would like to encourage you to support additional funding for mental health extended services. This program provides job coaches to support people with severe mental health needs in community based jobs as well as re-employment dollars for those who have lost their jobs.

Our company has employed people with disabilities who receive supported employment services for 14 years. We feel that this program is very important to the clients for their well being and to our company. They work very hard, do a great job, are very reliable, and our guests and employees enjoy their company as well. If there is a job that needs a lot of direction it is nice to know the job coaches are always there to help them along to make sure that we get a job well done.

Without supported employment services, it would be very difficult for our company to provide job supports at the level needed to help individuals with severe mental health needs to be successful in positions of employment. I feel job coaches are essential part of making work a success for individuals with mental health issues. For example Friendship has been employed with us for 14 years and it has been a great experience. I would hate to loose their services.

I hope you will see the benefits of services that keep people successfully employed in their communities and support the additional funding needed for mental health extended in HB – 1012.

Respectfully,

Karan Devereaux

Karan Devereaux
Housekeeping Manager
Kelly Inn Main

January 22, 2009

RE: HB1012 – Mental Health Extended Services

To whom it may concern:

My name is Sasha Willette I am the Assistant Manager of the Housekeeping Department of the Kelly Inn in Fargo, North Dakota. I would like to encourage you to support additional funding for mental health extended services. This program provides job coaches to support people with severe mental health needs in community based jobs as well as re-employment dollars for those who have lost their jobs.

Our company has employed people with disabilities who receive supported employment services for 14 years. We feel that this program is very important to the clients for their well being and to our company. They work very hard, do a great job, are very reliable, and our guests and employees enjoy their company as well. If there is a job that needs a lot of direction it is nice to know the job coaches are always there to help them along to make sure that we get a job well done.

Without supported employment services, it would be very difficult for our company to provide job supports at the level needed to help individuals with severe mental health needs to be successful in positions of employment. I feel job coaches are essential part of making work a success for individuals with mental health issues. For example Friendship has been employed with us for 14 years and it has been a great experience. I would hate to loose their services.

I hope you will see the benefits of services that keep people successfully employed in their communities and support the additional funding needed for mental health extended in HB – 1012.

Respectfully,

Sasha Willette

Sasha Willette
Housekeeping Manager
Kelly Inn Main

January 21st, 2009

RE: HB 1012 – Mental Health Extended Services

To Whom It May Concern:

My name is Ryan Smith and I am the former Director of Operations for the Wendy's Restaurants in Fargo. I am writing this letter to show my support for the proposed funding increases for the extended services job support program.
I have worked with and employed people with disabilities who receive supported employment services for several years. We have worked with different area agencies to help people with disabilities learn job tasks and learn ways to increase job performance. The assistance from the job coaches has been invaluable in our fast-paced working environment. They are able to provide the extra support needed to help people remain in their positions and grow in their work skills.

I support services that keep people successfully employed in their communities and support the additional funding needed for mental health extended services in HB 1012.

Respectfully,

Ryan Smith
Fargo, ND
701-793-1477

HB 1012
January 27, 2009
Human Resources Division of House Appropriations

To Whom It May Concern:

My name is Crystal Farmer. I'm from District 21 in Fargo, ND. I'm here today to talk about increased funding for Mental Health Extended Services. This is a program that helps individuals maintain employment. This is my story.

When I first started to receive special services my confidence and self-esteem increased dramatically. I don't know what I would do without these services. The services have helped me change my attitude, my outlook on life, and achieve some of my goals. I currently have my own popcorn business, which has been very successful for me. I have help with doing the taxes because I still have trouble doing it myself.

Most likely if I lose my services, I would quit my job because I can't do this entirely on my own. I would no longer have extra money in case of an emergency. Overall this would lower my self- esteem, make me feel lonely, hopeless, useless, and bored. I wouldn't even want to go outside as often as I do now.

I don't want any of this to happen. I want to keep my job and independence growing, so one day I can have a career I love. Please, help our people who have a mental illness keep these services because we need them everyday, rain or shine, cloudy or sunny, no matter what time of the year it is, we need them now and we will need them in the near future.

Thank you for your time and consideration,

Crystal Farmer

Crystal A. Farmer
303 Roberts Street North #5
Fargo, ND 58102

Q2

HB 1012
January 27th, 2009
Human Resources Division of House Appropriations

To Whom It May Concern:

My name is James Baumgarter from District 21 in Fargo, ND. This is my story.

I had a really good job working at Quality Film Developing for 25 years. I was doing really good and felt good about my life. Then a woman came into my life who took advantage of me. I was crazy about her and went out of my way to do anything for her. She had a gambling problem. I lost so much. My retirement fund, my severance pay, a lot of my collectables, and even my weight went from 200 lbs to 160 lbs. I went into a deep depression and wanted to leave my life. I ended up in the hospital and got help. I got involved with Southeast Human Services and Vocational Rehabilitation. They helped me get my life back. Right now I have two good part-time jobs, The Avalon and John's Janitorial Service. Thanks to Friendship, Inc., I got those jobs. They helped learn my job tasks and still provide minimal supports to help with my anxiety. So I am doing all right thanks to Southeast and Friendship, Inc. I do not receive Social Security or housing assistance, so my job is very important to me.

There are a lot of people in need of help, so we have to keep these programs that helped me and so many going. I support increased funding for Mental Health Extended Services.

The thing is we have to help one another because if we don't what kind of a future will there be for mankind and womankind? So we all have to do our part. We have to help each other survive.

I thank you all for your time.

Sincerely,

James Baumgartner

James Baumgartner
26 Roberts Street #325
Fargo, ND 58102

HB 1012
January 27th, 2009
Human Resources Division of House Appropriations

To Whom It May Concern:

My name is Valerie Koivunen and I live in District 27 in Fargo. I would like to inform you of my support for increased funding for the Mental Health Extended Services program under HB1012. I am a job coach, but also a mother of a daughter who receives Extended Services for her mental health issues.

I would like to tell you about some of the people that I provide supports to. Not only do they need their jobs for income, but also for social interaction and community inclusion as well. Many of our people would suffer from isolation, loss of self-esteem and self-confidence if they did not have meaningful and constructive work. Extended Services keeps people with mental health problems out of the State Hospital, out of nursing homes and incarceration. This is because like the rest of us, their identity is tied to the work they do and the pride they have in earning a paycheck for a job well done.

On a personal level, I know my daughter would be insecure, angry and withdrawn without the employment supports she receives. She appreciates the interaction of her co-workers and the feedback from her job coach.

I appreciate your time and attention on this matter.

Thank you,

Valerie Koivunen

Valerie Koivunen
1103 43 ½ St SW #106
Fargo, ND 58103

Q4

Testimony on House Bill 1012
House Appropriations Committee, Chairman Chet Pollert
January 27th 2009
Submitted by Taylor Petermann

Chairman Pollert and members of the Committee, my name is Taylor Petermann. I live in Fargo and I am here today to ask for continued funding for the services that have been so beneficial for me as I've recovered from a serious mental illness.

I went from being in the State Hospital to being a productive member of society because of treatment and the services I have received in the community. The services that I think have been necessary are: case management and job coaching. My case manager helped me get into my own apartment and annually complete the forms needed to stay there. She helped me sign up for food stamps, the Workers With Disabilities Program, and a weekly medication distribution service - just to name a few things she has helped me with.

I have also benefited greatly by having a job coach who has patiently taught me my job and who has always been there when I had a question. A year and ½ ago I didn't think I'd be able to work more than 2 hours per day. But today I get up early 5 days a week, jump on the bus, and work for 5 or more hours. My skills and confidence have improved and having a Job Coach has made this possible. It's critical that people like myself keep these services to ensure that they can hold their jobs in the community. Without these services they may not be able to hold jobs and may become unproductive.

Thank you, Chairman Pollert and committee members for listening to my testimony.

HB 1012
January 27, 2009
Human Resources Division of House Appropriations

Chairman Pollert and members of the Committee, my name is Katie Storm. I am from Friendship Inc. I am one of their clients. I am here today to talk about Extended Services for people with mental illness. This is a program that helps individuals maintain employment. Because the Department of Human Services does not have sufficient funds in their budget, they are changing the eligibility criteria for Extended Services. This is forcing some clients out of this program. I am one of them. Here is my story.

I am proud to be associated with Friendship Inc. I am grateful that everyone there has been willing to work with me, when I have been at my best and my worst. They have helped me to help myself realize my potential in the work place and to make friends. When I first started with Friendship about three years ago, I was lacking many of the skills that are necessary to hold down a job and properly interact with my coworkers. I was given the opportunity to work at many different job sites and have one-on-one support from Suzanne.

To me it was especially Suzanne's willingness to find time; to teach me one-on-one made the biggest different for me. She made sure that I learned the proper way to approach people in a work environment and even helped me to fill out some practice job applications. It was also while I was working with her that I filled out an application to work at Wal-Mart. I am currently starting my second year as a Wal-Mart employee and I have the good people at Friendship to thank.

I value this program and would see it as a disservice to the disabled community and every one at Friendship Inc, if funding was cut for the program. After all everyone at Friendship Inc, has been working hard so that their clients can enjoy the dignity and satisfaction of participating in the work force.

I am asking that you ensure that the Department of Human Services has enough money for people with disabilities to receive Extended Services if they need them. Also, the Department of Human Services should not be able to change who is eligible for services without a formal change in rules that requires public comment.

Thank you for your time and consideration. I will be glad to answer any questions.

HB 1012
January 27, 2009
Human Resources Division of House Appropriations

Chairman Pollert and members of the Committee, my name is Paula Storm. I am from Friendship Inc. I am the parent of one of their clients. I am here today to talk about Extended Services for people with mental illness. This is a program that helps individuals maintain employment. Because the Department of Human Services does not have sufficient funds in their budget, they are changing the eligibility criteria for Extended Services. This is forcing some clients out of this program. I am one of them. Here is my story.

My daughter Katie has a learning disability which affects her Written Language skills, Math skills, and ability to process and integrate information. She has difficulty adjusting from old to new situations, developing social judgment skills and learning to read nonverbal cues in social situations. In complex situations, like learning to drive a car, where lots of visual information must be processed quickly to make a decision, she becomes overwhelmed by her inability to rapidly integrate the constantly changing visual cues with the skills of controlling the car. She does not drive a car. Katie attended college for several years and did not graduate with a degree. As the subject matter became more complex, Katie began to have problems with attending class, work completion, anger, and depression. After college we were at a loss for what was next. Katie was unhappy, unemployable, angry, and disruptive to her family. My husband and I were left with a sense of failure and frustration with ourselves and Katie, and with an education system that does not teach to the needs of the student to prepare them for a future but rather teaches to the mandates that the government requires.

We were at a loss until one day I was at the local Hornbachers store and noticed a young person getting coached on filling my grocery bags, and the light bulb went on. My daughter needed the same thing, that extra crutch to solve a problem at work and learn the social skills of the work environment. Through her counselor at Southeast Human Services, we were referred to Friendship Inc. The dedicated staff and the services provided at Friendship have turned our daughter's life around and that of our entire family. Through the on-the-job work skill training program and job coaching support, she has been able to apply for, successfully acquire and maintain employment. In addition, Friendship Inc. has helped us work out transportation to and from her two jobs using Mat Para Transit of the FM area.

Katie's continued employment and positive job performance relies on the continued support of having a job coach. To eliminate a service that is clearly working is foolish. The support provided by her job coaches has allowed Katie to be productive, as an employed wage earner and taxpayer. There are obvious positive benefits to society, in addition to the positive sense of self worth that comes from being employed and working toward independence.

Further, in the Fargo Forum Sunday January 25th edition in an article entitled "Nonprofits Bend Dorgan's Ear" Senator Dorgan was talking about a stimulus package that Congress hopes to soon pass, to pay for ready-to-go projects. Job coaching is not only ready-to-go it is working and needs to continue.

It would be of huge benefit to parents and students with learning problems to assign them a career counselor/case manager separate from the High school Counselors. A Counselor who has the knowledge and access to services available and who would be assigned to work with the student and family through this transitional period from High School, to work training, to employment and finally to independent living. A High School counselor who is working with the college bound does not have the time to help and follow these young adults. Nor do the special education teachers and staff who are over burdened with responsibilities of teaching them skills to pass tests.) In its simplest terms dot the necessary I's and cross the T's that provide the dollars for the school to meet the current Federal Requirements.

I am asking that you ensure that the Department of Human Services has enough money for people with disabilities to receive Extended Services if they need them. Also, the Department of Human Services should not be able to change who is eligible for services without a formal change in rules that requires public comment.

Thank you for your time and consideration. I will be glad to answer any questions.

Paula Storm
4901 Meadow Creek Dr. SW
Fargo, North Dakota 58104

Q7

Hi, Mr. Chairman and committee members, my name is Gail Eickstadt,

I worked independently for eight years at the Fargo Country Club as a dishwasher. I had to quit this job because I was unable sleep and was having a lot of seizures. My Case Manager referred me to Vocational Rehabilitation for supported employment services. I started working with Friendship, Inc. I went through a time when I was not eating well and not taking my meds this led to increased seizure activity and job loss

I have had many jobs and volunteer opportunities over the years. I was also let go from volunteer sites because I didn't have the support of my job coach to assist me with learning job tasks.

These past few years with Job Coach supports have been very successful for me. I am working at Texas Road House and CHI. I love my jobs! I want my coaching to continue. I like earning money and feel good about myself.

Last spring I received the APSE "Best of the Best Award" This was an Honor for me. My name was drawn and I won a trip to the National APSE " The Net work on Employment" Conference in Louisville Kentucky! This trip would of not been possible for me if my Employment Specialist did not accompany me on this trip I had a wonderful time at the conference.

Thank you for your time,

Gail Eickstadt

Gail Eickstadt

NORTH DAKOTA

Governor's Prevention Advisory Council on Drugs and Alcohol

2008

advisory council members

- First Lady Mikey Hoeven
- JoAnne Hoesel, Program and Policy Director, North Dakota Department of Human Services
- Ryan Bernstein, Policy Advisor, North Dakota Office of the Governor
- Representative Ron Carlisle
- Senator Larry J. Robinson
- Dr. Terry Dwelle, State Health Officer, North Dakota Department of Health
- Lee Erickson, State Coordinator, Students Against Destructive Decisions (SADD)
- William G. Goetz, Chancellor, North Dakota University System
- Cheryl Kulas, Executive Director, North Dakota Indian Affairs Commission
- Officer Perry L. Lauer, Bismarck Police Department
- Colonel Mark Nelson, Superintendent, North Dakota Highway Patrol
- Carol K. Olson, Executive Director, North Dakota Department of Human Services
- Dr. Wayne G. Sanstead, State Superintendent, Department of Public Instruction
- Francis G. Ziegler, Director, North Dakota Department of Transportation
- Mike Edwards , Executive Director, North Dakota Teen Challenge

With assistance from:

- Linda Butts, Deputy Director, Driver and Vehicle Services, North Dakota Department of Transportation – Francis Zeigler designee
- Valerie Fischer, Director of School Health, North Dakota Department of Public Instruction – Dr. Wayne G. Sanstead designee
- Dr. Karin Walton, Director, North Dakota Higher Education Consortium for Substance Abuse Prevention – William Goetz designee

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road map

July 1, 2007 – June 30, 2009

I. Executive Summary

The Governor's Prevention Advisory Council on Drugs and Alcohol was established by Executive Order 2007-03 (Appendix A) under Governor John Hoeven. The Council was created to coordinate knowledge and resources that will result in evidence based alcohol and drug abuse prevention strategies. Successful implementation of these strategies will reduce, postpone, or eliminate alcohol and drug related destructive behaviors and their consequences to individuals, families and communities.

The Council is comprised of North Dakota First Lady Mikey Hoeven, two legal representatives, two advocacy group representatives, an addiction counselor, the Chancellor of Higher Education, a non-voting member from the Governor's Office, two members of the North Dakota Legislative Assembly, the Executive Director of the North Dakota Department of Human Services, the Director of the North Dakota Department of Health and the Director of the North Dakota Department of Transportation. The Executive Order directs the Council to:

- Explore the interrelationship between substance abuse prevention, education, and enforcement programs.
- Address traffic safety issues including driving under the influence of drugs and/or alcohol.
- Develop prevention policies that promote safe, stable families and communities.
- Develop a plan to access additional funding.
- Organize under the Governor for the purpose of receiving and distributing any appropriations and other funding sources.

North Dakota Senate Bill No. 2276 was passed on January 3, 2007, providing duties to the Council along with a continuing appropriation of funds. An amount of $100,000 was appropriated for the biennium beginning July 1, 2007, and ending June 30, 2009. The bill also allows for the Council to accept grants and gifts of any money, property, or service from any public or private source.

Council activity to-date includes the following activities:

- Gathering and analysis of state data of key indicators for high risk populations and specific areas of need for intervention activities.
- Determining the target audience for the initial round of Council prevention activities (grades K-6 and parents).
- Review of the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs and Practices for alcohol and drug interventions.
- Initiation of a grant request process, and subsequent award of grants to five eligible programs for a total of $94,326.85.
- Creation of a state program matrix (Appendix B) to facilitate a gap analysis that will allow the Council to recommend collaboration opportunities and avoid duplication of services.

This roadmap will outline initial activities that the Council will facilitate at local, state and federal levels to create and support initiatives for a positive change.

II. Background

Data Analysis: Since its inception, the Council has devoted considerable efforts to the analysis of data that will provide insight into key indicators of high risk populations and specific areas of need for prevention efforts. Two major sources of this data were the Youth Risk Behavior Survey (YRBS) (Appendix C, Summary) and the North Dakota State Epidemiology Outcome Workgroup (SEOW) (Appendix D, Executive Summary). Another major source of data was the Community Readiness Survey to Gauge Perceptions of Alcohol and Other Drug Use (Appendix E, Executive Summary) funded and prepared for the North Dakota Department of Human Services, Division of Mental Health and Substance Abuse Services. The survey was conducted in the spring of 2008 and sent to 14,400 households and 1,725 key informants to measure perceptions about alcohol and drug use and current prevention efforts.

The State Epidemiological Outcome Workgroup (SEOW) was initiated in 2006 through efforts of the North Dakota Department of Human Services (ND DHS) and was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The SEOW used North Dakota and national data sources to compile the profile. Among the data sources was the Youth Risk Behavior Survey (YRBS), which has generated weighted data since 1991. In 2007, the High School YRBS was completed by 9,750 students from 104 schools, and the Middle School Survey by 6,745 students from 110 middle schools. The data showed that for persons aged 12 to 20 years, North Dakota was ranked number one among U.S. states in binge drinking. Another of the SEOW's sources, the National Survey of Drug Use and Health (Office of Applied Studies (OAS) 2007) estimated that almost one-third (31.5 percent) of North Dakotans aged 12 years and older had binged on alcohol on one or more occasion in the past 30 days. Binge drinking rates have risen markedly among middle school respondents according to the YRBS. A 2006 study by SAMHSA suggested a strong connection between the onset age of drinking and the likelihood of becoming a chronic user.

Target Audience: In order to reach out to population segments that may not be the focus of existing studies, the Council decided to focus their primary efforts on students in grades K-6 and their parents. The North Dakota Epidemiological Profile (NDEP) of March 2007 suggested that there was a "generational concept" of alcohol use in the state. The demonstrated high rates of alcohol use and binging among all age groups support this theory. Members of the Council chose to target the youth and their parents in all prevention efforts to promote a change in the cultural behaviors that contribute to the high risk factors found in our state's youth.

The 2007 NDEP also stated that North Dakota had the highest rates in the nation for alcohol use and abuse (National Survey on Drug Use and Health (NSDUH), 2004; Behavioral Risk Factor Surveillance System (BRFSS), 2005). In order for communication strategies to be effective in youth, adults must be invested in supporting prevention efforts through their own behaviors. Results of the Community Readiness Survey sent to 14,400 adults in April of 2008 will help the Council identify how prepared adults are to take action against destructive behaviors in their communities. Prevention specialists and community members will have access to information from the survey that will allow them to target strategies to specific cultural behaviors in their local areas.

July 1, 2007 – June 30, 2009

III. Council Activity

Identify Best Practices and the Grant Process: A Request For Proposal (RFP) was posted by the Council on May 30, 2008. Eligible organizations were invited to apply for grant money to fund innovative projects discouraging alcohol and drug abuse in the targeted audience identified by the Council (students grades K-6 and their parents). Applicants were encouraged to submit initiatives based on the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs. However, the Council recognized the potential impact of innovative projects that may not be within the SAMHSA directory. For non SAMHSA based applications the Council chose to use National Academy of Science's Features of Positive Development Settings criteria for the analysis of the project. Those criteria were:

- Physical and psychological safety
- Appropriate structure
- Supportive relationships
- Opportunities to belong
- Positive social norms
- Support of efficacy and mattering
- Opportunities for skill building
- Integration of family, school and community efforts

A pre-proposal technical conference was held two-weeks prior to the proposal deadline of June 30, 2008.

Pursuant to Council review and decision, awards were announced on August 20, 2008 for the following organizations:

- Northern Lights Youth Services, Inc., Hillsboro;
- West Dakota Parent and Family Resource Center, Dickinson;
- United Tribes Technical College, Bismarck;
- Casselton Youth Task Force, Casselton;
- Sunrise Youth Bureau, Dickinson

A sixth applicant withdrew during the review process due to a staffing shortage. A decision was made by the Council to contact the applicant for a possible award to be made with remaining Council funds. Safe Communities Coalition (Altru Health Systems) was ultimately funded.

The Department of Human Services agreed to handle the grant monitoring and administration.

July 1, 2007 – June 30, 2009

III. Council Activity

Assessment of Gaps in Prevention Efforts: It is a primary goal of the Council to support activities that enhance current offerings to leverage efforts by working collaboratively to effectively reach goals.

A gap analysis of programs and services being offered in the state is being done with the help of information provided by state agencies about their prevention activities. Programs and services were put into a matrix that allowed the Council opportunity for analysis of each program as well as an evaluation of the coverage provided to each region, age group and access point (home, school or community).

To further identify the existence of gaps in resources, a survey of individuals from various sectors and disciplines will be undertaken to gather information "from the field". Results of these surveys will provide valuable direction about the needs identified at the grass roots level. Contacts are being made with alcohol distributors and hospitality associations as well as intervention programs like Students Against Destructive Decisions (SADD) to assess resources and initiatives already in place.

By establishing a clear picture of both the resources and the needs at the local and state level the Council feels they can be most effective. By providing grant funding, and coordinating knowledge and resources between entities, the Council can encourage innovative solutions and collaborations that will most efficiently produce results.

Assist with Communities' Involvement in Prevention Outreach: Grant recipients from this year's cycle are required to present a report to the Council one year from the project award date. Promotion of successful projects to other state and local entities is one way the Council intends to encourage participation and grow the pool of organizations involved in prevention efforts.

Support State Efforts to Increase Prevention Efforts: The North Dakota Department of Human Services applied for the Strategic Prevention Framework State Incentive Grant (SPFSIG) through SAMHSA. The application is for a 5 year grant funded annually at up to 2.3 million dollars. The goal of the grant is to build statewide infrastructure. Eighty-five percent (85%) of the funding must flow through to the community level. The Council will serve as the Advisory Council for the SPFSIG.

July 1, 2007 – June 30, 2009

IV. Initial Recommendations for Future Activities

Goal: Lead a multi-system prevention effort to advance and coordinate knowledge of healthful behaviors and decisions that reduce, postpone and eliminate the problems resulting from a destructive decision.

Objectives:

- Design a Council infrastructure that will allow the Council to lead a sustaining multi-system prevention effort
- Explore the interrelationship between substance abuse prevention, education and enforcement programs
- Access additional funding for statewide prevention efforts
- Design a mechanism to receive and distribute prevention funds to regional and community levels.

Goal: Build a highly effective collaboration network of federal, state and local ideas and resources.

Objectives:

- Evaluate current North Dakota program matrix for regional or age gaps
- Conduct a public health mid-management survey to identify prevention and intervention programs and gaps in services
- Collect information from alcohol distributors and hospitality associations on current initiatives, outcomes and additional resources
- Obtain input from Students Against Destructive Decisions (SADD) or other intervention programs on successful strategies and resources available for future initiatives
- Gather information from partners about risk behaviors that are not being addressed by current programs

Goal: Identify opportunities to leverage funding that will create a sustaining and effective resource base for prevention and intervention efforts.

Objectives:

- Explore opportunities to partner with private sector companies or corporations
- Research federal grant opportunities
- Identify possible collaboration for funding between the Council and community organizations

IV. Initial Recommendations for Future Activities

Goal: Implement key communication strategies.

Objectives:

› Firmly establish, with the authority of the Governor's Office, that North Dakota is a Zero Tolerance state
- Clearly communicate to all segments of the population what the Zero Tolerance Law means (persons under the age of 21 operating a vehicle with a .02 percent blood-alcohol level or over are subject to DUI penalties)
- Encourage the Department of Labor and employers to promote the law among employees

› Address the seriousness of the behaviors documented by statistics
- Communicate statistics from YRBS and SEOW that indicate higher than average number of drinkers and bingers of all ages in North Dakota
- Highlight the connection between onset age of drinking and later addiction
- Remind ND citizens of the numbers of deaths and serious injuries caused by alcohol or drug related vehicle crashes

› Make the problem real to parents, curb enabling behavior and denial
- Change the culture of acceptance and permissiveness
- Encourage modeling appropriate attitudes towards drinking
- Provide skill building, real-life strategies

› Create individual and societal awareness about the cost of alcohol/drug abuse
- Educate on the effects of alcohol on the adolescent brain

› Work with community members in localizing messages to be more effective and relevant to their particular target audience
- Spheres of influence within communities, speaking opportunities, press releases, local talk show appearances, public service announcements, media kits

Appendices:

› Appendix A: Governor's Executive Order

› Appendix B: Funding Matrix

› Appendix C: Youth Risk Behavior Survey (YRBS)

› Appendix D: North Dakota State Epidemiology Outcome Workshop (SEOW) Executive Summary

› Appendix E: Community Readiness Survey to Gauge Perceptions of Alcohol and Other Drug Use - Executive Summary

State of
North Dakota
Office of the Governor

John Hoeven
Governor

Appendix A: Click here to view full document.

Executive Order 2007-03

Governor's Prevention Advisory Council on Drugs and Alcohol

WHEREAS, the Governor's Prevention Advisory Council on Drugs and Alcohol recognizes that preventative behavior reduces adverse personal, social, health, and economic consequences resulting from destructive decisions and that prevention fosters safe and healthy environments for individuals, families, and communities; and

WHEREAS, the Council will advance and coordinate knowledge, resulting in the adoption of policy-based prevention strategies and prevention innovations and will share knowledge of healthful behaviors and decisions that reduce, postpone, or eliminate the problems resulting from destructive decisions; and

WHEREAS, the Council will lead a multi-system prevention effort, drawing upon the resources and talents of those at the community, state and federal levels.

NOW, THEREFORE, I John Hoeven, by the authority invested in me as Governor of the State of North Dakota, do hereby create the Governor's Prevention Advisory Council on Drugs and Alcohol, and order and direct the following:

I. Establish the Governor's Prevention Advisory Council on Drugs and Alcohol, appointed by the Governor, consisting of the following members, who serve at the pleasure of the Governor;

- North Dakota First Lady
- 2 Legal Representatives (County Sheriff or Local Police, Highway Patrol, States Attorney, Defense Attorney)
- 2 Advocacy Group Representatives (Teen Challenge and SADD)
- An Addiction Counselor
- Chancellor of Higher Education, or designee
- A non-voting member from the Governor's Office Two members of the North Dakota Legislative Assembly
- Executive Director of the North Dakota Department of Human Services, or designee
- State Health Director, or designee
- Director of Department of Transportation, or designee

600 E Boulevard Ave
Bismarck, ND 58505-0001
Phone: 701.328.2200
Fax: 701.328.2205
www.nd.gov

- Director of the Department of Public Instruction, or designee
- Director of Indian Affairs, or designee

II. The council will make recommendations to the Governor for purpose of improving the delivery of prevention services that reduce problems resulting from destructive decisions.

III. The council shall a) explore the interrelationship between substance abuse prevention, education, and enforcement programs; b) address traffic safety issues including driving under the influence of drugs and/or alcohol; and c) develop prevention policies that promote safe, stable families and communities; and d) develop a plan to access additional funding; and e) be organized under the Governor for the purpose of receiving and distributing any appropriations and other fund sources.

It is further ordered the Governor's Committee on DUI and Traffic Safety, Executive Order 1993-10, be rescinded and dissolved immediately.

The Governor is vested with the executive authority to issue this Order pursuant to Article V, Section 1 of the North Dakota Constitution.

This executive Order is effective immediately and will continue until further order of the Governor.

Executed in Bismarck, North Dakota, this 9th day of May, 2007.

John Hoeven
Governor

ATTEST:

Secretary of State

Deputy

State Department Source	Name of Program	Contractor(s), Service Provider, or Agency *Who Provides the Service?*	Program Description *1. What does it do?* *2. Whom does it serve?* *3. What is the desired outcome?*	Geographic Region Served	Approximate Annual Funding			Age Group/Location Impacted									
					Federal	State	Special (Fees, etc.)	0-5	6-9	10-12	13-15	16-18	19-22	23-26	27+	School	Home	Comm
NDDOT	*Drunk Driving. Over the Limit. Under Arrest.* High-Visibility Enforcement (HVE) Campaign	Participating law enforcement agencies	1. High Visibility Enforcement is a proven method of deterring impaired driving through targeted, intense distribution of the "Drunk Driving. Over the Limit. Under Arrest." message through TV, radio and billboard ads coupled with overtime enforcement by law enforcement. 2. All residents of North Dakota. 3. To decrease the number of individuals who drive impaired.	Statewide	$ 250,000.00													
NDDOT	Social-norming media campaigns	NDDOT	1. Social-norming messages such as "Buzzed Driving is Drunk Driving." 2. These messages are directed at all citizens through various media including TV, radio, email, social media venues (blogs, websites, etc.), billboards, newspaper, magazines, etc. 3. To change the social perception of drinking and driving by educating the public on the dangers and risks.	Statewide	$ 225,000.00													
NDDOT and some programs are self-sustaining through income generated through the program	Responsible Beverage Server Training	Server training is conducted through Safe Communities Programs and/or local law enforcement agencies	1. Attempts to change the drinking environment through education/behavior change of those selling and serving alcohol. 2. Informs servers and owners of alcohol establishments of the state laws that prohibit alcohol sales to minors and obviously intoxicated persons. 3. To decrease the violation of laws related to alcohol sales to minors and obviously intoxicated persons and to reduce the risk of impaired driving by those who are underage or intoxicated. And to assist alcohol establisments to develop and implement policies, train management, and train the servers on these issues.	- Grand Forks - Fargo - Jamestown - Bismarck - Dickinson - Williston - Minot - Barnes County - Cass County - Traill County	$ 25,000.00													
NDDOT	Traffic Safety Resource Prosecutor (TSRP)	North Dakota Association of Counties (Attorney Aaron Birst)	1. Provides training, technical assistance and resources to law enforcement, prosecutors, judges and other court personnel. 2. The TSRP serves the NDDOT, law enforcement, prosecutors, and judges. 3. To assure appropriate prosecution and adjudication of impaired driving offenders.		$ 100,000.00													
NDDOT	Parents LEAD *(Listen, Educate and Discuss Alcohol With Your Kids)*	NDDOT	1. Provides education to parents about the dangers and consequences of underage drinking and the importance of discussing underage use and overconsumption with their children. The program uses a website, a spokeswoman whose son died of overconsumption, and unique message distribution methods. 2. Parents and youth/young adults. 3. Skilled parental intervention to deter underage drinking and overconsumption.	Statewide	$50,000													

State Department Source	Name of Program	Contractor(s), Service Provider, or Agency *Who Provides the Service?*	Program Description *1. What does it do?* *2. Whom does it serve?* *3. What is the desired outcome?*	Geographic Region Served	Approximate Annual Funding			Age Group/Location Impacted									
					Federal	State	Special *(Fees, etc.)*	0-5	6-9	10-12	13-15	16-18	19-22	23-26	27+	School	Home	Comm
NDDOT and some programs are self-sustaining through income generated through the program	Victim Impact Panels	Safe Communities programs	1. Victims of impaired driving crashes tell their stories to offenders describing the impact the event had on their lives and the lives of their families. 2. DUI offenders. 3. The goal is to reduce recidivism and to give the victims an opportunity to share their stories in a meaningful way.	- Richland County - Fargo - Bismarck - Dickinson - Williston	$5,000													
NDDOT	Club NDSU	NDDOT funding. Program conducted by NDSU and Safe Communities	1. Provides activities for NDSU students with free non-alcoholic beverages during scheduled weekend events. Students swipe a magnetic-stripped card with each non-alcoholic drink they consume and they are emailed an educational item the next day informing them what their blood alcohol would have been had the drinks contained alcohol. 2. College/university students. 3. Provide education related to alcohol impairment to deter impaired driving.	NDSU Campus	$5,000													
NDDPI	Title IV - Safe & Drug Free Schools and Communities	ND Dept of Public Instruction	1. Prevent violence in and around schools; prevent the illegal use of alcohol, tobacco, and drugs. 2. Involve parents and communities; and, 3. Are coordinated with related efforts and resources to foster a safe and drug free learning environment that promotes student acheivement.	Statewide	$ 1,300,000.00													
NDUS	North Dakota Higher Education Consortium for Substance Abuse Prevention (NDHECSAP)	North Dakota University System	1.To provide campuses with skills, attitudes, abilities, & knowledge that will enable them to address collegiate alcohol/substance abuse. To provide an environment in which students will be given the opportunity to take full advantage of their university experience and to lead productive & satisfying lives. The NDHECSAP advocates for stronger prevention policies, collaborates in campus-community partnerships, and assists members of the NDHECSAP to develop evidence-based prevention programs. A key feature of the NDHECSAP's work is the promotion of prevention strategies that affect the campus environment as a whole and have a large-scale impact on the entire campus community. This includes research in the area of college drinking and other drug use behaviors, attitudes, and perceptions. 2. Stakeholders: North Dakota students. Strategic Plan identifies establishing relationships and partnerships with other stakeholders (communities, state agencies, and diverse populations) to establish protocols within and between campuses and communities supporting positive prevention efforts for all North Dakotans. 3. Reduce risk factors and increase protective factors to positively influence behavior related to substance abuse in North Dakota college students. Create campus communities where policies, practices, and programs promote student safety and success.	Statewide		$ 100,775.00													

State Department Source	Name of Program	Contractor(s), Service Provider, or Agency *Who Provides the Service?*	Program Description *1. What does it do?* *2. Whom does it serve?* *3. What is the desired outcome?*	Geographic Region Served	Approximate Annual Funding			Age Group/Location Impacted										
					Federal	State	Special *(Fees, etc.)*	0-5	6-9	10-12	13-15	16-18	19-22	23-26	27+	School	Home	Comm
DHS	Outreach Coordinator Position *(funding cut as of June 30, 2009)*	SAPT Block Grant allocated through the Division of Mental Health and Substance Abuse Prevention Services to North Dakota University System.	1. Higher Education Outreach Coordinator position serves as a liaison to the campuses and a resource for local campus work, assists campuses in the implementation of environmental management strategies, the identification of evidence-based programs, and the evaluation of campus program effectiveness. Assists campuses in the development of a campus task force and action plans for campus task force work, including policy development and review. Participates in community coalition meetings and connection to the comunity. 2. Stakeholders: North Dakota students. 3. Higher Education statewide initiative to support local campus work and due to the diversity of the campuses the ORC will be the contact to assist each campus individually to identify campus programs and best practices implementation appropriate to each campus vision. At the campus level, time and resources are limited and inconsistent. Only 2 out of 11 NDUS campuses have identified staff and often are strained beyond primary responsibilities and with limited resources available for prevention efforts. The Outreach Coordinator fills this gap.	Statewide	$ 65,000.00												
DHS	*"Let's Keep Our Kids Alcohol Free"* *Campaign by the Office of the First Lady*	ND Highway Patrol	1. The campaign is designed to increase awareness about the problem of underage drinking across the state of North Dakota and to encourage children to say no to underage drinking. 2. The campaign is targeted to the parents across the state in an effort to encourage them to talk to their children on an on-going basis about the dangers of underage drinking. 3. To decrease the incidence of underage drinking across the state of North Dakota.	Statewide	$ 30,000.00												
	Alive at 25	North Dakota Safety Council *(ND Highway Patrol provides instructors to the NDSC for no charge.)*	1. Provides young drivers a foundation to make safe decisions while operating a motor vehicle. 2. Drivers age 14-24. 3. Reduce serious injury and fatal crashes through education.	Statewide	$ 7,500.00		*Funding is also provided from participant fees.*											
DHS	Safe & Drug Free Schools and Communities *(Governor's Portion)*	Community Readiness Survey *Minot State University*	1.Baseline Assessment for all regions in ND - completed in Fall of 2008. 2. 09-11 biennium will fund community-focused best practice programs-statewide using the community readiness survey results. 3. Tribal Survey development in process.	Statewide	$ 284,670.00													

State Department Source	Name of Program	Contractor(s); Service Provider, or Agency *Who Provides the Service?*	Program Description *1. What does it do?* *2. Whom does it serve?* *3. What is the desired outcome?*	Geographic Region Served	Approximate Annual Funding			Age Group/Location Impacted									
					Federal	State	Special *(Fees, etc.)*	0-5	6-9	10-12	13-15	16-18	19-22	23-26	27+	School	Home	Comm
DHS	Regional/Tribal Prevention Coordinators	Regional coordinators are based out of local non-profits such as Community Action Partnership or Dakota Medical Foundation. Tribal are based out of the tribe or tribal Boys and Girls Clubs.	1. Twelve coordinators provide community prevention efforts throughout their regions/tribal areas. 2. They assist coalitions and assist in coalition development.	Statewide	$ 780,000.00													
DHS	Prevention Resource Center	PRC is a clearinghouse and library located in the Division of Mental Health & Substance Abuse.	1. The PRC provides free materials and resources regarding substance abuse prevention and mental health topics. 2. Provide clearinghouse materials throughout the state and per request. 3. Substance abuse library including books, videos, media and learning kits, prevention materials and tools.	Statewide	$ 130,000.00													
DOH	Community Health Grant Program: *To youth groups through local public health*	Local public health units/schools	1. Preventative health services in schools and communities with an emphasis on tobacco control. 2. Serves the entire state. 3. Education and policy changes regarding the dangers of tobacco use.	Statewide	$ 3,760,000.00													
DHS	Enforcement of Underage Drinking Laws (EUDL)	Highway Patrol & Local Law Enforcement	1. Compliance checks, shoulder taps, point of purchase operations, and party patrols. Server Law campaign for spring 2009 in collaboration with Attorney General's office. 2. Safety and education - prevention messages and media. 3. Overtime hours for officers in order to do the above listed activities. Youth advisory council activities.	Statewide	$ 175,000.00													
DOH	Statewide tobacco cessation for primary prevention including city/county/state programs and the Quitline	Contractors, UND School of Medicine, Mayo Clinic, BC/BS of ND, NDPERS, and various local public health units	1. Provides cessation services to those that want to quit using tobacco. 2. Quitline serves all citizens of North Dakota, city/county/state programs are specific to those employees. 3. Cessation from tobacco products.	Statewide			$ 1,069,000.00											
DOH	Tobacco prevention and control for Centers for Disease Control and Prevention (CDC)	Local public health units, tribal agencies, and various other contractors	1. Overall, tobacco prevention and cessation for the state of North Dakota. 2. All residents of North Dakota. 3. Education, policy, and cessation related to tobacco prevention.	Statewide	$ 2,540,260.00													

State Department Source	Name of Program	Contractor(s), Service Provider, or Agency *Who Provides the Service?*	Program Description *1. What does it do?* *2. Whom does it serve?* *3. What is the desired outcome?*	Geographic Region Served	Approximate Annual Funding			Age Group/Location Impacted									
					Federal	State	Special *(Fees, etc.)*	0-5	6-9	10-12	13-15	16-18	19-22	23-26	27+	School	Home	Comm
Governor's Office	"Guiding Good Choices" "Project Alert"	Casselton Youth Task Force	Implementation of "Guiding Good Choices" to parents of children in grades 4th through 8th and "Project Alert" utilizing teen leaders for students in grades 6th and 7th. There programs are listed on the SAMHSA National Registry of Evidence-Based programs and practices.	Casselton		$ 6,852.85												
Governor's Office	"Circle of Youth Dream Catcher"	United Tribes Technical College	"Circle of Youth Dream Catcher" is implemented at Theodore Jamerson Elementary School at United Tribes Technical College and is geared toward 4th through 6th grades. The project's objectives are to provide youth with prevention based topics infused with Native American culture, to provide prevention based activities, and provide youth and their parents community prevention strategies.	United Tribes Technical College		$ 8,500.00												
Governor's Office	"Reality Check"	Northern Lights Youth Services, Inc.	The "Reality Check" program trains 120 high school students to provide prevention lessons to 1,500 elementary students. "Reality Check" uses positive role modeling activities of high school students with information on alcohol, tobacco, and other drug use prevention strategies.	Hillsboro		$ 58,390.00												
Governor's Office	"Project Northland" "Slick Tracy Home Team Program" "Incredible Years"	West Dakota Parent and Family Resource Center	Implementation of "Project Northland" for 6th graders and their parents, "Slick Tracy Home Team Program" for 6th graders and their parents to discuss alcohol related issues, and the "Incredible Years" which is a parenting education program for the project. These are also listed on the SAMHSA National Registry of Evidence-Based programs and practices.	Dickinson		$ 15,011.00												
Governor's Office	"About Protecting You/Protecting Me"	Sunrise Youth Bureau	The program is geared toward children in grades 1st through 5th and reaches children before they have fully shaped their attitudes and opinions about alcohol use by youth and their role in preventing it. This program is listed on the SAMHSA National Registry of Evidence-Based programs and practices.	Dickinson		$ 5,573.00												
Governor's Office	"Keep a Clear Mind"	Safe Communities Coalition	"Keep a Clear Mind" is a drug education program for elementary school children and their parents. The program is listed on the SAMHSA National Registry of Evidence-Based programs and practices.	Grand Forks		$ 4,718.00												
					$ 9,727,430.00	$ 199,819.85	$ 1,069,000.00											

Appendix C: Click here to view full document.

Youth Risk Behavior Survey

Elizabeth Miller, YRBS Data Manager
(701) 328-2098

The Youth Risk Behavior Survey was developed in 1990 by the Centers for Disease Control and Prevention (CDC) to monitor priority health risk behaviors that contribute markedly to the leading causes of death, disability and social problems among youth and adults in the United States. The YRBS was designed to monitor trends, compare state health risk behaviors to national health risk behaviors and intended for use to plan, evaluate and improve school and community programs. North Dakota began participating in the YRBS survey in 1995. Students in grades, 7-8 and 9-12 are surveyed in the spring of odd years. The survey is voluntary and completely anonymous.

The six monitored priority health risk behaviors, often established during childhood and early adolescence and result in unintentional and intentional injuries, include: Tobacco Use, Unhealthy Dietary Behaviors, Physical Inactivity, Alcohol & Other Drug Use, Sexual Behavior/STD's/HIV/AIDS/Unintended Pregnancies and Violence/Injury.

REALITY CHECK

Effects on Thinking Tasks:

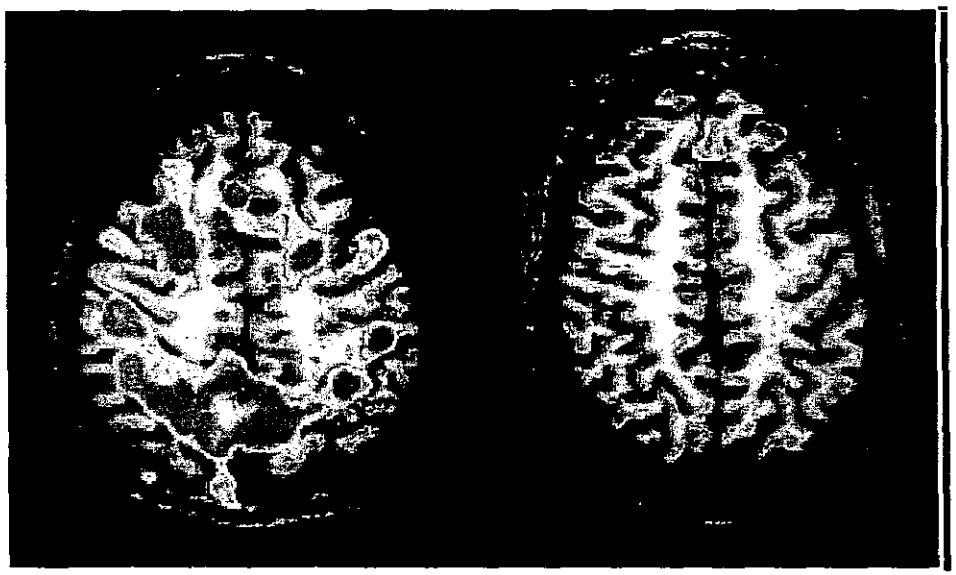


Image from Dr. Susan Tapert, University of California, San Diego

The image on the left is an MRI scan of a healthy 15 year old non-drinker.

Colored areas show parts of the brain activated by thinking tasks.

The image on the right is that of a 15 year old heavy drinker

* These images were taken when the drinker was SOBER, NOT DRUNK!

528

JOIN TOGETHER

Home > News > Funding News > Tips & Trends

Funding Prevention Makes Economic Sense, Researchers Say

February 4, 2009

Funding Tips & Trends

Every dollar invested in substance-abuse prevention yields $10 in savings, according to researchers from Iowa State University who recently presented their findings to the United Nations.

Researchers Richard Spoth, director of the Partnerships in Prevention Science Institute at Iowa State, and colleague Max Guyll told attendees at the U.N. Office on Drugs and Crime/World Health Organization meeting in December that studies of PPSI's Iowa Strengthening Families Program (ISFP) and Life Skills Training Program (LST) demonstrated significant cost benefits.

The research estimated how many cases of drug use each intervention prevented, then compared the cost of each successful intervention to the cost savings to the community. Spoth and Guyll said that ISFP yielded a $9.60 return for each $1 invested in preventing alcohol disorders, while LST has a $9.98 return on investment in terms of preventing methamphetamine use.

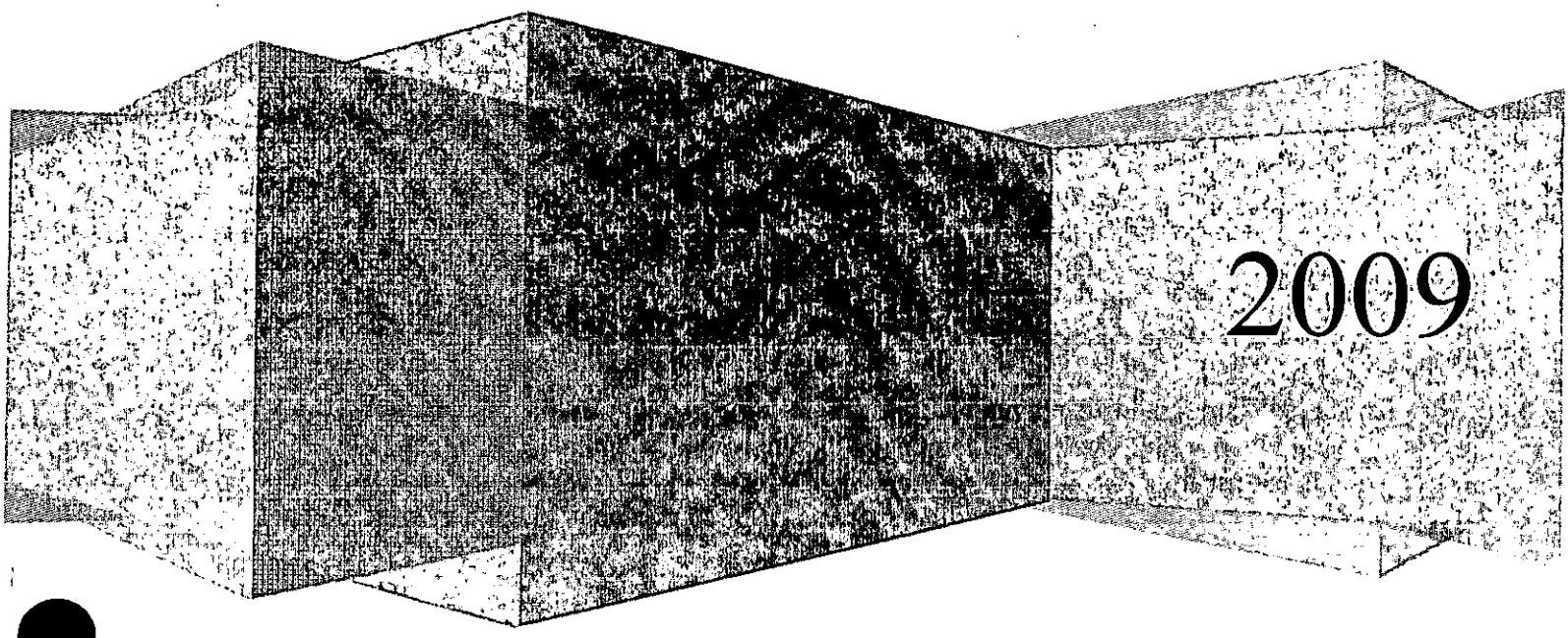
The International Narcotics Control Board has asked Spoth to help develop a report on the state of the art of prevention. The reports on ISFP and LST are available online.

ShareHouse

ROBINSON RECOVERY CENTER

18 Month Comparative Analysis

Anna M. Johnson, LAC, LADC



ROBINSON RECOVERY CENTER
18 MONTH COMPARATIVE ANALYSIS
NARRATIVE
JANUARY 1, 2006 TO DECEMBER 31, 2008
ANNA M. (ANDI) JOHNSON, LAC
SHAREHOUSE DIRECTOR OF OPERATIONS

(For purposes of this summation report the initial 18 month timeline refers to January 1, 2006 to June 30, 2007. The 2nd 18 month refers to July 1, 2007 to December 31, 2008.)

The Robinson Recovery Center opened its doors on January 3, 2006 as a result of legislation passed in the 59th Legislative Assembly. ShareHouse has been honored to provide methamphetamine specific treatment to clients and their families and has admitted 194 clients since January 1, 2006. This has given us a keen opportunity to learn more about persons addicted to methamphetamine and the conglomerate of issues which pervade their lives. Within these past 3 years we have continued to gain experiential, therapeutic, and residential knowledge about the methamphetamine addict in hopes of improving treatment and recovery outcomes.

Upon admission to the Robinson Recovery Center, the methamphetamine client presents with decreased cognitive abilities, heightened sexual responsivity, lack of social skills, physical deterioration, high degree of impulsivity, poor dental hygiene, increased dual diagnosis, significant criminal history, and increased potential for the development of infectious diseases.

Our continued attempt to balance residential rule enforcement and retention in treatment therapeutically continues to be our greatest challenge requiring innovative and creative thinking on the parts of the RRC staff to include the residential coordinator, four social workers (case managers), two licensed addiction counselors, and the clinical director.

Due to increased relapse potential, impulsivity, heightened sexual sensitivity, and increased violence resulting in property damage and danger to RRC employees, the residential rules were significantly revised in November 2006 to include no cell phones, no computers, no cameras, increased facility and room searches, and increased need to segregate the methamphetamine population by gender. This resulted in segregating all group sessions, allowing only one gender to attend self help support groups in the community each night, and segregated smoke breaks. Most recently, the schedule has changed to discontinue TV and radio diversions during the day and during all evening programming. These rules remain the same to date.

These residential rule changes, dissimilar to primary rules at ShareHouse, have significantly improved management of the facility. Their impact on retention therapeutically continues to be researched. In dealing with the retention effort, ShareHouse has incorporated the best practice of contingency management in our programming efforts beginning January 2007.

It became clear that the intensity of the case management effort required an additional position which was added June 2006. Issues contributing to the case management effort include higher incidence of legal involvement, higher incidence of CPS involvement, high level of impulsive thinking and behavior increasing the potential to relapse, high degree of dual diagnosis, negative peer associations, high degree of criminal thinking, increased need for monitoring efforts, and increased need for support for each client.

With the doubling effort which began July 1, 2007, the human service centers have continually responded to the need for increased treatment for the methamphetamine addict which impacted admissions for methamphetamine specific treatment on a residential level. Therefore, the number of beds which remained available for treatment averaged 15 during the biennium. The Division of Mental Health and Substance Abuse met with key administrators from the RRC to discuss the intent of the legislation to include opiate and cocaine addiction on a residential level. This increased admissions slightly during the biennium.

Staff changes have included a change in Program Director, the addition of 2 full time Social Workers, and an increase in Residential Supervisors on site 24 hours per day.

Facility changes have included obtaining additional space in the same building on the ShareHouse campus. The Robinson Recovery Center is located in a 12 plex apartment building, 4 apartments per floor. The upper floor is identified as the male resident's floor and houses 20 males at any one time. The middle floor is comprised of 2 staff office apartments and 2 apartments which houses 10 residents. The bottom floor is also comprised of 2 staff office apartments and 2 apartments which houses 10 residents.

This facility has increased the need for security with the doubling effort. However, in an effort to remain therapeutic rather than penalistic, ShareHouse has chosen to increase Residential Supervisor staff rather than to purchase door locks and security cameras throughout the facility. This has impacted gender specific admissions due to the security needs of the building. Due to the high level of impulsivity and heightened sexual responsivity of the residents, the need for ongoing monitoring of gender specific interventions remains high. As a resident, female apartments must be monitored at all times. With the Residential Supervisor's office located on the main floor, the females are housed on the main floor. Female residents cannot be housed on the 2nd floor due to increased access to male residential apartments. This has kept the availability of female admissions to the Robinson Recovery Center at only 10. However, as identified in the summation report, female referrals and admissions to the facility has decreased dramatically and did not remain at 50% as identified in the previous 18 month summation report.

Synopsis of Comparative Analysis

Referrals:

Robinson Recovery Center received a total of 490 unduplicated referrals since January 2006. The Fargo region remains the largest contributor with just over half of the referrals coming from that region. This was followed by Grand Forks during the initial 18 months

but this region decreased referrals by 11.80%. During the second 18 month period, Bismarck increased it's referrals by 9.66% becoming the 2nd largest referent. The Western Region of the state increased its referrals by 4.59% from 18.22% to 22.81% while the Eastern Region contributed to the majority of referrals with 77.19% during the 2nd 18 month time period.

The largest reason for denied access was unresolved legal issues which increased 5.02% during the 2nd 18 month period. This was due to the presence of a combination of class A, class C and federal class a felony charges stemming from methamphetamine use, manufacturing, or dealing. This was also related to previous charges which impacted minimum mandatory sentences for clients involved. I was unable to accept these clients due to the high potential of minimum mandatory sentences leading to incarceration. Due to their ability to receive treatment while in prison, they were unable to be admitted to this project. During the initial 18 month period, refusing treatment was the 2nd largest contributor which decreased 8.93% during the 2nd 18 month period. Inability to locate the client became the 2nd largest reason for denied admission although this decreased by 4.80% during the 2nd 18 month period. Medical issues exceeding the facility's ability to treat the client increased by 2.37% largely due to the increase in opiate addiction to the facility.

Admissions:

The Robinson Recovery Center admitted a total of 194 clients since opening in January 2006. In the first 18 months, 93 were admitted while 101 were admitted during the 2nd 18 months increasing admissions by 4.12%. The percentage of admissions from referrals increased 4.56% during the 2nd 18 month period.

The largest number of admissions came from Fargo which averaged 49.48% of admissions in the past 3 years. Grand Forks had a dramatic decrease in admissions (14.58%) from the initial 18 months while Bismarck had a dramatic 16.66% increase during the 2nd 18 month period. This contributed to Bismarck having the 2nd largest admission rate during this period.

The Western region of the state contributed to an average of 19.59% of all admissions to the Robinson Recovery Center thus far while the Eastern region contributed to an average of 80.41%.

Inconsistent with the national average, male admissions have exceeded female admissions during the 2nd 18 month period thus decreasing the availability of female methamphetamine residential treatment beds in our state. Regarding age, the youngest and oldest client remained roughly the same at 18 and 52 respectively.

The length of stay for clients at the Robinson Recovery Center is directly proportional to their ability to maintain active recovery following treatment. For clients who remain in treatment longer, their success following treatment improves dramatically. The average length of stay increased roughly 3 weeks from 3.15 months during the initial 18 months to 3.84 months recently. For those persons who did not successfully complete the

program, their average length of stay was 2.54 months while those successfully completing treatment increased 1.165 months from 6.02 months during the initial 18 months to 7.185 months during the 2nd 18 month period.

After successful completion of 2 months of intensive treatment incorporating the Matrix Model, cognitive restructuring, therapeutic community, anger management, healthy relationships, schedule review, continuing care, family group sessions, recreation group, and exercise group, the client is expected to seek a minimum of 20 hours of employment per week to aid in community transition. Full time employment has dramatically increased while unemployment continues to dramatically decrease consistent with the initial 18 month report.

Academic and Residential status has also improved consistent with results from the initial 18 month report. Although this information was not formally reported during or following treatment, an interview with each of the case manager's reviewing each client by name and number has indicated similar results with the initial 18 month report.

Changes in legal status included significantly more admissions while on probations (almost double) during the second 18 month reporting period than the initial 18 month period. This appears to be due to increased flexibility to offer treatment as an alternative to incarceration.

Addiction is a disease of the brain. As a disease, one of the most important dynamics of recovery is support from others. For this reason, sponsorship in the Robinson Recovery Center programming is a requirement. Each resident is expected to obtain a temporary sponsor within 2 weeks from admission and a permanent sponsor within 30 days from admission. Engaging the sponsor in the treatment program has been a pivotal dynamic to aid in treatment success for each client.

Child Protection Services has been involved cumulatively in 41 (21.13%) of the 194 admissions with 15 (75.61%) women. Having children reunited with parents in a stable environment is a cherished benefit and a strong extrinsic motivator of ongoing recovery.

Use of Methamphetamine and other drugs of abuse were calculated during the 2nd 18 month period secondary to increased flexibility in admission criteria consistent with the intent of the grant. Thus methamphetamine contributed to 65.35% of admissions, opiates to 26.73% of admissions and cocaine to 7.92% of admissions.

Dual Diagnosis statistics have remained high with an average of 79.38% of admissions having a dual diagnosis. To meet this criterion, dual diagnosis is defined as someone having another diagnosis of depression, anxiety, ADHD, personality disorder, or other qualifying mental health problem. This is noted to be a high incidence relatively speaking which impacts rates of recovery for persons dually diagnosed. In addition to mental health issues, medical and dental problems have increased dramatically, largely due to the increase in the treatment of opiate addiction.

Discharge Statistics:

The Robinson Recovery Center identifies the following criteria for successful discharge from this program:

- Completed a minimum 4 months of treatment
- Maintained gainful employment or successfully completed his/her GED
- Has maintained attendance to self help support groups in the community
- Has made a commitment to continued attendance to aftercare groups
- Has identified 1-2 permanent sponsors and involved them in the treatment process
- Continues to successfully manage any dual diagnosis issues
- Has resolved medical and dental issues during treatment
- Continues to submit to random UA screens for a minimum 6 months following treatment programming.

During the initial 18 months of treatment 44.44% of participants successfully completed the program. During the 2nd 18 months of treatment 28.99% of participants successfully completed the program to produce an average rate of 33.33%. The following dynamics appeared to contribute to Temporary Discharges with ability to return:

- Significant Cognitive Deficits
- High level of impulsivity behaviorally and cognitively
- High incidence of dual diagnosis
- Highest level of care for addiction treatment
- Environmental issues (legal, residential, academic, employment, and family)
- High incidence of AMA discharges secondary to issues of fraternization (heightened sexual responsivity and level of impulsivity) regardless of gender specific treatment and intervention measures.

However, when taking this a step further, I decided to review 10 charts and discuss the findings with the Robinson Recovery Center (RRC) staff. I reviewed charts in which residents had participated in the treatment program for 3 months or longer and received a temporary discharge with ability to return. As progress is identified within 6 dimensions (withdrawal/intoxication, medical, psychiatric, motivation, relapse potential, recovery potential), I gave one point within each dimension if progress was identified in that dimension. In each of the 10 charts pulled, progress was made in each of the 6 dimensions with the exception of one chart scoring 5 of 6 points. Therefore, significant progress was made by each client irrespective of the type of discharge.

When meeting with the clinical staff and reviewing the aforementioned findings, they began to problem solve different scenarios asking if more could have been done to help clients achieve success on discharge and beyond. All concluded that could be done and challenged themselves within the initial 3 months of 2009 to achieve a much higher rate of success at Robinson Recovery Center. At the end of 3 months, I will share with them the rate of discharge and review differences with them.

Conclusions:

There is a marked paradigm shift in the addiction profession that is aimed at gaining a better understanding of recovery as a process rather than as an event. This is directly related to identifying addiction as a disease with identifiable symptoms and pattern of recovery similar to that of other diseases. There is a pattern of behavior that accompanies this disease and a timeline for "remission." With this is a "prescription" for life improvement rather than a medication to "cure" or "manage" this disease. That "prescription" includes:

- Involvement in a self help group
- Obtaining the support of a sponsor
- Attending aftercare counseling (either individually or group sessions)
- Abstaining from mind altering chemicals
- Maintaining gainful employment
- Maintaining health
- Responsible fiscal management

With this in mind, the following conclusions are reached:

- Treatment is not a single event but a process along the continuum with measurable periods of remission following successful completion of treatment which matches the level of severity of the current symptoms of the disease.
- Within treatment for the methamphetamine addict gender specific treatment is required.
- Adherence to regulatory rule enforcement to aid in the provision of structure is an important component of treatment. The higher the level of distractions, the higher the incidence of impulsive thinking and impulsive behavior, the higher the probability of relapse potential in the community. This also presents a dichotomous effect regarding temporary discharge status which will continue to be monitored.
- The longer the treatment episode, the higher the probability of success within the community following treatment and the longer period of remission. This involves ongoing attendance to aftercare in the community.
- When the probation officer and CPS worker is actively engaged in the treatment process, the probability of success increases.
- A commitment to aftercare involvement and maintained self help group attendance increases the likelihood of success for the methamphetamine addict.
- The potential for relapse appears higher for the methamphetamine addict secondary to level of impulsivity and decreased cognitive functioning.
- Due to the high incidence of dual diagnosis, an increased level of dual diagnosis programming and direct involvement of psychologists and psychiatrists to the process of treatment is needed. Psychological testing to identify current level of IQ and concrete/abstract thinking ability is needed to tailor treatment to the current abilities of the client.
- A higher staff to client ratio is needed due to the intensity of treatment services and numerous aforementioned issues.

- Due to the high degree of fraternization secondary to the vulnerable emotional status of each of the residents, the need for separate facilities is highly recommended to segregate gender residentially. ShareHouse offers gender specific residence in two separate facilities: Sister's Path located in Fargo, North Dakota and Stepping Stones located in New York Mills, MN. Success rates were analyzed in both of those facilities for 2007 – 2008. Success Rates in these facilities were 42.42% to 63.16%.

In answer to the question, was the doubling effort beneficial? Briefly, yes. Since the doubling effort, the count residentially has never been below 20 and has accommodated the need for the methamphetamine, opiate, and cocaine addict. It has been successful as an alternative to incarceration for many of these individuals.

Is treatment needed and successful? In short, yes. Would anyone negate the need for cancer treatment with the knowledge that it is one of the leading causes of death in our society today. Would anyone deny an asthmatic hospitalization with double pneumonia knowing the cause to be directly related to their disease? Would anyone not make an attempt to resuscitate an individual having a heart attack on the senate or house floors simply because we knew them to have heart disease? The resounding answer to these questions is NO – we would not. The debate about the helpfulness of treatment in the face of this disease is a repeated question to this legislative body. The numbers on any of the reports viewed by the legislature does not appear to be a fair representation of the enormous success of the individuals participating in these treatment programs as evidenced by the fact that progress was identified in 10 individuals who are able to return to the program but who were not considered successful completions at the time of this report.

The many clients, family members, and friends would like to say a word of thanks to the North Dakota legislators for boldly affirming the need for methamphetamine treatment and giving them a second chance at life.

In closing, the work of the addict in treatment is a difficult road with little to no cognitive direction. Once engaged in the treatment process, dual diagnosis can contribute to ongoing difficulties. Poor boundaries contribute to fraternization issues and ongoing emotional reactions. Upon successful completion of treatment, the direction becomes clearer but the road remains long with normal life struggles tempting each client to relapse. Only with ongoing support, recovery maintenance, and understanding will the recovery of the methamphetamine client continue and succeed.

Respectfully Submitted,

Anna M. (Andi) Johnson, LAC
ShareHouse Director of Operations
Robinson Recovery Center

SHARE HOUSE INC.

Robinson Recovery Center

18 Month Comparative Analysis

Anna M. Johnson, LAC, LADC

1/1/2009

A comparative analysis of statistics from the Robinson Recovery Center between its initial 18 months (January 2006 to June 2007) and its recent 18 months (July 2007 to December 2008).

ROBINSON RECOVERY CENTER

SHAREHOUSE

SUMMATION REPORT
18 MONTH COMPARATIVE ANALYSIS

REFERRALS BY REGION

January 06 to June 07 (249)				July 07 to December 08 (241)		
Region 1	8	3.21%	Williston	Region 1	6	2.49%
Region 2	5	2.01%	Minot	Region 2	4	1.67%
Region 3	11	4.42%	Devil's Lake	Region 3	16	6.64%
Region 4	49	19.68%	Grand Forks	Region 4	19	7.88%
Region 5	106	42.57%	Fargo	Region 5	128	53.11%
Region 6	27	10.84%	Jamestown	Region 6	13	5.39%
Region 7	9	3.62%	Bismarck	Region 7	32	13.28%
Region 8	21	8.43%	Dickinson	Region 8	10	4.15%
Unknown	13	5.22%		Unknown	13	5.39%
Western	43	18.22%		Western	52	22.81%
Eastern	193	81.78%		Eastern	176	77.19%

REFERRALS BY MONTH

Month	2006		2007		2008	
January	28		14		18	
February	14		23		15	
March	13		16		13	
April	7		19		10	
May	6		13		11	
June	12		11		15	
July	8		15		9	
August	8		12		14	
September	15		11		7	
October	8		18		22	
November	16		7		8	
December	13	148	12	171	24	166

DENIED ADMISSIONS

January 2006 to June 2007				July 2007 to December 2008		
Total: 156 (62.65%)				Total: 140 (58.09%)		
Unresolved Legal Issues	49	31.41%		Unresolved Legal Issues	51	36.43%
Refused Tx.	34	21.79%		Refused Tx.	18	12.86%
Inappropriate Level of Care	15	9.21%		Inappropriate LOC	13	9.29%
Unable to locate	32	20.51%		Unable to Locate	22	15.71%
Unable to Court Commit	5	3.21%		Unable to Court Com.	0	0%
Medical issues exceed facility	3	1.92%		Med. Iss. Exceed fac.	8	5.71%
Lack of referral follow through	4	2.56%		Lack of ref. follow through	6	4.29%
Hx of violence/sexual behavior.	8	5.13%		Hx. of viol./sexual behavior	8	5.71%
Pending	6	3.85%		Other	14	10%

ADMISSIONS

January 2006 to June 2007				July 2007 to December 2008		
Total: 93 (37.35% of referrals)				Total: 101 (41.91% of referrals)		
Region 1	2	2.15%	Williston	Region 1	1	0.99%
Region 2	2	2.15%	Minot	Region 2	1	0.99%
Region 3	6	6.45%	Devil's Lake	Region 3	12	11.88%
Region 4	20	21.51%	Grand Forks	Region 4	7	6.93%
Region 5	44	47.31%	Fargo	Region 5	52	51.49%
Region 6	7	7.53%	Jamestown	Region 6	8	7.92%
Region 7	2	2.15%	Bismarck	Region 7	19	18.81%
Region 8	10	10.75%	Dickinson	Region 8	1	0.99%
Western	16	17.20%		Western	22	21.78%
Eastern	77	82.80%		Eastern	79	78.22%

ADMISSION STATISTICS

January 2006 to June 2007				July 2007 to December 2008		
Total: 93				Total: 101		
Male	46	49.46%		Male	59	58.42%
Female	47	50.54%		Female	42	41.58%
Age						
Average	28.20			Average	29.655	
Youngest	18			Youngest	18	
Oldest	54			Oldest	52	
Length of Stay						
Average	3.15 months			Average	3.84	
Temp D/C				Temp D/C	2.54	
Succ. Com.	6.02 months			Succ. Com.	7.185	
Employment						
Full Time	9			Full Time	6	
Part Time	3			Part Time	8	
Unemployed	81			Unemployed	87	
Employment during or following treatment						
Full time	40			Full time		
Part Time	6			Part Time		
Unemployed	48			Unemployed		
Academic (upon admission)						
Less HS	22			Less HS	8	
HS/GED	56			HS/GED	67	
College	15			College	26	
Academic (during or following treatment)						
Less HS	19			Less HS		
HS/GED	59			HS/GED		
College	15			College		
Residential (upon admission)						
Own	3			Own	5	
Rent	17			Rent	20	
Homeless	73			Homeless	76	
Residential (during or following treatment)						
Own	5			Own		
Rent	28			Rent		
Homeless	39			Homeless		
Legal (upon admission)						
Yes/Pending	33				17	
None	31				30	
On Prob.	29				54	

Sponsorship (upon admission)					
Yes	2		Yes	5	
No	91		No	96	
Sponsorship (during and after treatment)					
Yes	62		Yes	87	
No	31		No	14	
Child Protection					
Yes	23	W - 18	Yes	14	W-13
No	70		No	87	
Other Drug Use					
Yes	80	86.02%	Meth	66	65.35%
No	13	13.98%	Opiates	27	26.73%
			Cocaine	8	7.92%
Dual Diagnosis					
Yes	78	83.87%	Yes	76	75.25%
No	15	16.13%	No	25	24.75%

Discharge Statistics

January 2006 to June 2007			**July 2007 to December 2008**		
Total: 81			Total: 69		
Successful Completion	36	44.44%	**Successful Completion**	20	28.99%
Temporary Discharge	35	43.21%	**Temporary Discharge**	48	69.57%
Unable to return	8	9.88%	**Unable to Return**	1	1.01%
Left AMA	2	2.47%	**Left AMA**	29 (of 48)	60.42%

Prepared by the North Dakota Legislative Council staff for the Budget and Finance Committee
August 2008

COMPULSIVE GAMBLING TREATMENT

This memorandum provides information on state lottery proceeds used for compulsive gambling treatment services, casino and tribal contributions for compulsive gambling treatment services, and a history of lottery revenue transferred to the general fund.

COMPULSIVE GAMBLING TREATMENT

Pursuant to subsection 4 of North Dakota Century Code (NDCC) Section 53-12.1-09, $50,000 of net proceeds must be transferred from the lottery operating fund to the compulsive gambling prevention and treatment fund each quarter for a total of $400,000 each biennium. The Department of Human Services has a continuing appropriation authority under Section 50-06-22 to use this funding for compulsive gambling prevention and treatment services. The schedule below presents information relating to gaming taxes and net lottery proceeds, funding provided for compulsive gambling treatment services, and the percentage of gaming and net lottery proceeds provided for compulsive gambling treatment services:

Biennium	Gaming Taxes Deposited in General Fund[1]	Net Lottery Proceeds[2]	Total Gaming and Net Lottery Proceeds	Amount Provided for Compulsive Gambling Treatment	Percentage of Gaming and Net Lottery Proceeds Provided for Compulsive Gambling Treatment
2003-05	$19,050,271	$7,669,005	$26,719,276	$400,000	1.50%
2005-07	17,748,914	13,000,000	30,748,914	400,000	1.30%
2007-09	20,540,000[3]	12,400,000[3]	32,940,000[3]	400,000	1.21%
Total	$57,339,185	$33,069,005	$90,408,190	$1,200,000	1.33%

[1]Gaming taxes include the tax levied on games of chance conducted by licensed charitable gaming organizations and taxes on pari-mutuel horse racing.

[2]These amounts reflect net lottery proceeds that include $400,000 per biennium transferred to the compulsive gambling treatment fund and $105,625 transferred each quarter in the 2007-09 biennium to the Attorney General multijurisdictional drug task force grant fund.

[3]These amounts reflect 2007 legislative estimates for the 2007-09 biennium.

INDIAN CASINO AND TRIBAL FUNDING FOR COMPULSIVE GAMBLING TREATMENT

Subsection 1 of Section 29 of the gaming compact between North Dakota Indian tribes and the state of North Dakota provides that the tribes intend to continue voluntary donations in support of effective programs to address gambling addiction. The Indian casinos and tribes do not provide funding to the state for compulsive gambling treatment services. However, according to information received from Lutheran Social Services, the Indian casinos and tribes have provided funding to Lutheran Social Services since 1999 for compulsive gambling treatment services. Lutheran Social Services received $30,000 each year in 2006 and 2007 and in 2008 Lutheran Social Services has received $45,000 for these services. Lutheran Social Services uses this funding to provide training to casino employees and financial assistance to individuals for 16 weeks of treatment and transportation costs.

USE OF LOTTERY REVENUE

Pursuant to NDCC Chapter 53-12.1, all revenue from the sale of tickets, interest income, and other fees or collections, less prizes and retailer commissions, are to be deposited in the lottery operating fund. Except for appropriations made by the Legislative Assembly for administrative and operating costs of the lottery, disbursement of other money in the lottery operating fund must be for the following purposes:

- Payment of a prize for a valid winning ticket;
- Notwithstanding NDCC Section 53-12.1-10, payment of marketing expense that is directly offset by cosponsorship funds collected;
- Payment of a gaming system or related service expense, retailer record and credit check fees, game group dues, and retailer commissions; and
- Transfer of net proceeds:

  $50,000 must be transferred each quarter to the compulsive gambling prevention and treatment fund;

  An amount of the lottery's share of a game's prize reserve pool must be transferred to the Multi-State Lottery Association;

  Starting July 1, 2007, $105,625 must be transferred each quarter to the Attorney General multijurisdictional drug task force grant fund; and

  The balance of the net proceeds, less holdback of any reserve funds the director may need for continuing operations, must be transferred on at least an annual basis to the general fund. The following schedule presents information on net lottery proceeds transferred to the general fund:

Biennium	Transfer to General Fund
2003-05	$7,269,005
2005-07	12,600,000
2007-09	11,155,000[1]
Total	$31,024,005

[1]This amount reflects the 2007 legislative estimate for the 2007-09 biennium.

According to information received from the Attorney General's office, there have been no delays in the use or transfers of lottery revenue.

The following schedule presents information on the distribution of total lottery revenue for the 2003-05 and 2005-07 bienniums:

	2003-05 Biennium	2005-07 Biennium
Prizes	$11,875,949	$22,333,788
General fund revenue	7,269,005	12,600,000
Contractual services	2,579,212	4,743,058
Retailer commission	1,244,795	2,321,849
Administration and operating	1,044,457	1,421,258
Advertising and marketing	447,044	870,134
Compulsive gambling fund	400,000	400,000
Multi-State Lottery Association prize reserve pool	251,116	359,111
Total	$25,111,578	$45,049,198

A

Good morning (afternoon). My name is Jonathan Holth, and I am a recovering compulsive gambler and alcoholic. It's an honor to be here to speak to you about a subject so near and dear to my heart. When I was younger, I dreamt of sitting in your chair. I always wanted to be a politician. My mother used to joke about the fact that while my friends were out playing with trucks in the dirt, I would be inside reading books about presidents. This dream of mine is one of many dreams left unfulfilled throughout my childhood and early adulthood.

I am a product of North Dakota. I was born and raised in Grand Forks. I love everything about this state, including the weather.

When I was in high school, I had a plan for myself. I knew exactly what type of person I wanted to be, what I wanted to do for a living, where I wanted to live, who I was going to marry, how many children I was going to have, and at what age I wanted to achieve all of this.

As I began to implement my plan, a few things started to change. As I entered my college years, I began to experiment more and more with alcohol and with gambling. I began to take frequent trips to the casino, spending money from both my part time jobs that I couldn't seem to hold on to, and then, from my student loan checks.

Eventually, after maintaining a 4.0 grade point average throughout high school, graduating with honors, receiving numerous scholarships to college, and having the world in the palm of my hand, I dropped out of college. I chalked it up to bad luck. I began working restaurant jobs. Serving, bartending, and eventually, managing. My plan that I had for myself in high school was out the window. All aspects of my plan were forgotten. I continued to gamble, and began to explore different gambling avenues. This is right about when the poker boom began, and I was right in the middle of that boom. I began to play poker whenever I could, in casinos, home games, online, even in the World Series of Poker in Las Vegas. I began winning, and making money. It was then that my career plans changed – I was going to be a professional poker player. The whole time that I was experiencing success at poker, I was becoming more and more blind to the simple, daily tasks of a productive, functioning member of society. Although I was making money, I wasn't saving a penny. My health was slipping. I began to lie about my whereabouts. I kept ridiculous, insane hours. I lost friends. I alienated family. My work slipped.

Everything came second to gambling. But, I was making money, so nothing was wrong with my life, right? That's the way of thinking that I maintained. Insane thinking. In late 2005, I had the opportunity to realize one of my dreams, opening my own restaurant. This required me to spend a lot more time at work, and a lot more time away from the tables. Instead of pushing gambling aside and concentrating on building a successful business, I searched steadfastly for new ways to gamble, new ways to feed the appetite of my addiction. It didn't take me very long to discover sports betting. I now could gamble at any hour, for as long as I wanted, wherever I wanted, and I could do it alone without anyone knowing. Perfect. As fast as I found sports betting, I began to lose control. I was running out of money fast, and I needed to find new sources of income. How would I do this? Stealing and manipulating, that's how.

I began stealing from whoever I could, my parents, siblings, even my business partner. My life was spinning out of control. I made a good salary, and had no money. I owed tens of thousands of dollars, and had nothing to show for it. I was about to lose my business. I could easily have been in jail, or even dead. I was placing bets with criminals, with people that I would never have associated with had it not been for a deep gambling addiction. Then, something happened.

That something is recovery. I got help. By having the proper resources available, I was able to fight the addiction. Recovery is a lifelong process. It is something that must stay at the forefront.

Since I have experienced recovery, I have had amazing things happen. I feel, for the first time in my life, like a productive, contributing member of society. I am in the process of opening up a second restaurant. I have written a book about sobriety. I have had the chance to participate in fundraisers to help those less fortunate. These are all things that wouldn't be possible without recovery, and recovery wouldn't be possible without the necessary resources. That plan that I had for myself in high school that I spoke of earlier? Well, some of those things are gone and I will never be able to get them back. However, the part about what type of person I wanted to be – that part I am slowly achieving through the gift of recovery. To me, that's the most important part, and that gives me peace of mind.

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B

same testimony given to Senate

HUMAN RESOURCES SUB-COMMITTEE

Testimony presented by Lisa Vig, LAC, CGC
On behalf of the Problem Gambling Advisory Committee

January 27, 2009

My name is Lisa Vig. I am a licensed addiction counselor and a nationally certified gambling counselor. I am a member of the Problem Advisory Committee, which is comprised of other gambling service providers, representatives from Mental Health America which administers a statewide helpline, representatives from Indian Gaming, consumers and other concerned citizens. I'm here to request support for an additional $300,000 that is being considered for problem gambling services within the Department of Human Services budget. Here are a few facts about problem/pathological gambling in North Dakota.

- In 1990 and 2001, incidence and prevalence studies were conducted in North Dakota.
- There are up to 12,400 North Dakota residents that can be classified as problem or pathological gamblers.
- Pathological gamblers are defined as those with a continuous or periodic loss of control over gambling, who display a progression in gambling frequency and amounts wagered, are preoccupied with gambling and in obtaining monies with which to gamble, and continue to gamble despite adverse consequences. Problem gamblers have gambling related difficulties that are less serious than those of pathological gamblers, but have patterns of gambling behavior that compromise, disrupt or damage personal and family relationships or their employment.
- There is no health insurance coverage for a diagnosis of compulsive gambling.

In order to address these issues, we need to have a comprehensive, statewide effort.

- An extensive, statewide public awareness campaign conducted through a variety of media such as television ads, billboards, newspaper and radio advertisement with appropriate messaging about responsible gambling behaviors and how a problem gambler might find help
- The Mental Health America local help-line number, 2-1-1 needs to be promoted as a statewide referral and initial screening point.
- Fee for service providers need to be in place in areas of the state where outpatient services are not available.
- Training opportunities need to be made available for professionals who work with compulsive gamblers and family members.
- Educational materials need to be placed in Resource and Addiction Libraries around the state so that individuals who wish to become educated about gambling addiction have access to current, reliable materials
- Prevention and awareness programs need to be established and made available to middle schools where most of the gambling behaviors and attitudes are formed and again, at a college level where most of the gambling behavior is beginning to escalate.
- Continued access to outpatient treatment programs across the state, that have trained and skilled staff and the necessary tools to provide a comprehensive treatment program with outcome measurement capabilities.

Lutheran Social Services of ND began providing counseling to gamblers in 1989. Over the years, programming has been modified to meet the changing needs of gamblers and their families. Presently, five, gambling trained, mental health professionals and three peer professionals are available in Williston, Fargo, Grand Forks, Minot and Bismarck. Despite the high numbers of projected gamblers in North Dakota we see relatively few for treatment. **Proper public awareness and education will affect this greatly**.

In 2004, 108 gamblers received treatment. In 2005, 148 gamblers received treatment. In 2006, 136 gamblers received treatment. In 2007, 142 gamblers received treatment and in 2008, 138 gamblers received treatment. Since the inception of the lottery in March of 2004, a capped amount of $400,000 has been allocated to the compulsive gambling fund. Initially, this amount served us well as we established a baseline of service delivery across the state, advertised those services and offered a training program for other mental health professionals who would be identified as a 'fee for service provider' in more rural or underserved parts of North Dakota. However, after 4 years of 'capped' funding, the comprehensive services that were in place, have begun to suffer. Staff hours have been reduced at all of the service delivery sites. There is very little advertising happening, no training events or workshops held locally and virtually no funding to attend conferences out of town.

This directly impacts the licensure and/or certification for professionals providing the service. Untreated gambling problems are very costly to the state and its citizens. We have a responsibility to inform, educate and provide help for compulsive gambler and their family members.

There are countless stories of how recovery has positively impacted an individual's life, his family, workplace, community and state. Thank you for your support of this funding increase, insuring that more lives are positively impacted in North Dakota because of recovery.

Dear Gamblers Choice,

I wanted to take a few minutes to let you know how much your organization has changed my life. I use to waste so much time and money gambling which led to severe depression, not to mention it really turned me into a nasty and uncaring person. My marriage was all but over, my relationship with my kids was nonexistant, and the relationship with my brothers & sisters had ceased to exist. I had become such a liar and nasty person I didn't even like myself in fact I hated myself. I had become a person that couldn't be trusted. I am now rebuilding my marriage, getting active with kids life and getting reacquainted with my brothers & sisters. I have quit the lying and am starting to show people I can be trusted again.

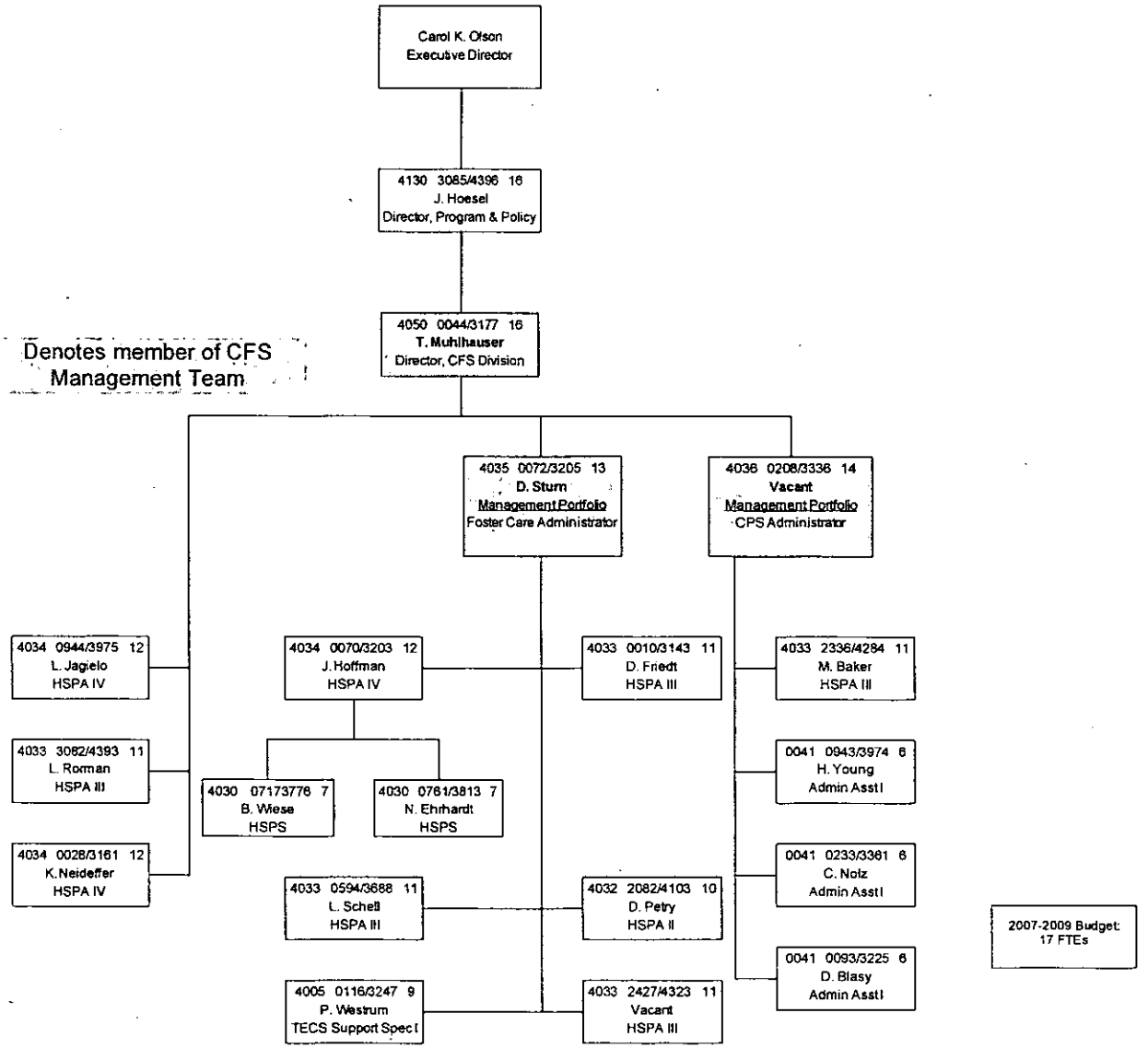
Everyone likes the new me and so do I. The other day I was given the opportunity to help a person who lost control of their vechile on ice and ended up in the ditch. We hooked up our winch and pulled them out. They offered us some money but we turned it down. Before

them $50. I was so excited given the chance to help a stranger that it was reward enough. Doing that made me feel so much better about myself Thanks to you I know longer put myself first, the needs of other comes first. Thank you so much for helping me turn my life around I know it wasn't easy for you to do. May God bless everyone in your organization because without you I would be broke, homeless, in jail, divorced, insane, or dead. Probably the last one. You have given me a second chance at leading my life with meaning.

Thank You so very much,

Dennis

North Dakota Department of Human Services
Children & Family Services Division



Revised 1/14/09

Testimony
House Bill 1012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
January 13, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, my name is Tara Lea Muhlhauser, and I am the Director of Children and Family Services (CFS) in the Department of Human Services. I am here today to provide you an overview of Division of Children and Family Services for the Department of Human Services.

Programs

- **Child Protective Services**: provides protection for children who have been or are at risk of being neglected and/or abused. Services provided include child protection assessment, case management, child fatality review, institutional child protection services and child abuse and neglect prevention programs.

- **Family Preservation Services**: provides therapeutic intervention to families whose children have been or are at risk of abuse, neglect and out-of-home placement. Services include parent aide, prime time child care, intensive in-home treatment services, respite care, family group conferencing and safety/permanency funds to prevent placement.

- **Foster Care Services**: provides a substitute temporary living environment for children who cannot safely remain with their families. Services include recruitment and retention of foster homes; and licensing and placement services for relative homes, family foster homes, group homes, and residential child care

facilities and licensed child placing agencies. This also includes foster care eligibility determination and payment, case planning and reviews, subsidized guardianship, Interstate Compact on the Placement of Children, Independent Living services to assist transitioning youth, including skills assessment, training and stipends.

- **Adoption Services**: provides permanent adoptive homes for eligible children. Services include recruitment, adoption assessment, placement, follow-up services, post adoption services, adoption subsidy, birth family services, adoption search, licensure of child placing agencies, and the Interstate Compact on the Placement of Children for Adoption.

- **Early Childhood Services**: coordinates activities, establishes standards, and provides training to providers of early childhood care and education. Services include licensing, child care resource and referral, providing consultation to the tribes on licensing, and coordination through the Head Start Collaboration Office.

- **Refugee Services**: provides resources to eligible refugees so they can become self-sufficient. Services include job development and employment enhancement, case management, cash assistance, refugee medical assistance, and education.

All these services are **provided either by the county social service agencies or through contracts with non-profit providers** and they focus on the safety, permanency, and well-being of children and their families.

Caseloads

The number of **Child Abuse and Neglect assessments** completed for FFY 2008 was 4011.

A caseload decrease can be noted in the **number of children placed in foster care.** The daily snapshot of children in foster care on 12/14/08 was 1,109 children in comparison to the daily snapshot on 12/14/06 which included 1,331 children. This snapshot includes tribal IV-E cases, Division of Juvenile Services (DJS) youth placed in foster care, and pre-adoptive placements. Approximately 29% of these children are Native American (321 children) in the most recent daily snapshot.

As of November 30, 2008, 41 youth were placed out-of-state in institutional care. This number has varied in 2008 from a low of 37 to a high of 50. This number has also continued to decline in the past two years.

The number of foster children gaining permanency through subsidized adoption has increased over the last three years and this trend is projected to continue through the 2009-11 biennium. Of the 110 finalized special needs adoptions in 2008, 86% of these children were adopted by their foster parents. In mid-2008, there were 128 children whose parents' rights had been terminated and who were waiting for a permanency option of adoption, guardianship or another planned permanent living arrangement.

At current, there are 37 children benefitting from a subsidized guardianship, with five pending. In 2008, there was a total of 48 children in this program during the year, 47 in 2007.

Refugees entering North Dakota from 2000 to 2006 (October 1 – September 30) are as follows:

Year	Number of Refugees
2000	**647**
2001	**367**
2002	**51**
2003	**111**
2004	**223**
2005	**225**
2006	**182**
2007	**400**
2008	**425**

These numbers do not include secondary migration refugees who resettle in other states and move to North Dakota, which averages about 165 each year. The numbers increased quite dramatically in 2007-2008 in ND and nationally due to the numbers of increased arrivals supported by the US Department of State. It is anticipated the arrivals will be maintained at this level over the next few years.

Trends/Issues/Accomplishments/Major Program Changes

CFS continues to place emphasis on safety, permanency and well-being of children across all programs in the division. **Family preservation programs** and **involvement of relatives and kin** when children are in need of placement, during service delivery and during reunification efforts are central to our work in achieving this emphasis. This past September, a new federal law, P.L. 110-351 "Fostering Connections" brought us

several new federal requirements related to notification of relatives when a child is placed in care, and guidance for involving school, medical providers, relatives and other services providers in providing a comprehensive plan for a child while in care, and at the time of transition to adulthood from care.

The second **Federal Child and Family Services Review (CFSR) took place in April 2008.** Although completed, we have no official notification of the results of this review. Based on comments from the Exit Interview with the federal team, we did not reach "substantial conformity" (e.g. we did not pass). No state has yet passed the CFSR in either the first or second rounds of these federal reviews. We were noted in this round to have many strengths and a few challenges that will require a Performance Improvement Plan (PIP). The first Federal CFSR Review was completed in September 2001. Though North Dakota received the highest rating in the nation in that first review, all 50 states and two territories were found to be deficient and were required to negotiate a Program Improvement Plan (PIP). North Dakota successfully completed this program improvement plan in 2006.

In August 2008, North Dakota successfully "passed" the **Federal IV-E Audit.** Official notification of this is forthcoming; this official notification will provide us with additional information on how many cases were found to be in error. This audit is conducted every three years. North Dakota successfully passed this audit in 2005 with only one error found in the 80 cases under review. In both the 2005 and 2008 audits around the nation, there were a number of states that did not achieve "substantial conformity" in these audits. Fiscal sanctions are applied when cases are found in error.

Family Preservation programs and prevention services (to prevent child abuse and neglect or to prevent child placement) continue to be a primary focus of the work of CFS. Foster care placements are down, when placements occur we have increased the number of children placed with relatives, and we have placed emphasis on reunification efforts to keep child connected with families and in close proximity to relatives.

The Village Family Services, in collaboration with the Department, was awarded a grant from the Bush Foundation to provide **Family Group Decision Making** in the State of North Dakota. These services have been available to county social services, the Division of Juvenile Services and the tribes. This service brings family members to the table to develop a plan for children who are either in foster care, at risk of being placed in foster care, or children who are being cared for by their extended family. This also brings significant people in the life of the child(ren) together to discuss how to maintain and build family connections. As of March 1, 2006 (through September 2008), Family Group Decision Making has had 352 referrals, with 225 completed conferences. As of December 2008, 235 families (including 327 children) have been served by this program.

Over the past two years we have worked very hard with our IT partners to develop a new component to our **child welfare data system**. This will allow us to take the current individual program applications, streamline and connect them. This will reduce duplication and create ease in using all the programs developed for safety, permanency and well-being together; enhancing program and data links. This will also support the generation of more usable data to assist with data-driven decision making

for child welfare programs in the Division. This new component is in the testing phase now and will be ready for the counties to use for all child welfare programs in August 2009.

There are still significant challenges in the **availability of quality child care** across the state. In 2000, 90.1% of all North Dakota children lived with both parents or with a single mother, the largest proportion in the nation. In addition, the proportion of North Dakota mothers (with children ages 0 to 17) in the labor force was 81.2% in 2000, the 2nd highest proportion nationwide. The proportion of working mothers is slightly smaller for mothers with young children ages 0 to 5 (76.1%), but rises to 84.9% for mothers with older children (ages 6 to 17). Current national and state-level 2006 data indicate that these proportions have changed little since 2000. This has created a demand for assurances of quality and safety in childcare settings and the need to provide training opportunities for this 10th largest workforce industry in North Dakota. This industry includes workers in home-based and center-based care settings.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / Decrease
Salary and Wages	2,140,960	2,689,667	548,707
Operating	5,746,214	5,723,601	(22,613)
Grants	113,233,761	118,086,508	4,852,747
Total	121,120,935	126,499,776	5,378,841
General Funds	21,918,091	26,673,520	4,755,429
Federal Funds	81,146,301	80,142,814	(1,003,487)
Other Funds	18,056,543	19,683,442	1,626,899
Total	121,120,935	126,499,776	5,378,841

FTE	17.0	18.0	1.0

- The Salary and Wages line item increased by $548,707 and can be attributed to the following:
  - $234,044 in total funds of which $109,478 is general funds to fund the Governor's salary package for state employees.
  - $308,496 in total funds all of which are general funds to process background checks for childcare providers. Included are 4 temp staff, a .5 FTE Administrative Assistant position, and a .5 FTE Program Administrator position. It is anticipated that this group will process 9,000 background checks each year of the biennium.
  - The remaining $6,167 is a combination of increases and decreases needed to sustain the salary of the 18.0 FTE in this area of the budget.

- The Operating line item decreased by ($22,613) and is a combination of the increases and decreases expected next biennium. Some of the significant changes are as follows:
  - A decrease in the county wide cost allocation fees ($644,053), due to contract negotiations with the vendor.
  - An increase in the Adoption Services contract, permanency for children who cannot return home, $328,887. Currently serving more children than outlined in the performance based contract and additional funds are needed to meet the anticipated demand for the 2009-2011 biennium.
  - An increase in the Family Preservation Services contract, in-home services designed to keep families together, for the 7%/7% provider inflation included in the Governor's budget - $169,589.

- An increase in printing costs of $25,009 for printing projects for the Head Start and Early Childhood Services programs as well as to accommodate the 9% annual increase for OMB during the 2009-2011 biennium.
- An increase in professional development of $60,849 which includes $57,600 for a $50 daily rate increase for those participating in the CFS reviews as well as to increase the number of reviewers from 8 to 12. The daily rate increase will aid in recruiting the adequate number of staff to participate in the reviews.

- The Grants line item increased by $4,852,747 which can be attributed to the following:
  - Subsidized adoption is projected for 992 children per month for a total program increase of $4,210,886 of which $1,669,619 is general fund.
  - A decrease in the Foster Care caseload of 347 cases per month from the 2007-2009 biennium is offset by; the rate increase for family foster homes for the MARC Report (Minimum Adequate Rates for Children), which established guidelines for the payment of family foster homes, these providers will receive an increase from 23% to 46% depending on the age of the child placed in their home and will aid in the recruitment and retention of family foster homes, funding changes due to elimination of Targeted Case Management for foster care as a billable service to Medicaid, and the 7% inflationary increase for foster care providers each year of the biennium for a overall program decrease of ($1,898,323) of which $27,302 is general funds.

- The 7% inflationary increase for family preservation services for each year of the biennium totals $584,957 of which $479,664 is general funds.
- Increase of $708,511 of which $241,555 is general funds for 25 additional child abuse and neglect assessments per month.
- The 7% inflationary increase for Child Abuse Services for each year of the biennium totals $558,513 all of which are general funds.
- An additional $300,000 was added to expand family preservation services to the Standing Rock and Spirit Lake Tribes.
- Attachment A lists the major grants and describes how the foster care budget has been developed.

This concludes my testimony on the 2009 – 2011 budget requests for CFS. I would be happy to answer any questions.

Children and Family Services

Attachment A

Listing of Major Grants:

- Child Abuse and Prevention Activities: ($2,100,000)
- Independent Living Program: ($1,100,000)
- Refugee payments: ($4,000,000)
- Child Care licensing payments to counties: ($700,000 includes inflationary increase of 7% and 7% per year)
- Child Care Quality grants to nonprofit entities: ($3,200,000)
- Child Abuse/Neglect Assessments by counties: ($5,800,000 includes inflationary increase of 7% and 7% per year)
- Reimbursement to counties for Administration of Child Welfare Programs: ($12,600,000)
- Family Preservation grants: ($6,600,000 includes inflationary increase of 7% and 7% per year).
- Training of child welfare professionals and family foster parents through the UND School of Social Work, a stipend-training program for future child welfare professionals and a contract with the Native American Training Institute: ($1,900,000)
- Subsidized Adoption grants is budgeted for an average of 992 children per month for an average cost per child of $760 ($18,100,000)
- Foster care grants to family, residential child care facility providers, group homes, therapeutic foster care providers and subsidized guardianship services (59,400,000 which includes an inflationary increase of 7% and 7% per year)

The foster care budget is built with the following trend data:

- Average number of children in family homes - 523 per month; average cost per child – $1,715 per month.
- Average number of children in RCCF/GH – 252 per month; average cost per child - $4,818 per month.
- Average number of children in therapeutic foster care - 242 per month; average cost per child - $1,111 per month.
- Foster care services – 196 children per month; average cost per child of $553.
- Subsidized Guardianship - 40 children per month; average cost per child - $477 per month.

DEPARTMENT OF HUMAN SERVICES

Summary by Subdivision and Bgt_Acct with Funding Sources

2009 - 2011

Class	FB	Budget Account Code		Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-46 CHILDREN AND FAMILY SERVICES									
		S101 FULL-TIME EQUIVALENTS (FTEs)		17.000	17.000	0.000	1.000	0.000	18.000
32510	B	511000 Salaries - Permanent		1,524,901	1,506,513	738,911	391,364	(6)	1,897,871
32510	B	513000 Temporary Salaries		0	70,000	61,158	(70,000)	0	0
32510	B	514000 Overtime		10,080	5,000	2,821	(2,000)	1	3,001
32510	B	516000 Fringe Benefits		495,847	559,447	264,170	(4,701)	73,862	628,608
32510	B	599110 Salary Increase		0	0	0	0	139,434	139,434
32510	B	599160 Benefit Increase		0	0	0	0	20,753	20,753
			Subtotal:	2,030,828	2,140,960	1,067,060	314,663	234,044	2,689,667
32510	F	F_1991 Salary - General Fund		530,561	588,367	294,188	312,150	109,478	1,009,995
32510	F	F_1992 Salary - Federal Funds		1,439,953	1,475,856	738,513	10,192	122,969	1,609,017
32510	F	F_1993 Salary - Other Funds		60,314	76,737	34,359	(7,679)	1,597	70,655
			Subtotal:	2,030,828	2,140,960	1,067,060	314,663	234,044	2,689,667
32530	B	521000 Travel		312,469	387,091	164,397	7,895	0	394,986
32530	B	531000 Supplies - IT Software		4,963	4,199	1,882	(129)	0	4,070
32530	B	532000 Supply/Material-Professional		29,573	21,900	3,640	3,650	0	25,550
32530	B	535000 Miscellaneous Supplies		5,586	5,500	509	(3,480)	0	2,020
32530	B	536000 Office Supplies		8,322	8,250	3,020	(175)	0	8,075
32530	B	541000 Postage		2,574	4,086	354	(1,186)	0	2,900
32530	B	542000 Printing		74,633	65,538	36,234	25,009	0	90,547
32530	B	551000 IT Equip under $5,000		0	250	210	(250)	0	0
32530	B	553000 Office Equip & Furniture-Under		4,272	925	566	(925)	0	0
32530	B	571000 Insurance		0	100	30	(20)	0	80
32530	B	582000 Rentals/Leases - Bldg/Land		7,207	6,484	2,904	3,177	0	9,661
32530	B	591000 Repairs		5,814	996	152	(676)	0	320
32530	B	601000 IT - Data Processing		5,176	4,164	3,302	4,319	0	8,483
32530	B	602000 IT-Communications		2,414	3,594	1,385	536	0	4,130
32530	B	603000 IT Contractual Services and Re		174	400	157	0	0	400
32530	B	611000 Professional Development		215,275	238,538	110,881	60,849	0	299,387
32530	B	621000 Operating Fees and Services		878,549	4,992,199	2,331,177	(119,707)	0	4,872,492

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-46 CHILDREN AND FAMILY SERVICES								
32530	B	623000 Fees - Professional Services	5,359	2,000	115	(1,500)	0	500
		Subtotal:	1,562,360	5,746,214	2,660,915	(22,613)	0	5,723,601
32530	F	F_3991 Operating - General Fund	192,879	2,057,420	979,217	156,186	0	2,213,606
32530	F	F_3992 Operating - Federal Funds	1,330,650	3,325,425	1,529,494	(132,729)	0	3,192,696
32530	F	F_3993 Operating - Other Funds	38,831	105,903	26,077	(51,637)	0	54,266
32530	F	F_3995 Operating - County Funds	0	257,466	126,127	5,567	0	263,033
		Subtotal:	1,562,360	5,746,214	2,660,915	(22,613)	0	5,723,601
32560	B	712000 Grants, Benefits & Claims	102,456,302	113,233,761	51,055,013	4,852,747	0	118,086,508
		Subtotal:	102,456,302	113,233,761	51,055,013	4,852,747	0	118,086,508
32560	F	F_6991 Grants - General Fund	17,105,159	19,272,304	8,280,103	4,177,615	0	23,449,919
32560	F	F_6992 Grants - Federal Funds	70,740,822	76,345,020	34,479,682	(1,003,919)	0	75,341,101
32560	F	F_6993 Grants - Other Funds	4,777,583	5,376,295	2,813,818	607,365	0	5,983,660
32560	F	F_6994 Grants - Swap Funds	216,322	119,183	68,856	13,654	0	132,837
32560	F	F_6995 Grants - County Funds	9,403,009	12,120,959	5,412,554	1,058,032	0	13,178,991
32560	F	F_6996 Grants - IGT Funds	213,407	0	0	0	0	0
		Subtotal:	102,456,302	113,233,761	51,055,013	4,852,747	0	118,086,508
		Subdivision Budget Total:	106,049,490	121,120,935	54,782,988	5,144,797	234,044	126,499,776
300-46 CHILDREN AND FAMILY SERVICES		**General Funds:**	17,828,599	21,918,091	9,553,508	4,645,951	109,478	26,673,520
		Federal Funds:	73,511,425	81,146,301	36,747,689	(1,126,456)	122,969	80,142,814
		Other Funds:	4,876,728	5,558,935	2,874,254	548,049	1,597	6,108,581
		SWAP Funds:	216,322	119,183	68,856	13,654	0	132,837
		County Funds:	9,403,009	12,378,425	5,538,681	1,063,599	0	13,442,024
		IGT Funds:	213,407	0	0	0	0	0
		Subdivision Funding Total:	106,049,490	121,120,935	54,782,988	5,144,797	234,044	126,499,776

Children and Family Services

Detail of Budget Account Code 621000 - Operating Fees & Services

Operating Fees & Services	Amount	General Fund	Federal/Other Funds
Adoption Contract	$ 2,410,527	$ 1,471,081	$ 939,446
Family Preservation Contract	1,747,891	508,014	1,239,877
County-wide Cost Allocation Plan	429,234		429,234
Background checks for foster care, adoption, and child care	147,548	35,004	112,544
Sponsored Training	93,000	7,750	85,250
Professional Services (consultants, grant writers)	11,811	2,657	9,154
Years of Service Awards	2,084	632	1,452
Freight and Express	1,370	337	1,033
Publications	20,827		20,827
Childcare Licensing Accreditation reimburseements	4,500		4,500
Other Miscellaneous Fees & Services	3,700	448	3,252
Total Operating Fees & Services Budget Account Code	$ 4,872,492	$ 2,025,923	$ 2,846,569

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
CHILDREN AND FAMILY SERVICES
GRANTS SUMMARY 2009-2011 BIENNIUM

Description	Bgt_Acct_Desc	Current Budget 2007 - 2009	Cont Prgm Changes	Cost Changes	Caseload Changes	FMAP Changes	Provider Inflation/ Other Executive Budget Recommendations	Total Budget Changes	2009-2011 "To House"
Foster Care	Grants - General Fund	$4,960,905	$194,134	$2,979,552	($4,932,969)	$126,321	$607,174	($1,025,788)	$3,935,117
Foster Care	Grants - Federal Funds	$32,601,125	$58,856	$12,793,180	($16,253,218)	($154,240)	$3,231,997	($323,425)	$32,277,700
Foster Care	Grants - Other Funds	$3,909,589		$809,632				$809,632	$4,719,221
Foster Care	Grants - County Funds	$8,574,706		$3,889,053	($4,174,572)	$27,919	$850,806	$593,206	$9,167,912
Foster Care	**Grants, Benefits & Claims**	**$50,046,325**	**$252,990**	**$20,471,417**	**($25,360,759)**		**$4,689,977**	**$53,625**	**$50,099,950**
Foster Care Services	Grants - General Fund	$1,208,892		($76,680)	($100,086)	$10,122	$112,044	($54,600)	$1,154,292
Foster Care Services	Grants - Federal Funds	$2,475,038		($1,334,726)	($100,766)	($11,650)	$110,436	($1,336,706)	$1,138,332
Foster Care Services	Grants - County Funds	$182,410		$121,490	($26,860)	$1,528	$29,952	$126,110	$308,520
Foster Care Services	**Grants, Benefits & Claims**	**$3,866,340**		**($1,289,916)**	**($227,712)**		**$252,432**	**($1,265,196)**	**$2,601,144**
Foster Care Therapeutic	Grants - General Fund	$2,165,900		$815,036		$9,720	$321,334	$1,146,090	$3,311,990
Foster Care Therapeutic	Grants - Federal Funds	$4,492,494		($2,578,618)		($11,182)	$204,422	($2,385,378)	$2,107,116
Foster Care Therapeutic	Grants - County Funds	$326,810		$604,450		$1,462	$100,224	$706,136	$1,032,946
Foster Care Therapeutic	**Grants, Benefits & Claims**	**$6,985,204**		**($1,159,132)**			**$625,980**	**($533,152)**	**$6,452,052**
Subsidized Guardianship	Grants - General Fund	$152,880		($4,056)	($34,344)			($38,400)	$114,480
Subsidized Guardianship	Grants - Federal Funds	$458,640		($12,168)	($103,032)			($115,200)	$343,440
Subsidized Guardianship	**Grants, Benefits & Claims**	**$611,520**		**($16,224)**	**($137,376)**			**($153,600)**	**$457,920**
Other Foster Care Grants	Grants - General Fund	$1,098,701	($70,000)					($70,000)	$1,028,701
Other Foster Care Grants	Grants - Federal Funds	$2,501,632	$252,233					$252,233	$2,753,865
Other Foster Care Grants	Grants - County Funds	$208,360	($37,500)					($37,500)	$170,860
Other Foster Care Grants	**Grants, Benefits & Claims**	**$3,808,693**	**$144,733**					**$144,733**	**$3,953,426**
Subsidized Adoption	Grants - General Fund	$5,738,361		$485,807	$375,803	$83,925	$724,084	$1,669,619	$7,407,980
Subsidized Adoption	Grants - Federal Funds	$6,263,674		$434,706	$861,220	($111,303)	$807,123	$1,991,746	$8,255,420
Subsidized Adoption	Grants - County Funds	$1,892,040		$162,555	$120,756	$27,378	$238,832	$549,521	$2,441,561
Subsidized Adoption	**Grants, Benefits & Claims**	**$13,894,075**		**$1,083,068**	**$1,357,779**		**$1,770,039**	**$4,210,886**	**$18,104,961**
Child Abuse Neglect Grants	Grants - General Fund	$804,254	$309,664				$558,513	$868,177	$1,672,431
Child Abuse Neglect Grants	Grants - Federal Funds	$5,108,559	$649,534					$649,534	$5,758,093
Child Abuse Neglect Grants	Grants - Other Funds	$157,087	$267,750					$267,750	$424,837
Child Abuse Neglect Grants	**Grants, Benefits & Claims**	**$6,069,900**	**$1,226,948**				**$558,513**	**$1,785,461**	**$7,855,361**
Family Preservation Grants	Grants - General Fund	$850,833	$48,654				$779,664	$828,318	$1,679,151
Family Preservation Grants	Grants - Federal Funds	$6,324,872	($1,513,136)				$98,236	($1,414,900)	$4,909,972
Family Preservation Grants	Grants - County Funds	$936,633	($886,498)				$7,057	($879,441)	$57,192
Family Preservation Grants	**Grants, Benefits & Claims**	**$8,112,338**	**($2,350,980)**				**$884,957**	**($1,466,023)**	**$6,646,315**
Early Childhood Services Grants	Grants - General Fund	$207,933	($41,712)				$67,707	$25,995	$233,928
Early Childhood Services Grants	Grants - Federal Funds	$2,911,400	($81,283)					($81,283)	$2,830,117
Early Childhood Services Grants	Grants - County Funds	$1,211,116	($395,274)					($395,274)	$815,842
Early Childhood Services Grants	**Grants, Benefits & Claims**	**$4,330,449**	**($518,269)**				**$67,707**	**($450,562)**	**$3,879,887**
Refugee Assistance Grants	Grants - Federal Funds	$4,300,717	($334,307)					($334,307)	$3,966,410
Refugee Assistance Grants	**Grants, Benefits & Claims**	**$4,300,717**	**($334,307)**					**($334,307)**	**$3,966,410**
Collaboration Grants	Grants - Federal Funds	$1,575,000	($74,158)					($74,158)	$1,500,842
Collaboration Grants	**Grants, Benefits & Claims**	**$1,575,000**	**($74,158)**					**($74,158)**	**$1,500,842**
County Reimbursement	Grants - General Fund	$2,083,645	$828,204					$828,204	$2,911,849
County Reimbursement	Grants - Federal Funds	$7,331,869	$2,167,925					$2,167,925	$9,499,794
County Reimbursement	Grants - Other Funds	$98,503	($74,743)					($74,743)	$23,760
County Reimbursement	Grants - SWAP Funds	$119,183	$13,654					$13,654	$132,837
County Reimbursement	**Grants, Benefits & Claims**	**$9,633,200**	**$2,935,040**					**$2,935,040**	**$12,568,240**
Total Children and Family Services Grants		**$113,233,761**	**$1,281,997**	**$19,089,213**	**($24,368,068)**		**$8,849,605**	**$4,852,747**	**$118,086,508**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
CHILDREN & FAMILY SERVICES CASELOAD COMPARISON
2009 - 2011 BIENNIUM

	2007-2009 Budgeted Avg Monthly		2009-2011 Budgeted Avg Monthly		Difference - Increase (Decrease)	
Description	Caseload	Cost Per Case	Caseload	Cost Per Case	Caseload	Cost Per Case
Therapeutic Foster Care	242	1,202.69	242	1,110.89	-	(91.80)
Services Foster Care	215	749.29	196	552.96	(19)	(196.33)
Foster Care - Family and PATH Homes	676	779.30	523	1,714.58	(153)	935.28
Foster Care - RCCF & GH	446	3,574.70	252	4,817.82	(194)	1,243.12
Subsidized Adoptions	911	635.36	992	760.46	81	125.10
Subsidized Guardianship	52	490.00	40	477.00	(12)	(13.00)

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
CHILDREN & FAMILY SERVICES CASELOAD COMPARISON
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Children and Family Services

Detail of Budget Account Code 582000 - Rentals/Leases - Building Land

Rentals/Leases	Total	General	Federal/Other
Booth and Room Rentals	$ 7,046	$ 1,098	$ 5,948
Rent for Paulette Westrum at NWHSC	2,615	1,257	1,358
Total Rentals/Leases - Building Land Budget Account Code	$ 9,661	$ 2,355	$ 7,306

A

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
CHILDREN AND FAMILY SERVICES DIVISION

	2007-2009 Biennium Budget	Governor's Budget 2009-2011	Other Bills / Amendments	Total
Parent Resource Centers	$ 335,880	$ 437,420	unsure	$ 437,420
Healthy Families	300,000	300,000	200,000	500,000
Family Group Conferencing / Intensive In-Home	1,578,302	1,747,891	1,456,372	3,204,263
Safety Permanency	198,686	298,686	-	298,686
Total	$ 2,412,868	$2,783,997	$ 1,656,372	$ 4,440,369

Parent Resource Centers are located in eight regional centers in the state, are networked through NDSU Extension , funded by a contract with CFS, and provide parent education and support programs to the public. This network has been in place for two years.

Healthy Families is a parent support and early intervention program for new parents. It is a national model with well-documented results nationally and locally. Current programs exist in Grand Forks, and more recently Burleigh/Morton County was recognized as an expansion site.

Family Group Conferencing/Family Group Decisionmaking is a service provided to bring families together to make decisions that prevent removal of children, or to facilitate reunification or permanence for children. This is a relatively new program in ND, but a well received program nationally with documented results in early intervention, preventing removals of children from their homes and facilitating permanency and family involvement . (Intensive In-Home is a service to parents to address issues that might create a need for present or future removal of their children. Services are provided to the parent(s) directly in their home and typically address safety and risk issues).

Safety Permanency Funds provide a flexible funding option for county casemanagers to assist a family with costs that will directly impact the need to remove a child from a home. These funds are administered through counties with regional and state oversight.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
CHILDREN AND FAMILY SERVICES DIVISION

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Healthy Families	300,000	300,000	200,000	500,000
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Safety Permanency	198,686	298,686	-	298,686
Total	$ 2,412,868	$ 2,783,997	$ 1,656,372	$ 4,440,369
General Fund	649,837	882,686	1,525,000	2,407,686

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Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
March 4, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, my name is Tara Lea Muhlhauser, and I am the Director of Children and Family Services (CFS) in the Department of Human Services. I am here today to provide you an overview of Division of Children and Family Services for the Department of Human Services.

Programs

- **Child Protective Services**: provides protection for children who have been or are at risk of being neglected and/or abused. Services provided include child protection assessment, case management, child fatality review, institutional child protection services and child abuse and neglect prevention programs.

- **Family Preservation Services**: provides therapeutic intervention to families whose children have been or are at risk of abuse, neglect and out-of-home placement. Services include parent aide, prime time child care, intensive in-home treatment services, respite care, family group conferencing and safety/permanency funds to prevent placement.

- **Foster Care Services**: provides a substitute temporary living environment for children who cannot safely remain with their families. Services include recruitment and retention of foster

homes; and licensing and placement services for relative homes, family foster homes, group homes, and residential child care facilities and licensed child placing agencies. This also includes foster care eligibility determination and payment, case planning and reviews, subsidized guardianship, Interstate Compact on the Placement of Children, Independent Living services to assist transitioning youth, including skills assessment, training and stipends.

- **Adoption Services**: provides permanent adoptive homes for eligible children. Services include recruitment, adoption assessment, placement, follow-up services, post adoption services, adoption subsidy, birth family services, adoption search, licensure of child placing agencies, and the Interstate Compact on the Placement of Children for Adoption.

- **Early Childhood Services**: coordinates activities, establishes standards, and provides training to providers of early childhood care and education. Services include licensing, child care resource and referral, providing consultation to the tribes on licensing, and coordination through the Head Start Collaboration Office.

- **Refugee Services**: provides resources to eligible refugees so they can become self-sufficient. Services include job development and employment enhancement, case management, cash assistance, refugee medical assistance, and education.

All these services are **provided either by the county social service agencies or through contracts with non-profit providers** and

they focus on the safety, permanency, and well-being of children and their families.

Caseloads

The number of **Child Abuse and Neglect assessments** completed for FFY 2008 was 4,011.

A caseload decrease can be noted in the **number of children placed in foster care.** The daily snapshot of children in foster care on 12/14/08 was 1,109 children in comparison to the daily snapshot on 12/14/06 which included 1,331 children. This snapshot includes tribal IV-E cases, Division of Juvenile Services (DJS) youth placed in foster care, and pre-adoptive placements. Approximately 29% of these children are Native American (321 children) in the most recent daily snapshot.

As of November 30, 2008, 41 youth were placed out-of-state in institutional care. This number has varied in 2008 from a low of 37 to a high of 50. This number has also continued to decline in the past two years.

The number of foster children gaining permanency through subsidized adoption has increased over the last three years and this trend is projected to continue through the 2009-11 biennium. Of the 110 finalized special needs adoptions in 2008, 86% of these children were adopted by their foster parents. In mid-2008, there were 128 children whose parents' rights had been terminated and who were waiting for a

permanency option of adoption, guardianship or another planned permanent living arrangement.

At current, there are 37 children benefitting from a subsidized guardianship, with five pending. In 2008, there was a total of 48 children in this program during the year, 47 in 2007.

Refugees entering North Dakota from 2000 to 2006 (October 1 – September 30) are as follows:

Year	Number of Refugees
2000	**647**
2001	**367**
2002	**51**
2003	**111**
2004	**223**
2005	**225**
2006	**182**
2007	**400**
2008	**425**

These numbers do not include secondary migration refugees who resettle in other states and move to North Dakota, which averages about 165 each year. The numbers increased quite dramatically in 2007-2008 in ND and nationally due to the numbers of increased arrivals supported by the US Department of State. It is anticipated the arrivals will be maintained at this level over the next few years.

Trends/Issues/Accomplishments/Major Program Changes

CFS continues to place emphasis on safety, permanency and well-being of children across all programs in the division. **Family preservation programs** and **involvement of relatives and kin**

when children are in need of placement, during service delivery and during reunification efforts are central to our work in achieving this emphasis. This past September, a new federal law, P.L. 110-351 "Fostering Connections" brought us several new federal requirements related to notification of relatives when a child is placed in care, and guidance for involving school, medical providers, relatives and other services providers in providing a comprehensive plan for a child while in care, and at the time of transition to adulthood from care.

The second **Federal Child and Family Services Review (CFSR) took place in April 2008.** Although completed, we have not yet received the final report from this review. Based on information from the Exit Interview with the federal team, and from the preliminary report given to us last month, we did not reach "substantial conformity" (e.g. we did not pass). No state has yet passed the CFSR in either the first or second rounds of these federal reviews. We were noted in this round to have many strengths and a few challenges that will require a Performance Improvement Plan (PIP). The first Federal CFSR Review was completed in September 2001. Though North Dakota received the highest rating in the nation in that first review, all 50 states and two territories were found to be deficient and were required to negotiate a Program Improvement Plan (PIP). North Dakota successfully completed this program improvement plan in 2006.

In August 2008, North Dakota successfully "passed" the **Federal IV-E Audit.** Official notification of this is forthcoming; this official notification will provide us with additional information on how many cases were found to be in error. This audit is conducted every three

years. North Dakota successfully passed this audit in 2005 with only one error found in the 80 cases under review. In both the 2005 and 2008 audits around the nation, there were a number of states that did not achieve "substantial conformity" in these audits. Fiscal sanctions are applied when cases are found in error.

Family Preservation programs and prevention services (to prevent child abuse and neglect or to prevent child placement) continue to be a primary focus of the work of CFS. Foster care placements are down, when placements occur we have increased the number of children placed with relatives, and we have placed emphasis on reunification efforts to keep child connected with families and in close proximity to relatives.

The Village Family Services, in collaboration with the Department, was awarded a grant from the Bush Foundation to provide **Family Group Decision Making** in the State of North Dakota. These services have been available to county social services, the Division of Juvenile Services and the tribes. This service brings family members to the table to develop a plan for children who are either in foster care, at risk of being placed in foster care, or children who are being cared for by their extended family. This also brings significant people in the life of the child(ren) together to discuss how to maintain and build family connections. As of March 1, 2006 (through September 2008), Family Group Decision Making has had 352 referrals, with 225 completed conferences. As of December 2008, 235 families (including 327 children) have been served by this program.

Over the past two years we have worked very hard with our IT partners to develop a new component to our **child welfare data system**. This will allow us to take the current individual program applications, streamline and connect them. This will reduce duplication and create ease in using all the programs developed for safety, permanency and well-being together; enhancing program and data links. This will also support the generation of more usable data to assist with data-driven decision making for child welfare programs in the Division. This new component is in the testing phase now and will be ready for the counties to use for all child welfare programs in August 2009.

There are still significant challenges in the **availability of quality child care** across the state. In 2000, 90.1% of all North Dakota children lived with both parents or with a single mother, the largest proportion in the nation. In addition, the proportion of North Dakota mothers (with children ages 0 to 17) in the labor force was 81.2% in 2000, the 2nd highest proportion nationwide. The proportion of working mothers is slightly smaller for mothers with young children ages 0 to 5 (76.1%), but rises to 84.9% for mothers with older children (ages 6 to 17). Current national and state-level 2006 data indicate that these proportions have changed little since 2000. This has created a demand for assurances of quality and safety in childcare settings and the need to provide training opportunities for this 10th largest workforce industry in North Dakota. This industry includes workers in home-based and center-based care settings.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget	House Changes	To Senate
Salary and Wages	2,140,960	548,707	2,689,667	(23,614)	2,666,053
Operating	5,746,214	(22,613)	5,723,601	(28,407)	5,695,194
Grants	113,233,761	4,852,747	118,086,508	(1,234,504)	116,852,004
Total	121,120,935	5,378,841	126,499,776	(1,286,525)	125,213,251
General Funds	21,918,091	4,755,429	26,673,520	(445,000)	26,228,520
Federal Funds	81,146,301	(1,003,487)	80,142,814	(661,578)	79,481,236
Other Funds	18,056,543	1,626,899	19,683,442	(179,947)	19,503,495
Total	121,120,935	5,378,841	126,499,776	(1,286,525)	125,213,251
FTE	17.0	1.0	18.0	-	18.0

Budget Changes from Current Budget to Executive Budget:

- The Salary and Wages line item increased by $548,707 and can be attributed to the following:
  - $234,044 in total funds of which $109,478 is general funds to fund the Governor's salary package for state employees.
  - $308,496 in total funds all of which are general funds to process background checks for childcare providers. Included are 4 temp staff, a .5 FTE Administrative Assistant position, and a .5 FTE Program Administrator position. It is anticipated that this group will process 9,000 background checks each year of the biennium.

- The remaining $6,167 is a combination of increases and decreases needed to sustain the salary of the 18.0 FTE in this area of the budget.

- The Operating line item decreased by ($22,613) and is a combination of the increases and decreases expected next biennium. Some of the significant changes are as follows:
  - A decrease in the county wide cost allocation fees ($644,053), due to contract negotiations with the vendor.
  - An increase in the Adoption Services contract, permanency for children who cannot return home, $328,887. Currently serving more children than outlined in the performance based contract and additional funds are needed to meet the anticipated demand for the 2009-2011 biennium.
  - An increase in the Family Preservation Services contract, in-home services designed to keep families together, for the 7%/7% provider inflation included in the Governor's budget - $169,589.
  - An increase in printing costs of $25,009 for printing projects for the Head Start and Early Childhood Services programs as well as to accommodate the 9% annual increase for OMB during the 2009-2011 biennium.
  - An increase in professional development of $60,849 which includes $57,600 for a $50 daily rate increase for those participating in the CFS reviews as increasing the number of reviewers from 8 to 12. The daily rate increase will aid in recruiting an adequate number of qualified staff to participate in the reviews.

- The Grants line item increased by $4,852,747 which can be attributed to the following:
  - Subsidized adoption is projected for 992 children per month for a total program increase of $4,210,886 of which $1,669,619 is general fund.
  - A decrease in the Foster Care caseload of 347 cases per month from the 2007-2009 biennium is offset by; the rate increase for family foster homes for the MARC Report (Minimum Adequate Rates for Children), which established guidelines for the payment of family foster homes, these providers will receive an increase from 23% to 46% depending on the age of the child placed in their home and will aid in the recruitment and retention of family foster homes, funding changes due to elimination of Targeted Case Management for foster care as a billable service to Medicaid, and the 7% inflationary increase for foster care providers each year of the biennium for a overall program decrease of ($1,898,323) of which $27,302 is general funds.
  - The 7% inflationary increase for family preservation services for each year of the biennium totals $584,957 of which $479,664 is general funds.
  - Increase of $708,511 of which $241,555 is general funds for 25 additional child abuse and neglect assessments per month.
  - The 7% inflationary increase for Child Abuse Services for each year of the biennium totals $558,513 all of which are general funds.

- An additional $300,000 was added to expand family preservation services to the Standing Rock and Spirit Lake Tribes.
- Attachment A lists the major grants and describes how the foster care budget has been developed.

House Changes:

- The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $7,754 general fund and $15,860 federal/other funds for a total of $23,614.

- The changes in operating are due to the House reduction of 50% of the department-wide travel increase, the CFS share of this decrease is $3,706 in total funds; $1,054 general fund, and the reduction of the inflationary increase for providers from 7% and 7% to 6% and 6% resulting in a decrease of $24,701 all of which are general fund in the operating fees and services line.

- The House reduction for inflationary increases from 7% and 7% to 6% and 6% for providers resulted in a decrease of $1,234,504 in the grants line of which $411,491 is general fund.

This concludes my testimony on the 2009 – 2011 budget requests for CFS. I would be happy to answer any questions.

See attachment A with testimony on 1-13-09

The foster care budget is built with the following trend data:

- Average number of children in family homes - 523 per month; average cost per child – $1,715 per month.
- Average number of children in RCCF/GH – 252 per month; average cost per child - $4,818 per month.
- Average number of children in therapeutic foster care - 242 per month; average cost per child - $1,111 per month.
- Foster care services – 196 children per month; average cost per child of $553.
- Subsidized Guardianship - 40 children per month; average cost per child - $477 per month.

C

HB 1012
Foster Care Payments
January 27, 2009

Same given to Senate

Jon Mielke & wife Carol
Licensed by Burleigh County for six years
Take children ages 0-2
President of local foster parent association & vice president of state association
Testifying in support of the foster care payment increases contained in HB 1012

As foster parents, we never know what the next phone call will bring
It might be a call in the middle of the night and we spend the next several hours going to the police department to pick up a child or two and then rocking a crying child to sleep while trying to explain why they can't go home. For the next day or two or more we try to console and comfort and reassure them.

In other cases the call from social services might result in a child coming into our home and our lives for several months or even years. Sometimes these kids are healthy but sometimes they come with oxygen tanks and tubes, heart and lung monitors, and breathing treatment apparatus. In one case, we received a little boy who was 10 months old and weighed only 10 pounds. Over the next 9 months we gave him breathing treatments 3 times a day and several different daily medications at various times throughout the day. He also had a total of 275 appointments during the next 9 months – things like family visits, medical appointments, and occupational and physical therapy.

The base rate for providing foster care to children age 4 and younger is $404 per month or 56 cents per hour. Please note that this amount is not the equivalent of net take home pay because foster parents use a portion of this stipend to pay for transportation to and from appointments, to buy things like diapers, and to pay babysitters when the parents need to get away for dinner or a movie.

You probably won't hear foster parents complaining because they are not in it for the money. It is, however, nice to be recognized for the services that we provide. North Dakota has a reputation of looking after the needs of its young people. This bill exemplifies this fact by providing acknowledgement to foster parents who are care givers to some of North Dakota's most needy children.

3-11-09 9

north dakota department of human services

Children and Family Services Division

(701) 328-2316
Toll Free 1-800-245-3736
Fax (701) 328-3538
ND Relay TTY 1-800-366-6888

John Hoeven, Governor
Carol K. Olson, Executive Director

MEMORANDUM

March 10, 2009

To: Senator Ray Holmberg, Chair-Senate Appropriations
From: TaraLea Muhlhauser, Director-CFS, ND Department of Human Services

Re: Question on Foster Care data during CFS budget presentation

Attached is a report on the foster care data the Committee inquired about during my testimony. In the report you will find rates of child placement for the urban communities that are regional "centers". The rates of foster care are listed for these communities next to the child population of these same communities.

I am available to provide explanations, interpretations, or answer questions in regard to this data.

NDDHS

North Dakota Foster Care Children

Placement Setting

2008

Table 1: Foster Care Placement Setting – County & Regional Totals (April 1, 2006-March 30, 2007)

Counties	Pre-Adoptive	Foster Family Relative	Foster Family Non-Relative	Institution	Trial Home Visit	Group Home	Total
Region I							
Divide	0	2	2	1	1	0	6
McKenzie	0	5	1	5	0	0	11
Williams	4	30	35	51	10	4	134
Total	4	37	38	57	11	4	151
Region II							
Bottineau	0	0	3	4	0	1	8
Burke	0	0	0	0	0	0	0
McHenry	4	2	6	4	0	4	20
Mountrail	0	10	17	6	6	1	40
Pierce	0	1	1	2	0	0	4
Renville	0	0	0	1	0	0	1
Ward	22	13	126	66	4	20	251
Total	26	26	153	83	10	26	324
Region III							
Benson	4	25	43	21	1	2	96
Cavalier	1	0	0	0	1	0	2
Eddy	0	0	1	1	0	0	2
Ramsey	7	36	37	25	18	6	129
Rolette	0	28	49	19	0	4	100
Towner	6	2	0	2	1	0	11
Total	18	91	130	68	21	12	340
Region IV							
G. Forks	26	98	111	54	40	18	347
Nelson	0	0	5	2	1	1	9
Pembina	1	8	8	3	3	0	23
Walsh	4	22	22	10	2	2	62
Total	31	128	146	69	46	21	441
Region V							
Cass	114	156	284	115	10	41	720
Ransom	2	1	5	2	0	2	12
Richland	7	6	31	9	0	2	55
Sargent	2	0	2	3	2	1	10
Steele	0	0	0	2	0	0	2
Traill	3	10	9	6	4	0	32
Total	128	173	331	137	16	46	831

Counties	Pre-Adoptive	Foster Family Relative	Foster Family Non-Relative	Institution	Trial Home Visit	Group Home	Total
Region VI							
Barnes	4	9	24	11	0	0	48
Dickey	1	5	11	0	0	0	17
Foster	0	0	2	4	0	0	6
Griggs	1	0	5	0	0	0	6
LaMoure	2	0	0	3	0	0	5
Logan	1	0	0	0	0	0	1
McIntosh	0	2	6	1	0	0	9
Stutsman	11	8	23	17	1	0	60
Wells	1	0	2	2	0	0	5
Total	21	24	73	38	1	0	157
Region VII							
Burleigh	27	31	78	109	18	8	271
Emmons	0	0	0	1	0	0	1
Grant	1	2	3	1	2	0	9
Kidder	1	0	3	2	0	0	6
McLean	0	3	0	4	0	0	7
Mercer	2	2	0	4	0	1	9
Morton	11	13	26	30	9	0	89
Oliver	1	0	0	1	0	0	2
Sheridan	0	0	0	1	0	0	1
Sioux	0	4	15	6	0	1	26
Total	43	55	125	159	29	10	421
Region VIII							
Adams	0	0	3	2	0	1	6
Billings	0	0	0	0	0	0	0
Bowman	1	0	4	4	0	0	9
Dunn	0	1	1	2	0	0	4
G. Valley	0	0	0	2	0	0	2
Hettinger	2	1	2	0	1	0	6
Slope	0	0	0	0	0	0	0
Stark	11	50	54	31	2	3	151
Total	14	52	64	41	3	4	178
Grand Total	285	586	1,060	653	137	123	2,845

AFCARS annual files: 2005b/2006a and 2006b/2007a (N=2,845).

Note: Runaways are included as a placement type in AFCARS. There were 12 runaways which were excluded in this table.

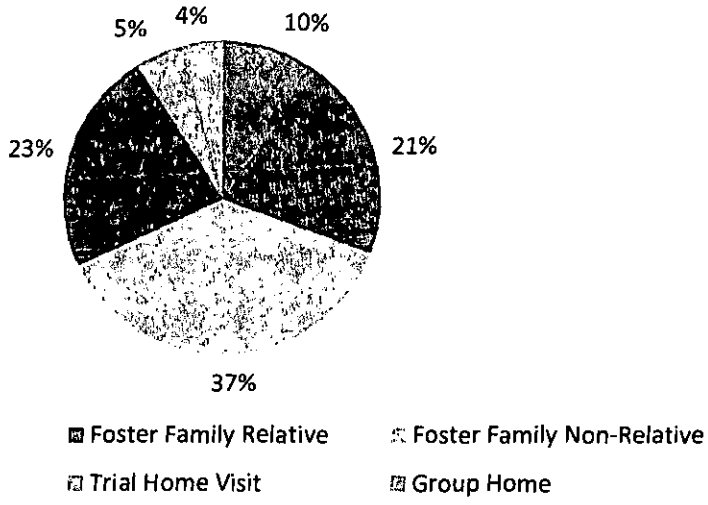
Table 2. Foster Care Placement Setting: Out-of-State by County & Region (April 1, 2006-March 30, 2007)

Counties	Pre-Adoptive	Foster Family Relative	Foster Family Non-Relative	Institution	Trial Home Visit	Group Home	Total
Region I							
Divide	0	2	0	0	0	0	2
Williams	0	2	0	3	0	0	5
Total	0	4	0	3	0	0	7
Region II							
Mountrail	0	2	0	0	0	0	2
Ward	1	7	0	9	0	0	17
Total	1	9	0	9	0	0	19
Region III							
Benson	0	0	1	3	0	0	4
Rolette	0	0	0	1	0	0	1
Total							
Region IV							
G. Forks	3	5	1	9	0	1	19
Walsh	0	0	2	2	0	0	4
Total	3	5	3	11	0	1	23
Region V							
Cass	22	30	28	23	3	1	107
Richland	1	1	2	1	0	0	5
Traill	1	0	0	4	0	0	5
Total	24	31	30	28	3	1	117
Region VI							
Dickey	1	4	0	0	0	0	5
McIntosh	0	1	2	0	0	0	3
Total	1	5	2	0	0	0	8
Region VII							
Burleigh	6	1	4	9	0	0	20
Kidder	0	0	0	1	0	0	1
McLean	0	0	0	2	0	0	2
Morton	0	2	0	1	3	0	6
Sioux	0	2	3	1	0	0	6
Total	6	5	7	14	3	0	35
Region VII							
Hettinger	0	0	0	0	1	0	1
Stark	2	4	0	3	1	0	10
Total	2	4	0	3	2	0	11
Grand Total	37	63	43	72	8	2	225

AFCARS annual files: 2005b/2006a and 2006b/2007a (N=225).

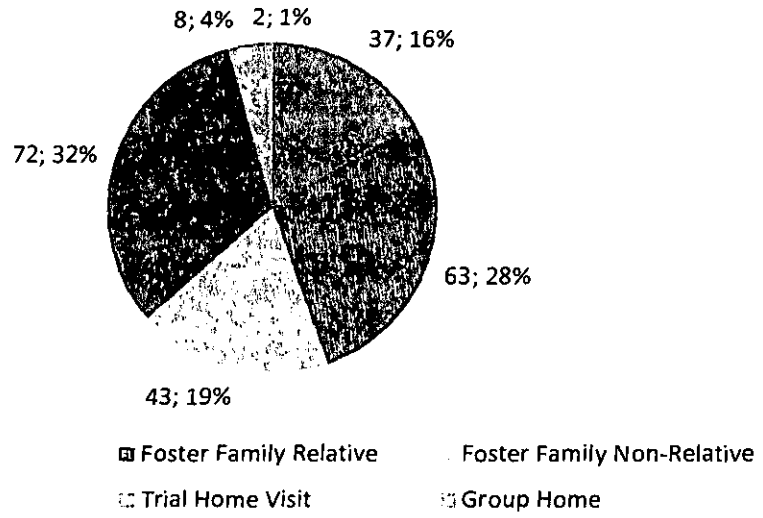
As depicted in Figure 1, from April 1, 2006 through March 30, 2007, 37% of foster care placements were in non-relative licensed foster family homes followed by institutions (23%) and relative (unlicensed) foster family homes (21%). Figure 2 represents out-of-state placements with 32% (72) of North Dakota children in institutions, 28% (63) in relative (unlicensed) foster family homes, and 19% (43) in non-relative licensed foster family homes.

Figure 1. North Dakota Foster Care Placement Setting
(April 1, 2006-March 30, 2007)



AFCARS annual files: 2005b/2006a and 2006b/2007a (N=2,845).

Figure 2. Number of Foster Care Children Out-of-State by Placement Setting
(April 1, 2006-March 30, 2007)



AFCARS annual files: 2005b/2006a and 2006b/2007a (N=225).

Table 3. Burleigh County General Child and Foster Care Populations by Child Age Range

Age	General Child Population	Foster Care Placements	Percent
Under 5	4,572	41	.9%
5-13	7,966	42	.5%
14-17	3,840	107	2.8%
Total	16,378	190	1.1%

2006 Census-County Population by Age. AFCARS annual files: 2005b/2006a and 2006b/2007a.
Note: The total number of placements includes children through age 17.

Table 4. Burleigh County Foster Care Placements by Child Age (April 1, 2006-March 30, 2007)

Age	Pre-Adoptive	Foster Family Relative	Foster Family Non-Relative	Institution	Trial Home Visit	Group Home	Total
Infant	1	0	0	0	0	0	1
1	1	0	3	0	0	0	4
2	6	1	8	0	0	0	15
Total	8	1	11	0	0	0	20
3	5	0	4	0	0	0	9
4	5	1	6	0	0	0	12
5	4	1	6	0	0	0	11
6	2	0	1	0	0	0	3
7	2	1	2	0	1	0	6
8	0	0	2	0	0	0	2
9	0	0	4	0	0	0	4
10	0	0	1	0	0	0	1
11	1	1	3	0	0	0	5
12	0	0	3	1	0	0	4
13	0	1	1	3	0	1	6
Total	19	5	33	4	1	1	63
14	0	0	1	5	0	0	6
15	0	1	5	17	4	0	27
16	0	2	4	10	2	1	19
17	0	11	8	26	9	1	55
18+	0	11	16	47	2	5	81
Total	0	25	34	105	17	7	188
Total	27	31	78	109	18	8	271

AFCARS annual files: 2005b/2006a and 2006b/2007a (N=271).
Note: The total number of placements includes children age 18 and older.

Table 5. Cass County General Child and Foster Care Populations by Child Age Range

Age	General Child Population	Foster Care Placements	Percent
Under 5	8,751	201	2.2%
5-13	14,543	248	1.7%
14-17	6,464	164	2.5%
Total	29,758	613	2.0%

2006 Census-County Population by Age. AFCARS annual files: 2005b/2006a and 2006b/2007a.
Note: The total number of placements includes children through age 17.

Table 6. Cass County Foster Care Placements by Age by Child Age (April 1, 2006-March 30, 2007)

Age	Pre-Adoptive	Foster Family Relative	Foster Family Non-Relative	Institution	Trial Home Visit	Group Home	Total
Infant	6	0	2	0	0	0	8
1	13	6	19	0	1	0	39
2	22	15	32	0	0	0	69
Total	41	21	53	0	1	0	116
3	12	11	23	0	1	0	47
4	9	11	18	0	0	0	38
5	12	13	14	0	0	0	39
6	5	8	21	2	0	1	37
7	6	6	15	0	0	2	29
8	2	10	12	1	0	2	27
9	6	6	10	0	0	3	25
10	7	6	11	1	1	1	27
11	3	11	15	0	0	2	31
12	2	4	5	0	0	3	14
13	2	6	6	3	1	1	19
Total	66	92	150	7	3	15	333
14	3	7	7	6	1	4	28
15	1	8	9	16	0	2	36
16	1	11	12	18	1	8	51
17	0	7	11	22	2	7	49
18+	2	10	42	46	2	5	107
Total	7	43	81	108	6	26	271
Grand Total	114	156	284	115	10	41	720

AFCARS annual files: 2005b/2006a and 2006b/2007a (N=720)
Note: The total number of placements includes children age 18 and older.

Table 7. Grand Forks County General Child and Foster Care Populations by Child Age Range

Age	General Child Population	Foster Care Placements	Percent
Under 5	4,239	78	1.8%
5-13	7,054	111	1.5%
14-17	3,229	92	2.8%
Total	14,522	281	1.9%

2006 Census-County Population by Age. AFCARS annual files: 2005b/2006a and 2006b/2007a.
Note: The total number of placements includes children through age 17.

Table 8. Grand Forks County Foster Care Placements by Age by Child Age (April 1, 2006-March 30, 2007)

Age	Pre-Adoptive	Foster Family Relative	Foster Family Non-Relative	Institution	Trial Home Visit	Group Home	Total
Infant	0	0	0	0	0	0	0
1	3	2	8	0	0	0	13
2	4	9	6	0	1	0	20
Total	7	11	14	0	1	0	33
3	9	5	12	0	5	0	31
4	1	4	9	0	0	0	14
5	1	6	5	0	0	0	12
6	1	4	7	0	1	0	13
7	1	1	4	0	1	0	7
8	0	4	8	1	2	0	15
9	0	3	6	0	4	0	13
10	1	6	4	2	3	0	16
11	1	4	4	0	2	0	11
12	0	3	3	2	2	0	10
13	2	4	2	2	2	2	14
Total	17	44	64	7	22	2	156
14	2	4	7	0	4	1	18
15	0	8	7	9	0	2	26
16	0	8	3	6	2	5	24
17	0	7	6	9	2	0	24
18+	0	16	10	23	9	8	66
Total	2	43	33	47	17	16	158
Grand Total	26	98	111	54	40	18	347

AFCARS annual files: 2005b/2006a and 2006b/2007a (N=347).
Note: The total number of placements includes children age 18 and older.

Table 9. Ramsey County General Child and Foster Care Populations by Child Age Range

Age	General Child Population	Foster Care Placements	Percent
Under 5	713	28	3.9%
5-13	1,276	49	3.8%
14-17	665	39	5.8%
Total	2,654	116	4.3%

2006 Census-County Population by Age. AFCARS annual files: 2005b/2006a and 2006b/2007a.
Note: The total number of placements includes children through age 17.

Table 10. Ramsey County Foster Care Placements by Child Age (April 1, 2006-March 30, 2007)

Age	Pre-Adoptive	Foster Family Relative	Foster Family Non-Relative	Institution	Trial Home Visit	Group Home	Total
Infant	0	0	0	0	0	0	0
1	2	0	2	0	1	0	5
2	0	0	2	0	2	0	4
Total	2	0	4	0	3	0	9
3	0	4	2	0	3	0	9
4	0	6	1	0	3	0	10
5	0	1	1	0	1	0	3
6	0	7	2	0	2	0	11
7	1	2	3	0	1	0	7
8	0	2	1	0	0	0	3
9	1	1	3	0	3	0	8
10	1	1	3	0	0	1	6
11	0	1	3	0	0	0	4
12	0	1	0	0	1	0	2
13	1	1	2	0	1	0	5
Total	4	27	21	0	15	1	68
14	0	2	2	0	0	2	6
15	0	0	5	6	0	0	11
16	0	1	2	6	0	0	9
17	1	3	3	6	0	0	13
18+	0	3	0	7	0	3	13
Total	1	9	12	25	0	5	52
Grand Total	7	36	37	25	18	6	129

AFCARS annual files: 2005b/2006a and 2006b/2007a (N=129).
Note: The total number of placements includes children age 18 and older.

Table 11. Stark County General Child and Foster Care Populations by Child Age Range

Age	General Child Population	Foster Care Placements	Percent
Under 5	1,368	21	1.5%
5-13	2,350	51	2.1%
14-17	1,305	47	3.6%
Total	5,023	119	2.3%

2006 Census-County Population by Age. AFCARS annual files: 2005b/2006a and 2006b/2007a.
Note: The total number of placements includes children through age 17.

Table 12. Stark County Foster Care Placements by Child Age (April 1, 2006-March 30, 2007)

Age	Pre-Adoptive	Foster Family Relative	Foster Family Non-Relative	Institution	Trial Home Visit	Group Home	Total
Infant	0	0	0	0	0	0	0
1	1	1	1	0	0	0	3
2	1	2	3	0	0	0	6
Total	2	3	4	0	0	0	9
3	2	2	2	0	0	0	6
4	0	4	2	0	0	0	6
5	1	1	3	0	0	0	5
6	0	1	1	0	0	0	2
7	0	4	2	0	0	0	6
8	2	3	3	0	0	0	8
9	1	5	3	0	0	0	9
10	1	2	1	0	0	0	4
11	2	1	2	0	0	0	5
12	0	1	2	1	0	0	4
13	0	1	5	2	0	0	8
Total	9	25	26	3	0	0	63
14	0	1	5	1	1	0	8
15	0	3	3	1	0	0	7
16	0	4	6	6	0	0	16
17	0	5	3	7	0	1	16
18+	0	9	7	13	1	2	32
Total	0	22	24	28	2	3	79
Grand Total	11	50	54	31	2	3	151

AFCARS annual files: 2005b/2006a and 2006b/2007a (N=151).
Note: The total number of placements includes children age 18 and older.

Table 13. Stutsman County General Child and Foster Care Populations by Child Age Range

Age	General Child Population	Foster Care Placements	Percent
Under 5	1,096	9	.8%
5-13	2,002	20	1.0%
14-17	1,082	31	2.8%
Total	4,180	60	1.4%

2006 Census-County Population by Age. AFCARS annual files: 2005b/2006a and 2006b/2007a.
Note: The total number of placements includes children through age 17.

Table 14. Stutsman County Foster Care Placements by Child Age (April 1, 2006-March 30, 2007)

Age	Pre-Adoptive	Foster Family Relative	Foster Family Non-Relative	Institution	Trial Home Visit	Group Home	Total
Infant	0	0	0	0	0	0	0
1	1	1	2	0	0	0	4
2	2	0	1	0	0	0	3
Total	3	1	3	0	0	0	7
3	0	2	0	0	0	0	2
4	0	0	0	0	0	0	0
5	2	0	2	0	0	0	4
6	1	2	1	0	0	0	4
7	0	1	0	0	0	0	1
8	2	0	2	0	0	0	4
9	0	0	1	0	0	0	1
10	2	0	2	0	0	0	4
11	1	0	0	0	0	0	1
12	0	0	1	0	0	0	1
13	0	0	0	0	0	0	0
Total	8	5	9	0	0	0	22
14	0	0	0	0	0	0	0
15	0	1	2	0	0	0	3
16	0	0	1	3	1	0	5
17	0	1	0	1	0	0	2
18+	0	0	8	13	0	0	21
Total	0	2	11	17	1	0	31
Grand Total	11	8	23	17	1	0	60

AFCARS annual files: 2005b/2006a and 2006b/2007a (N=60).
Note: The total number of placements includes children age 18 and older.

Table 15. Ward County General Child and Foster Care Populations by Child Age Range

Age	General Child Population	Foster Care Placements	Percent
Under 5	4,555	40	.8%
5-13	7,083	79	1.1%
14-17	3,138	68	2.1%
Total	14,776	187	1.2%

2006 Census-County Population by Age. AFCARS annual files: 2005b/2006a and 2006b/2007a.
Note: The total number of placements includes children through age 17.

Table 16. Ward County Foster Care Placements by Child Age (April 1, 2006-March 30, 2007)

Age	Pre-Adoptive	Foster Family Relative	Foster Family Non-Relative	Institution	Trial Home Visit	Group Home	Total
Infant	0	1	0	0	0	0	1
1	3	0	6	0	0	0	9
2	7	1	8	1	0	0	17
Total	10	2	14	1	0	0	27
3	2	0	1	0	0	0	3
4	2	0	8	0	0	0	10
5	2	0	8	1	0	0	11
6	0	2	6	0	0	0	8
7	1	0	8	0	0	0	9
8	1	0	4	1	1	0	7
9	1	0	10	0	0	0	11
10	2	1	5	0	1	0	9
11	1	1	8	1	0	0	11
12	0	2	2	1	1	0	6
13	0	0	6	0	1	0	7
Total	12	6	66	4	4	0	92
14	0	1	4	4	0	0	9
15	0	1	5	5	0	3	14
16	0	0	6	12	0	0	18
17	0	2	6	14	0	5	27
18+	0	1	25	26	0	12	64
Total	0	5	46	61	0	20	132
Grand Total	22	13	126	66	4	20	251

AFCARS annual files: 2005b/2006a and 2006b/2007a (N=251).
Note: The total number of placements includes children age 18 and older.

Table 17. Williams County General Child and Foster Care Populations by Child Age Range

Age	General Child Population	Foster Care Placements	Percent
Under 5	1,098	18	1.6%
5-13	2,117	35	1.6%
14-17	1,128	48	4.2%
Total	4,343	101	2.3%

2006 Census-County Population by Age. AFCARS annual files: 2005b/2006a and 2006b/2007a.
Note: The total number of placements includes children through age 17.

Table 18. Williams County Foster Care Placements by Child Age (April 1, 2006-March 30, 2007)

Age	Pre-Adoptive	Foster Family Relative	Foster Family Non-Relative	Institution	Trial Home Visit	Group Home	Total
Infant	1	0	0	0	0	0	1
1	2	0	1	0	0	0	3
2	1	2	4	0	0	0	7
Total	4	2	5	0	0	0	11
3	0	1	2	0	0	0	3
4	0	2	2	0	0	0	4
5	0	0	1	0	2	0	3
6	0	2	1	0	0	0	3
7	0	1	2	0	0	0	3
8	0	0	1	0	1	0	2
9	0	1	1	0	2	0	4
10	0	4	1	0	2	0	7
11	0	1	2	0	0	0	3
12	0	2	1	0	1	0	4
13	0	2	3	1	0	0	6
Total	0	16	17	1	8	0	42
14	0	4	1	5	0	0	10
15	0	1	3	5	1	0	10
16	0	3	2	10	0	0	15
17	0	1	2	9	0	1	13
18+	0	3	5	21	1	3	33
Total	0	12	13	50	2	4	81
Grand Total	4	30	35	51	10	4	134

AFCARS annual files: 2005b/2006a and 2006b/2007a (N=134).
Note: The total number of placements includes children age 18 and older.

D

Testimony

House Bill 1012 – Department of Human Services

House Appropriations - Human Resource Division

Representative Pollert, Chairman

January 27, 2009

Same given to Senate

Chairman Pollert and members of the House Appropriations Human Resources Committee, my name is Leanne Johnson and I am employed by Catholic Charities North Dakota and serve as the AASK Director (Adults Adopting Special Kids). I am providing this written testimony in regards to the Adoption Contracts line item of House Bill Number 1012.

I'd like you to meet Brad. Brad is 13 years old and was in foster care for 8 years and has emotional and mental health disabilities, along with learning disabilities brought about by several years of parental abuse and neglect. This past year, the AASK program successfully recruited an adoptive family for Brad - a family to call his own. After many years of foster care, which included family foster homes and residential treatment services, Brad is now successfully living with his adoptive family. This is the heart of the services provided by AASK.

The AASK program is a collaborative program between Catholic Charities North Dakota (CCND) and PATH ND, Inc. (PATH) responsible for providing adoption services to children in the North Dakota foster care system and the families adopting these children. The Department of Human Services awarded the Outcomes Based Adoption Services Contract to CCND in July 2005. Children with "special needs" can mean different things. They may be older children, children placed along with a sibling for adoption, children with a mental, physical, emotional disability, or at risk of such a disability or children of minority race which make them difficult to place. Often, children meet more than one of these criteria. Parents adopting these children can be relatives, foster parents, or parents wishing to start, add to, or complete their family. Research shows that

managing special needs adoption cases requires skills and commitment above and beyond the traditional adoption case. The AASK Program serves these children in this manner throughout the state of North Dakota. Attachment A provides detail on staff location and service areas.

AASK provides a continuum of foster care adoption services, ranging from early permanency planning services to post-adoption services. Broadly speaking, AASK becomes involved in the planning for a foster child when adoption is being considered as a permanency option. Once adoption becomes the active goal, the AASK program will work to assess and prepare the child and the family. Should a child not have a potential adoptive resource, such as a relative or foster parent, the program will provide recruitment services to identify an adoptive family for the child. Services to assist birth parents to make informed decisions are made available as requested. The AASK program will assist families through the adoption assistance application process, the adoptive placement process, and provide post-placement services until the adoption is finalized. At any given time, the program is working with approximately 150 children in the early permanency planning stages, 90 children with an active goal of adoption, and 100 families in various stages of the adoption process. Once an adoption is finalized, the AASK program remains a resource to the family for information and support. Additional post-adoption services currently provided include assistance with communication agreements between birth and adoptive families and information and referral support. These past two years, the program has been able to provide scholarships for families to attend post-adoption family camps, and initiate a pilot project for formal post-finalization adoption services in the Fargo region.

The Outcomes Based Adoption Services Contract, initiated in July 2005, outlines 4 pay points at which the AASK Program received payment for its services. Those points are: 1) when a child is placed for adoption, 2) when a child's adoption is finalized, 3) a timeliness payment when the child's adoption is

finalized within twelve months of the termination of parental rights, and 4) a degree of difficulty payment for the extended recruitment services some children require. In all three years of the contract with CCND and PATH, the AASK program has met or exceeded many of these targets and the state has paid in excess of the budgeted amount each fiscal year. For this current fiscal year, it is anticipated that the program will exceed all four pay points as the program is serving more children than were proposed. Details on these specifics can be found in Attachment B. Finally, these past two years permitted the development of more formalized post-adoption services, a great need for our state. Preliminary results of this pilot project, however, show that more time, attention and funding is needed to provide the level of service needed for post-adoption services.

Permanency for children is not only a federal and state mandate – permanency is a need for all children which leads to better outcomes for the child throughout their life. When children cannot be safely returned to the birth home, permanency through adoption is often the next best option for many children - an option that will save the state money. It is noted that an average per child cost for a child in foster care per month is $3,266. This represents the average per child per month cost for a child placed in a family foster/ therapeutic foster home or residential or group home setting which has an average per child cost of $1,715 and $4,818 respectively. However, the average cost per child in a subsidized adoption is only $760 per month. This difference does not include the additional cost-savings to the state, such as reduced case management and court services and Medical Assistance costs that are realized when a child is discharged from foster care.

One of the greatest needs for families adopting children with special needs is the need for formalized post-adoption services. Children being placed for adoption have very challenging needs and can be draining on a family system -- emotionally and financially. This is a service area that the AASK program seeks

to further develop and right now there is simply not enough financial resources. The AASK program seeks an additional $200,000 dedicated to the adoptions contract line item so that a sufficient level of services can be provided to the children and families of North Dakota. Attachment C provides additional detail regarding this request.

In closing, I leave you with these thoughts:

- ☐ Adoption is a success: it is a success to the children who need permanency and cannot return to the birth home, a success to families, and a success to the state.
- ☐ Adoption saves the state money.
- ☐ Absolute dedication and attention to the life-long adoption needs of children with special needs in foster care and their families results in greater outcomes for all.
- ☐ AASK as a collaborative with CCND and PATH has achieved higher outcomes than all of the history of special needs adoption in North Dakota and continues to strive towards greater achievements.

Please consider Brad, and other children who are in the state's care, custody and control as you make your final budget recommendations. In order to provide quality services to the children and families of North Dakota, I ask that you fully fund the adoption contract line item of the Departments budget by increasing the funding by $200,000 for the biennium. Thank you for the opportunity to provide information to your committee. I am available to answer any questions either today or through my contract information listed below.

Leanne Johnson, AASK Director
e-mail: ljohnson@catholiccharitiesnd.org
Office phone: 701.356-7986

Attachment A

AASK - A Collaborative Program of CCND and PATH
Service Map

PATH
2000 East Burdick Expressway, Minot, ND 58701 - (701) 852-2854
- Heather Kippen, Supervisor
- Alysha Berg, Divide, Ward, Williams, McKenzie, Burke, Mountrail
- Julie Hatfield, Ward, Renville, Bottineau, McHenry and Pierce

PATH-Turtle Mt
PO Box 1970
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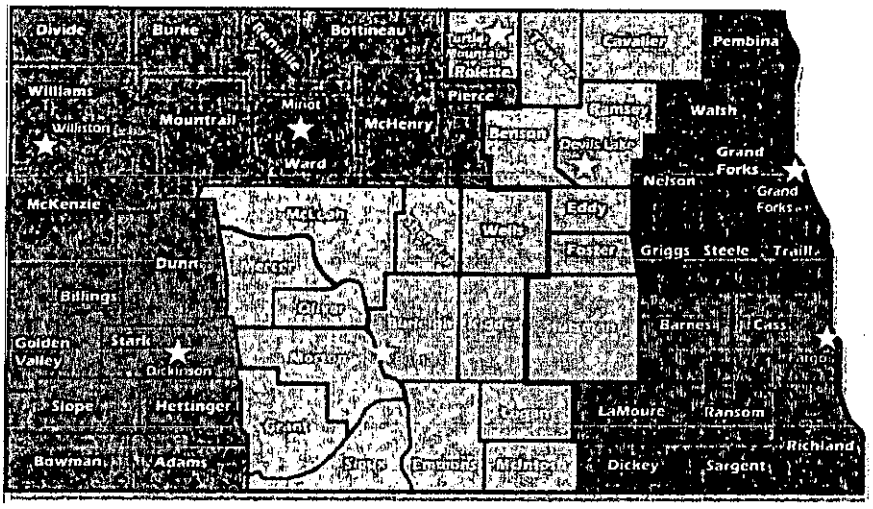
(701) 477-0525
- Janice Delorme

Path
420 4th Ave NE,
Devils Lake, ND 58301
(701) 662-4913
- Berta Soper



PATH
135 Sims St., Suite 204, Dickinson, ND 58601, (701) 225-3310
- Linda Gregory

PATH
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- Kelly [illegible]

Catholic Charities ND
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(701) 235-4457 or
(877) 551-6054
- Leanne Johnson, Program Director
- Danelle Klaman, Supervisor
- Nancy Germain: Cass, Lamoure and Dickey
- Kathy Quaife: Cass, Barnes, Griggs, and Stutsman
- Jennifer Foss: WWK; Richland, Ransom, Sargent and Cass
- Andrea Donais: Cass, Richland, Ransom, Sargent
- Sonja McLean: Cass, Richland

Effective 01/09

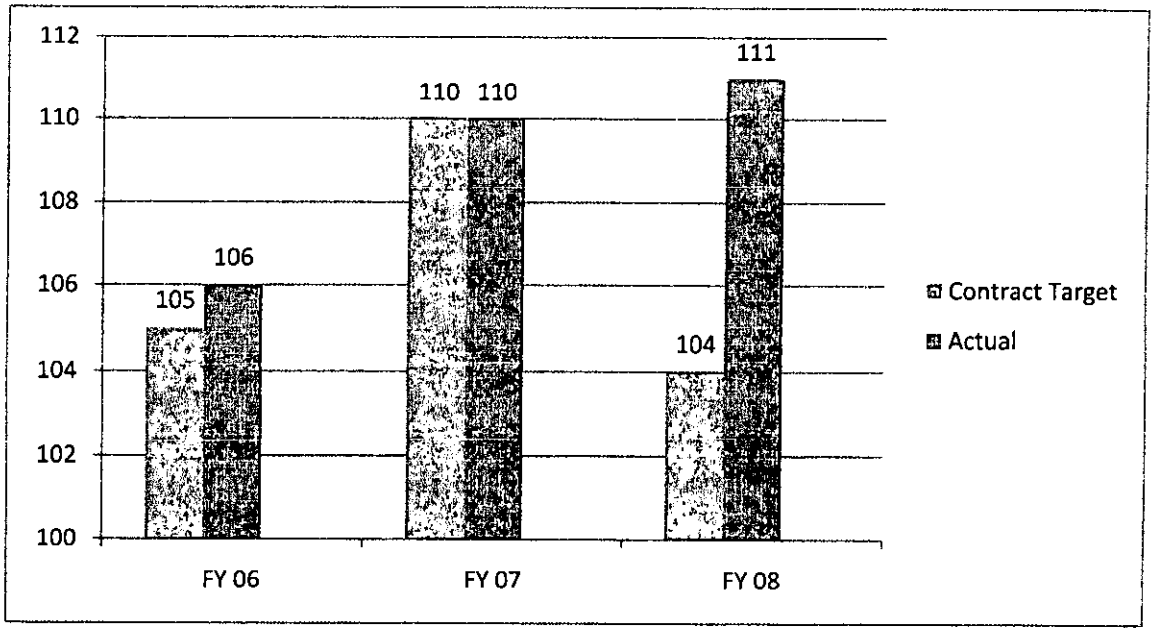
Attachment B

AASK Outcomes

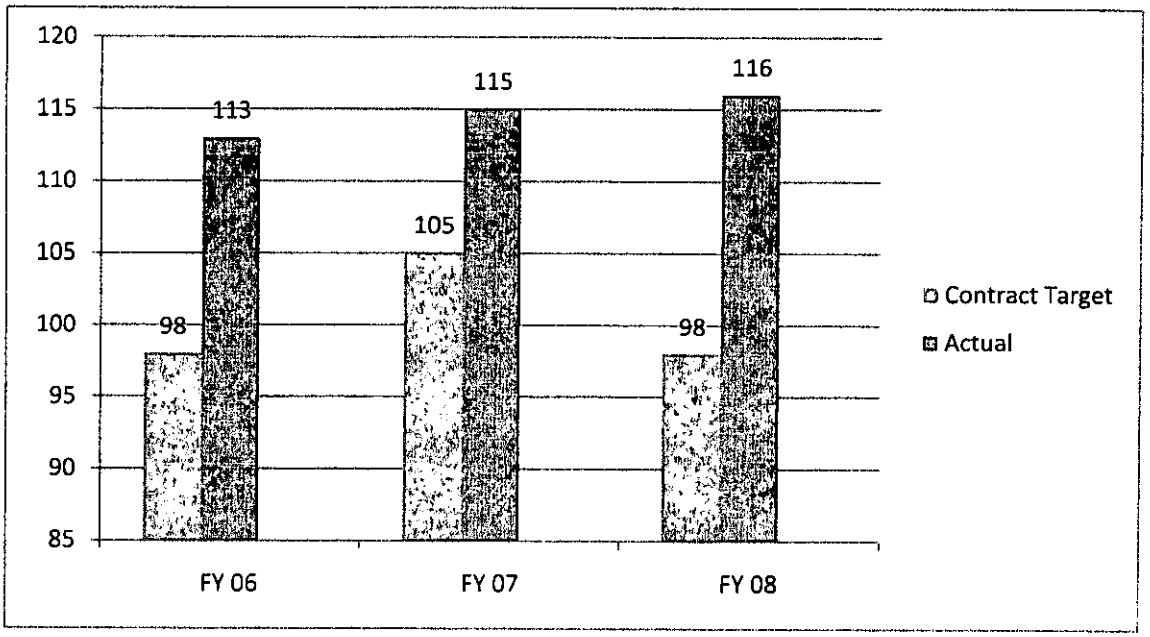
Outcomes Based Adoption Services Contract

FY 05 – FY 08

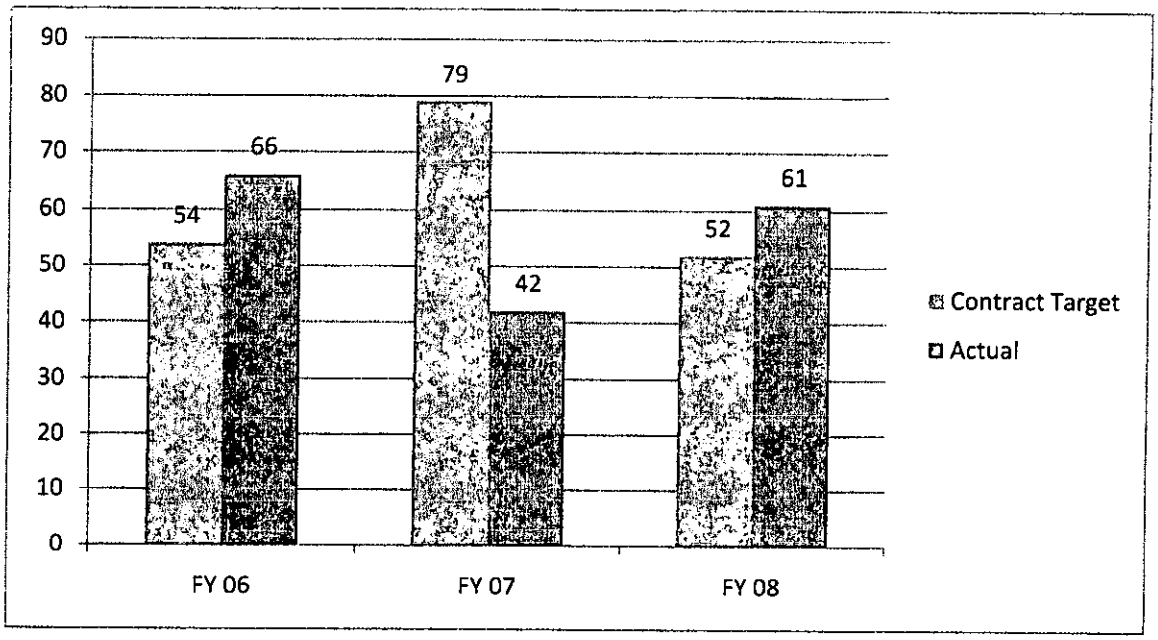
Placements



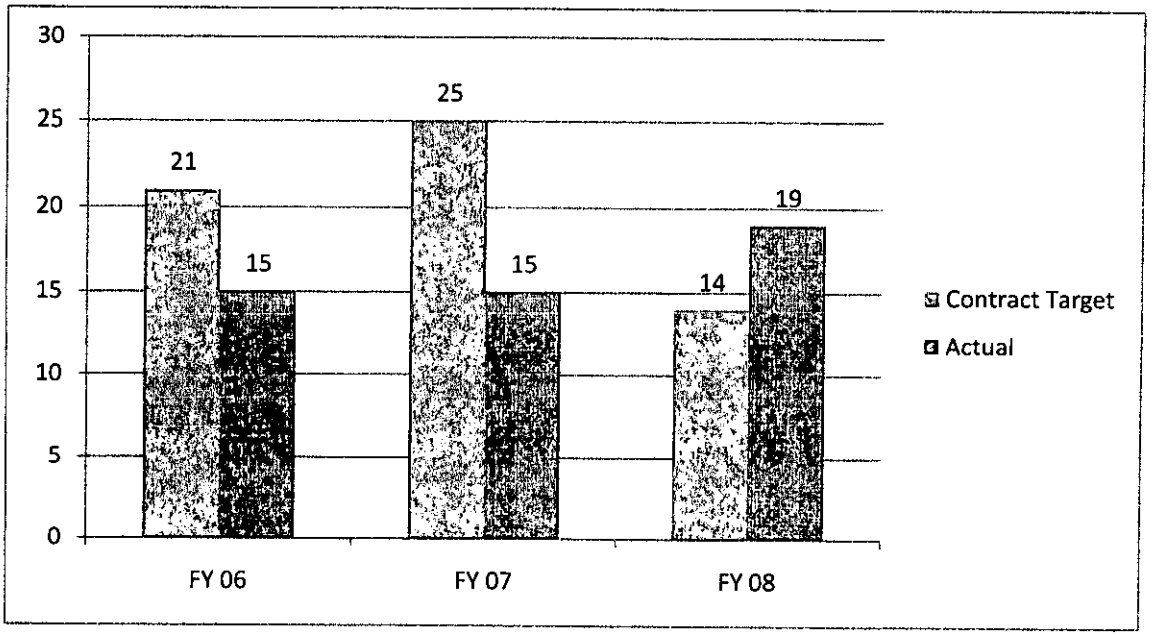
Finalizations



Timeliness



Degree of Difficulty



Attachment C

Adoption Services Contract Funding Needs

Proposed DHS budget for Adoption Services Contract	$	2,410,527
Projected Budget Needs 2010-2011	$	2,710,027
Less: Outside Funding Sources*	$	99,500
Budget Needs	$	2,611,491
Additional Funding Requested for development of a formalized Post Adopt Program/Coordinator	$	200,000

Please note that this budget is based on current staff levels and does not account for expansion needs

* Funding includes Program Fees, Wendy's Wonderful Kids' Grant, Contributions designated to program

T

Healthy Families Legislative Testimony

RE: HB 1012

Submitted By: Janell Regimbal,

Vice President of Children & Family Services

Lutheran Social Services of North Dakota

Mr. Chairman and Members of the Committee, thank you for allowing me the opportunity to testify here today. My name is Janell Regimbal. I am here today to ask for consideration of legislative support to **amend the Department of Human Services budget to allow for the addition of funds for the Healthy Families Program serving the counties of Burleigh and Morton.**

I serve in the capacity of Senior Vice President of Lutheran Social Services of North Dakota, a multi-service, comprehensive human service agency offering programs statewide. We are proud to be a part of the collaborative effort that has brought the valuable prevention effort of Healthy Families to North Dakota. Our agency acts as the legal and fiscal home of Healthy Families. This program serves Grand Forks, Nelson, Burleigh and Morton Counties.

Healthy Families is a *voluntary* home visiting program that serves highly challenged families either prenatally or at birth until the child reaches age 3. The service is provided at no cost

to the families. The ultimate goal of Healthy Families is to prevent child abuse and neglect and the long-term effects that it causes.

Research tells us that the first three years of life are a period of incredible growth in all areas of a baby's development. A newborn's brain is about 25 percent of its approximate adult weight; but by age 3, it has grown dramatically by producing billions of cells and hundreds of trillions of connections between these cells. While we know that the development of a young child's brain takes years to complete, we also know there are many things parents and caregivers can do to help children get off to a good start and establish healthy patterns for life-long learning and effective interactions with the world around them. The trauma of abuse and neglect on the other hand has lasting implications for this development.

Given the critical importance of the first three years of life for brain development and its implications going forward, it is important to note that children from birth to age three continue to be the age group most likely to be victims of maltreatment. Most maltreated babies are under age one and more than 1/3 were harmed during their first week of life. These numbers help us to understand that we cannot wait to intervene, but must do all we can to prevent this from occurring in the first place.

About 1 in 50 U.S. infants are victims of nonfatal child abuse or neglect in a year. Here in North Dakota in 2007 there were 7,657 reports of child abuse and neglect. Of those, 3,583 families had full assessments and 1,288 children were actual victims.

It is because of these issues that community conversation began in 1998 by leaders in the Grand Forks area centered on imagining what we could do throughout our region to create a promising future for ourselves and our children and to help create families where children can grow and thrive without maltreatment. After researching several national models of child abuse and neglect prevention, the committee chose the Healthy Families America (HFA) model for this project because of the documented success it has had in other states throughout the country, as well as the technical assistance available to implement the project. The program has served the counties of Grand Forks and Nelson since 2000 and recently expanded into Burleigh and Morton counties in July 2008 due to our earlier successes and wanting to further prevention to other parts of North Dakota.

The cost of child maltreatment is borne not only by abused children, but by all of us. Research during the past twenty years demonstrates that an array of human and social problems resist solutions if we do not respond to the urgent need to prevent the abuse and neglect of our children. Young children

especially, who are being abused or neglected, often do not come to the attention of our system because they are isolated in the home. They are often not in child care or preschool. Thus much damage may be done to the child before they may come to the attention of someone who can intervene. Studies such as the Adverse Childhood Experiences (ACE) Study have found many short and long-term outcomes of these traumatic experiences including a multitude of adult health and social problems such as:

- Alcoholism and alcohol abuse
- Illicit drug use
- Suicide attempts
- Unintended pregnancies

1/3 of abused and neglected children will eventually victimize their own children. This is why it is critical for us to focus on primary prevention and stop the generational pattern of abuse and neglect that so clearly exists.

We all pay for our failure to prevent child abuse. We pay as taxpayers for the high cost of prisons, children in foster care, for increased special education needed for the scars left behind from abuse already experienced. As the table attached to this testimony illustrates, the United States spends billions of dollars a year on direct costs and billions-plus for indirect costs, to treat the numerous consequences of child abuse and maltreatment, as we do on the state level as well. Research shows that primary

prevention programs can ultimately save our state millions of dollars.

Although the economic costs associated with child abuse and neglect are substantial, it is essential to recognize that it is impossible to calculate the impact of the pain, suffering, and reduces to quality of life that victims of child abuse and neglect experience. These "intangible losses", though difficult to quantify in monetary terms, are real and should not be overlooked. Intangible losses, in fact, may represent the largest cost component of violence against children and should be taken into account when allocating resources.

Healthy Families is an effective way of addressing these issues of abuse and neglect – a way to effectively intervene before it occurs. Healthy Families reaches out to high-risk parents during pregnancy and immediately after a child is born to offer voluntary home visiting services. Weekly home visits support families' progress in three areas that are critical to preventing child abuse and neglect:

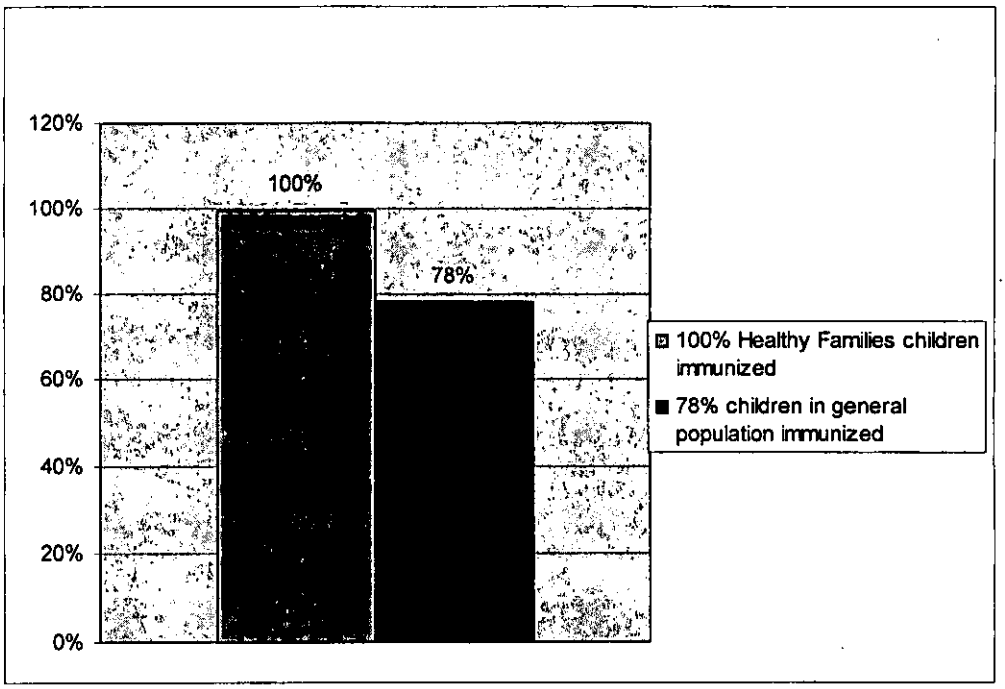
1. Teaching parenting skills - which includes skills for bonding with and dealing positively with the child, as well as understanding the child's development and needs;
2. Educating on healthy development - including good prenatal practices on the part of the mother and

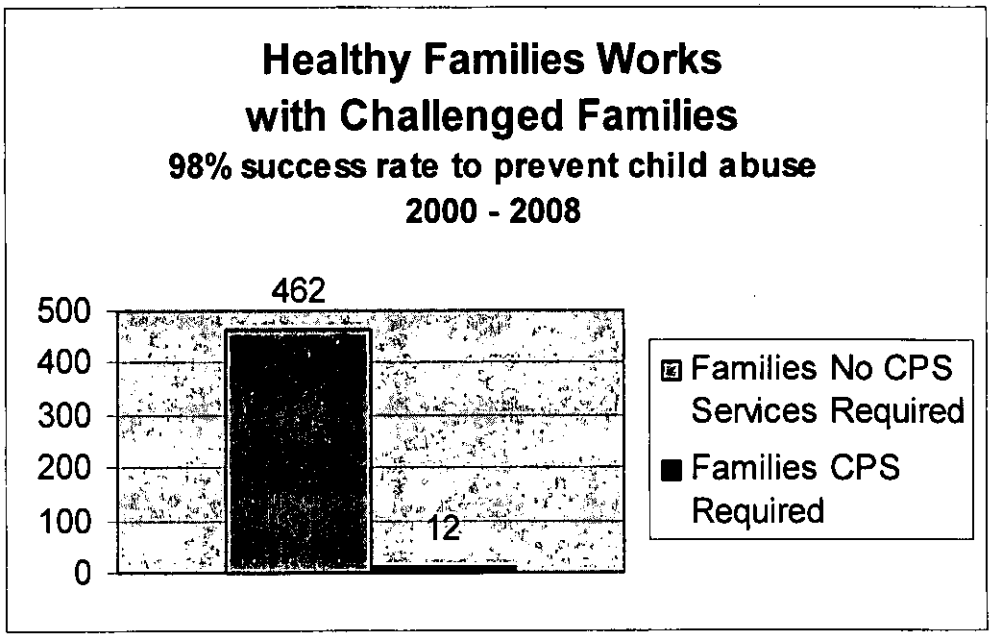
appropriate health care and developmental intervention for the child;

3. Teaching tactics to reduce family stressors - such as job seeking or job training, substance abuse treatment, or assistance with mental health problems or domestic violence.

All parents of newborns in Burleigh and Morton counties of ND are currently eligible for the service. Participants receive different levels of services dependent on the challenges they face. Home visitors, referred to as Family Support Workers, go into the home on a weekly basis, focusing on the relationship between the child and parents. The worker brings curriculum that focuses on bonding and attachment, child development, discipline and safety. Most importantly, the staff person develops a trusting relationship with the parents. The parents are willing to listen to their worker regarding raising their children and developing skills for self-sufficiency. The worker also makes referrals to other resources in the community. (See Addendum E)

Healthy Families believe our outcomes tracked since the beginning of the program in 2000 speak to the success of the program and indicate why we chose to expand into the counties of Burleigh and Morton and why we need your support.


120%
100%
80%
60%
40%
20%
0%
100%
78%
100% Healthy Families children immunized
78% children in general population immunized


Healthy Families Works
with Challenged Families
98% success rate to prevent child abuse
2000 - 2008
500
400
300
200
100
0
462
12
Families No CPS Services Required
Families CPS Required

On behalf of the Burleigh/Morton collaborative offering Healthy Families I am respectfully requesting that $200,000 be added to the DHS budget to support the Burleigh/Morton site. The additional $200,000 needed for operations over the biennium will be raised through private sources.

All young children should be given the opportunity to succeed in school and in life just as all parents should receive the support they need to nurture their children's development. While vulnerable children may have greater challenges to overcome, we should not assume that those challenges can only be addressed with services later in life. Instead, we should invest in programs where our investment can have the biggest payoff and help prevent problems or delays that become more costly to address as they grow older.

Thank you for your time and for your commitment to our state's children and families as we know that strong families are the greatest asset of strong communities.

Healthy Families Program
Addendum Directory

Addendum **A** Healthy Families Proposed Budget

B Total Estimated Cost of Child Abuse and Neglect in the United States

C Healthy Families America Fact Sheets

- **C-1** HF-A Program that Works
- **C-2** Ensuring Child Development
- **C-3** Promoting Self-Sufficiency
- **C-4** Promoting Positive Parenting
- **C-5** Reducing Child Maltreatment
- **C-6** Helps Ensure That Children are Ready to Learn

D Healthy Families Collaborating Agencies in Burleigh and Morton Counties

E Participant Support Letters

F Outcomes/Evaluation

A

HEALTHY FAMILIES BUDGET

	2009-2010		2010-2011	
INCOME				
United Way (Pending)	5,000		7,000	
Bush Foundation (Secured)	150,000			
Private Foundations (Pending)	24,122		18,069	
Basin Electric Power Cooperative (Secured)	10,000			
Individual Donors (Pending)	2,763		3,697	
Department of Human Services (proposed)	15,333		184,667	
Total Income		**$ 207,218**		**$ 213,433**
EXPENSES				
Personnel				
Program Director	4353		4484	
Site Manager	49,775		51,268	
Clerical Support	500		515	
Family Support Worker (2 .5 FTE)	46,111		47,494	
Supervision	3,068		3,160	
Employee Benefits	26,543		27,339	
Total Personnel Related Expenses		$ 130,350		$ 134,260
Other Expenses				
Occupancy	21,597		22,245	
Travel Expenses	11,330		11,670	
Training	5,000		5,150	
PhoneService	1,273		1,311	
Post., Supplies, Equip, Print.	13,197		13,593	
Other	567		583	
Total Other Expenses		52,964		54,552
Agency CAP (.1304)		23,904		24,621
Total Expenses		**$ 207,218**		**$ 213,433**

Prevent Child Abuse America
Chicago, Illinois

Total Estimated Cost of Child Abuse and Neglect in the United States

Ching-Tung Wang, Ph.D. and John Holton, Ph.D.

Child abuse and neglect are preventable, yet each year in the United States, close to one million children are confirmed victims of child maltreatment. An extensive body of research provides promising and best practices on what works to improve child safety and well-being outcomes and reduce the occurrence of child abuse and neglect. These efforts are essential as child abuse and neglect have pervasive and long-lasting effects on children, their families, and the society. Adverse consequences for children's development often are evident immediately, encompassing multiple domains including physical, emotional, social, and cognitive. For many children, these effects extend far beyond childhood into adolescence and adulthood, potentially compromising the lifetime productivity of maltreatment victims (Daro, 1988).

It is well documented that children who have been abused or neglected are more likely to experience adverse outcomes throughout their life span in a number of areas:

- Poor physical health (e.g., chronic fatigue, altered immune function, hypertension, sexually transmitted diseases, obesity);
- Poor emotional and mental health (e.g., depression, anxiety, eating disorders, suicidal thoughts and attempts, post-traumatic stress disorder);
- Social difficulties (e.g., insecure attachments with caregivers, which may lead to difficulties in developing trusting relationships with peers and adults later in life);
- Cognitive dysfunction (e.g., deficits in attention, abstract reasoning, language development, and problem-solving skills, which ultimately affect academic achievement and school performance);
- High-risk health behaviors (e.g., a higher number of lifetime sexual partners, younger age at first voluntary intercourse, teen pregnancy, alcohol and substance abuse); and
- Behavioral problems (e.g., aggression, juvenile delinquency, adult criminality, abusive or violent behavior) (Child Welfare Information Gateway, 2006; Goldman, Salus, Wolcott, & Kennedy, 2003; Hagele, 2005).

The costs of responding to the impact of child abuse and neglect are borne by the victims and their families but also by society. This brief updates an earlier publication documenting the nationwide costs as a result of child abuse and neglect (Fromm, 2001). Similar to the earlier document, this brief places costs in two categories: direct costs, that is,

This report was funded by The Pew Charitable Trusts

those costs associated with the immediate needs of children who are abused or neglected; and indirect costs, that is, those costs associated with the long-term and/or secondary effects of child abuse and neglect. All estimated costs are presented in 2007 dollars. Adjustments for inflation have been conducted using the price indexes for gross domestic product published by the Bureau of Economic Analysis (http://www.bea.gov).

Based on data drawn from a variety of sources, the estimated annual cost of child abuse and neglect is **$103.8 billion** in 2007 value. This figure represents a conservative estimate as a result of the methods used for the calculation. First, only children who could be classified as being abused or neglected according to the Harm Standard in the Third National Incidence Study of Child Abuse and Neglect (NIS-3) are included in the analysis. The Harm Standard requirements, compared to the Endangerment Standard requirements used in NIS-3, are more stringent (Sedlak & Broadhurst, 1996). Second, only those costs related to victims are included. We have not attempted to quantify other costs associated with abuse and neglect, such as the costs of intervention or treatment services for the perpetrators or other members of the victim's family. Third, the categories of costs included in this analysis are by no means exhaustive. As examples, a large number of child victims require medical examinations or outpatient treatment for injuries not serious enough to require hospitalization; maltreated children are at greater risk of engaging in substance abuse and require alcohol and drug treatment services; and youth with histories of child abuse and neglect may be at greater risk of engaging in risky behaviors such as unprotected sexual activities as well as greater risk of teen pregnancy. We were not able to estimate these types of costs as data are not readily available.

Although the economic costs associated with child abuse and neglect are substantial, it is essential to recognize that it is impossible to calculate the impact of the pain, suffering, and reduced quality of life that victims of child abuse and neglect experience. These "intangible losses", though difficult to quantify in monetary terms, are real and should not be overlooked. Intangible losses, in fact, may represent the largest cost component of violence against children and should be taken into account when allocating resources (Miller, 1993).

This report was funded by The Pew Charitable Trusts

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This report was funded by The Pew Charitable Trusts

Total Annual Cost of Child Abuse and Neglect in the United States

DIRECT COSTS

Direct Costs	Estimated Annual Cost (in 2007 dollars)
Hospitalization *Rationale: 565,000 maltreated children suffered serious injuries in 1993[1]. Assume that 50% of seriously injured victims require hospitalization[2]. The average cost of treating one hospitalized victim of abuse and neglect was $19,266 in 1999[3].* *Calculation: 565,000 x 0.50 x $19,266 = $5,442,645,000*	**$6,625,959,263**
Mental Health Care System *Rationale: 25% to 50% of child maltreatment victims need some form of mental health treatment[4]. For a conservative estimate, 25% is used. Mental health care cost per victim by type of maltreatment is: physical abuse ($2,700); sexual abuse ($5,800); emotional abuse ($2,700) and educational neglect ($910)[4]. Cross referenced against NIS-3 statistics on number of each incident occurring in 1993[1].* *Calculations: Physical Abuse – 381,700 x 0.25 x $2,700 = $257,647,500; Sexual Abuse – 217,700 x 0.25 x $5,800 = $315,665,000; Emotional Abuse – 204,500 x 0.25 x $2,700 = $138,037,500; and Educational Neglect – 397,300 x 0.25 x $910 = $90,385,750; Total = $801,735,750.*	**$1,080,706,049**
Child Welfare Services System *Rationale: The Urban Institute conducted a study estimating the child welfare expenditures associated with child abuse and neglect by state and local public child welfare agencies to be $23.3 billion in 2004[5].*	**$25,361,329,051**
Law Enforcement *Rationale: The National Institute of Justice estimated the following costs of police services for each of the following interventions: physical abuse ($20); sexual abuse ($56); emotional abuse ($20) and educational neglect ($2)[4]. Cross referenced against NIS-3 statistics on number of each incident occurring in 1993[1].* *Calculations: Physical Abuse – 381,700 x $20 = $7,634,000; Sexual Abuse – 217,700 x $56 = $12,191,200; Emotional Abuse – 204,500 x $20 = $4,090,000; and Educational Neglect – 397,300 x $2 = $794,600; Total = $24,709,800*	**$33,307,770**
Total Direct Costs	***$33,101,302,133***

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Total Annual Cost of Child Abuse and Neglect in the United States
INDIRECT COSTS

Indirect Costs	Estimated Annual Cost (in 2007 dollars)
Special Education *Rationale: 1,553,800 children experienced some form of maltreatment in 1993[1]. 22% of maltreated children have learning disorders requiring special education[6]. The additional expenditure attributable to special education services for students with disabilities was $5,918 per pupil in 2000[7].* *Calculation: 1,553,800 x 0.22 x $5,918 = $2,022,985,448*	**$2,410,306,242**
Juvenile Delinquency *Rationale: 1,553,800 children experienced some form of maltreatment in 1993[1]. 27% of children who are abused or neglected become delinquents, compared to 17% of children in the general population[8], for a difference of 10%. The annual cost of caring for a juvenile offender in a residential facility was $30,450 in 1989[9].* *Calculation: 1,553,800 x 0.10 x $30,450 = $4,731,321,000*	**$7,174,814,134**
Mental Health and Health Care *Rationale: 1,553,800 children experienced some form of maltreatment in 1993[1]. 30% of maltreated children suffer chronic health problems[6]. Increased mental health and health care costs for women with a history of childhood abuse and neglect, compared to women without childhood maltreatment histories, were estimated to be $8,175,816 for a population of 163,844 women, of whom 42.8% experienced childhood abuse and neglect[10]. This is equivalent to $117 [$8,175,816 / (163,844 x 0 .428)] additional health care costs associated with child maltreatment per woman per year. Assume that the additional health care costs attributable to childhood maltreatment are similar for men who experienced maltreatment as a child.* *Calculation: 1,553,800 x 0.30 x $117 = $54,346,699*	**$67,863,457**
Adult Criminal Justice System *Rationale: The direct expenditure for operating the nation's criminal justice system (including police protection, judicial and legal services, and corrections) was $204,136,015,000 in 2005[11]. According to the National Institute of Justice, 13% of all violence can be linked to earlier child maltreatment[4].* *Calculations: $204,136,015,000 x 0.13 = $26,537,681,950*	**$27,979,811,982**
Lost Productivity to Society *Rationale: The median annual earning for a full-time worker was $33,634 in 2006[12]. Assume that only children who suffer serious injuries due to maltreatment (565,000[1]) experience losses in potential lifetime earnings and that such impairments are limited to 5% of the child's total potential earnings[2]. The average length of participation in the labor force is 39.1 years for men and 29.3 years for women[13]; the overall average 34 years is used.* *Calculation: $33,634 x 565,000 x 0.05 x 34 = $32,305,457,000*	**$33,019,919,544**
Total Indirect Costs	***$70,652,715,359***
TOTAL COST	**$ 103,754,017,492**

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Healthy Families America: A Program That Works

Healthy Families America has been providing supportive home visiting services designed to strengthen families since 1992. What started as a pilot project with 25 sites has grown into a nationwide effort defined by three overarching goals: promoting positive parenting, improving child health and development, and preventing child abuse and neglect. Healthy Families America helps parents provide a safe and supportive home environment, gain a better understanding of their child's development, obtain access to health care and other supportive services, use positive forms of discipline, and nurture the bond with their child, reducing the risk factors linked to child maltreatment.

The flexible approach of this home visiting program enables communities and states to define their target populations according to their needs. Participants are a diverse group of parents facing a number of challenges. Most participants are single parents—many are teen mothers. Some live in relative isolation and have no social network to support them. Others struggle with substance abuse, mental illness, current or past family violence, unstable housing, joblessness and poverty. In spite of these obstacles, participants are making positive changes in their parenting practices. Results from a number of site and state-level evaluations conducted throughout the ten-year history of the program demonstrate the program's effectiveness.

⊙ Promotes Positive Parenting Practices.
Home visitors work with parents to build on their existing strengths and minimize potentially harmful behavior. They educate parents about interacting with their child, help them understand their child's capabilities at each developmental stage, and teach them positive forms of discipline. Home visitors help parents build a strong parent-child relationship and develop skills to increase their sensitivity and responsiveness towards their children.

⊙ Improves Family Health.
Families enrolled in the program are healthier and use medical services more appropriately than members of the general population, accessing preventive health care services and achieving higher immunization rates. Because these programs typically serve low-income families with multiple challenges, the program's ability to motivate parents to access timely well-baby care is impressive. Furthermore, participants are more likely to seek prenatal care, leading to fewer birth complications and low birth weight babies than individuals who did not receive services.

⊙ Enhances School Readiness.
Multiple factors contribute to a child being ready to benefit from school: basic health and nutrition, proper stimulation, and an ability to listen and concentrate. An undetected developmental delay can limit a child's ability to learn. Children participating in Healthy Families America receive early developmental screenings and, if needed, are referred to appropriate services to address delays. Home visitors help new parents to provide children with experiences that stimulate healthy brain development and to develop strong, nurturing parent-child bonds, so that their children are more cognitively, emotionally, socially, and behaviorally ready to enter school.

⊙ Increases Self-Sufficiency.
The more stable the home environment, the stronger the foundation on which to raise a child. Healthy Families America programs have been effective in improving mothers' lives by facilitating their re-enrollment in school, making referrals for employment and housing, encouraging them to seek counseling for substance abuse and domestic violence. In addition, the program helps delay subsequent pregnancies. Mothers who are more successful in delaying subsequent pregnancies are generally in a better position to complete school, obtain employment, leave welfare and provide more positive child-rearing environments for their children.

Healthy Families America Works.
The program continues to expand as communities recognize the importance of providing parents with the information and skill-building opportunities they need to raise their children in a healthy, nurturing environment. Experience confirms that Healthy Families America is reducing child maltreatment and having a positive impact on families across the country.

Healthy Families America Helps Ensure Healthy Child Development[1]

Families are healthier, better insured, and use medical services more appropriately.
Research shows that families enrolled in Healthy Families America are healthier and use medical services more appropriately than comparable members of the general population. Among reported findings in this area, 94% to 100% of participating children and 86% to 96% of parents were linked to a primary medical provider.

Health care utilization and insurance

⊙ **Iowa:** Only 11 participating families (1.3%) reported having no health care coverage. This compares to Iowa's average uninsured rate of 17%. Of the 633 families who received program services, 84% utilized Medicaid.

⊙ **Maryland (Klagholz):** Ninety-six percent of participating mothers and 100% of babies had a medical home.

⊙ **New York:** Seventy-five percent of children participating in the program received the recommended number of well-baby visits by 15 months compared to 46% of children enrolled in New York State Medicaid managed care plans. In New York City, 78% of participating children had five to six visits vs. 36% of the Medicaid population.

Emergency room usage

⊙ **Michigan:** Emergency room use among the control group and the short-term intervention group was 42% and 21% respectively. Among program participants, emergency use was much lower (6.2%).

⊙ **Virginia (Galano 1):** Over a three-year period, home-visited families made fewer visits to the emergency room per year than families in the control group.

Healthy Families America families have higher immunization rates.
Of the 13 studies measuring this outcome, immunization rates ranged from a low of 73% to a high of 100% (only three programs reported rates below 90%). Studies that included comparison data found immunization rates among program participants to be consistently higher than rates among comparison groups. Because Healthy Families America programs typically serve low-income families with multiple challenges, the program's ability to motivate parents to access timely well-baby care is impressive.

⊙ **Florida (Nelson):** Ninety-nine percent (272 of 276) of target children were compliant with recommended immunization schedules by age two.

⊙ **Georgia:** At one year of age, 98% of the children in the intervention group receiving home visitation services were completely up-to-date on their immunizations. The statewide immunization rate is about 80%.

⊙ **Michigan:** Ninety-nine percent of the participating children were current on immunizations compared to 72% of the children in the control group.

⊙ **New York:** Immunizations were up-to-date at twelve months of age for 96% of the home-visited children compared to 80% of children statewide.

⊙ **Oregon:** Ninety-seven percent of children in higher risk families receiving intensive services for 24 months or more were appropriately immunized.

-over-

Healthy Families America mothers are more likely to seek prenatal care.
Women enrolled in Healthy Families America during the prenatal period experienced fewer birth complications, delivered a greater number of full-term babies, and had fewer low birth weight babies than individuals who did not receive prenatal home visiting services.

⊙ **New Jersey:** Premature infants of prenatally enrolled mothers had higher mean birth weights than those of postnatal enrollees (6.3 lbs vs. 5.3 lbs.).

⊙ **Oregon:** Sixty-eight percent of mothers received early, comprehensive prenatal care during their first pregnancy before entering the program. In contrast, while enrolled in the program, 88% received adequate prenatal care for their second pregnancies.

⊙ **Virginia (Galano 1):** Only 18% of participating mothers had infants born with one or more birth complication compared with 40% of control group mothers. Overall, 85% of participating mothers had no pregnancy risk factors compared with about 50% of control group moms.

[1] This report highlights findings from 18 studies conducted in 11 states over the past decade. The study designs range from pre-post analysis to statewide comparison and randomized trials.

Healthy Families America Helps Families Promotes Self-Sufficiency[1]

Healthy Families America promotes self-sufficiency.
Prevention activities help families succeed at home, in school and at work. Healthy Families America has been effective in improving mothers' lives by facilitating their re-enrollment in school, making referrals for employment and housing, encouraging them to find counseling for substance abuse and domestic violence, and helping them strategize about ways to decrease stress in their lives.

⊙ **Arizona (Holtzapple):** Healthy Families America participants spent 121 fewer days on Aid to Families with Dependent Children (AFDC), 200 fewer days on Food Stamps, and 73 fewer days on Medicaid than a comparison group who qualified for but were not enrolled in Healthy Families America services (this study was begun prior to 1996 welfare reform changes).

⊙ **Arizona (LeCroy):** Seventeen percent of participants were employed at the beginning of services compared to 31% at six months and 40% at 12 months.

⊙ **Florida (Nelson):** During the reporting year, 35% of families ended their dependence on public assistance, 19% obtained a GED/job training, 64% obtained employment and 41% obtained better housing.

⊙ **Iowa:** Thirty-five percent of participating Healthy Families America families ended their dependence on public assistance. Of those families participating in Iowa's program for at least six months, 63.4% reported improved or resolved issues concerning their living situation, and 69% reported improved or resolved issues concerning domestic violence.

⊙ **Maryland (Klagholz):** At the end of year four, 88% of mothers had positive employment/educational status.

⊙ **New Jersey:** Mothers employment rates increased from 10% to 34% between program intake and 12 months.

⊙ **New York:** Program participants assessed life course indicators between intake and 12 months. In this time, social isolation fell from 36% to 30%, relationship difficulties fell from 52% to 44%, and domestic violence fell from 25% to 14%. Housing problems declined from 35% to 19%, substance abuse fell from 14% to 4%, and alcohol abuse fell from 11% to 3%. In addition, 87% of participants said problem-solving skills improved, and 84% said their program helped them improve their ability to access needed services and improve the future planning skills. Fifty-five percent said they learned a lot about how to manage their lives on a day-to-day basis.

Healthy Families America helps reduce subsequent pregnancies.
Delaying subsequent pregnancies by at least 18 months can improve the health of expectant mothers and their children considerably. Mothers who are successful in delaying subsequent pregnancies are generally in a better position to complete school, obtain employment, leave welfare and provide more positive child-rearing environments for their children.

⊙ **Florida (Williams):** Ninety-five percent of mothers enrolled in Healthy Families Florida did not have a subsequent pregnancy within two years of the target child's birth (the goal was 85%).

⊙ **Maryland (Klagholz):** One hundred percent of teen mothers and 94% of adult mothers did not have a repeat birth.

⊙ **Virginia (Galano I):** The repeat teen birth rate was substantially lower among participating families (9.4%) compared to the citywide rate of 35.8% and statewide rate of 29.8%.

[1] This report highlights findings from 18 studies conducted in 11 states over the past decade. The study designs range from pre-post analysis to statewide comparison and randomized trials.

Healthy Families America Promotes Positive Parenting[1]

Healthy Families America promotes positive parenting by educating parents about ways to interact with their child, helping them understand their child's capabilities at each developmental stage, identifying and shaping their attitudes towards parenting, and teaching them positive forms of discipline. Home visitors help parents recognize the importance of building a strong parent-child relationship and help them develop skills to increase their sensitivity, responsiveness and nurturing capabilities towards their children.

⊙ **Arizona (LeCroy):** Improved scores were noted on six out of seven scales of the Parenting Stress Index: competence, attachment, feelings of restricted role, depression, social isolation and positive mood at six and twelve months post-enrollment.

⊙ **Florida (Nelson):** Families' average scores at a six month post-participation interview were not statistically different than their scores on the exit interview, indicating that the parental knowledge and skills developed or enhanced through participation in the program were retained six months later.

⊙ **Georgia:** Enrolled parents have more appropriate expectations of their children and are more empathetically aware of their children's needs than comparison families.

⊙ **Maryland (Klagholz):** At enrollment, 86% of parents had passing scores on the Knowledge of Infant Development, a widely used assessment tool. After six months of participation, that rate had increased to 94%.

⊙ **New Jersey:** A statistically significant difference was found in the scores related to the risk characteristics that contribute to parental stress. Scores decreased from 2.22 at enrollment to 1.88 at 12 months.

⊙ **New York:** Eighty-five percent of participants said their patience with their child had improved and they were better at dealing with their child's difficult behavior because of the home visiting program. Participants indicated an increase in knowledge about caring for their children. Seventy-eight percent learned about child growth and development, 73% about home safety, 73% about proper health care for their baby and 65% about feeding their baby.

⊙ **Virginia (Galano I):** Compared to their scores at the initial assessment, mothers participating in the program had higher scores in the areas of parent-child interaction, bonding, communication and care-giving after two years of participation, while the scores of mothers in the control group decreased during the same time period.

[1] This report highlights findings from 18 studies conducted in 11 states over the past decade. The study designs range from pre-post analysis to statewide comparison and randomized trials.

Healthy Families America Reduces Child Maltreatment[1]

Healthy Families America reduces child abuse and neglect and helps keep families together. Innumerable scientific studies have documented the link between the abuse and neglect of children and a wide range of medical, emotional, psychological and behavioral disorders. For example, abused and neglected children are more likely to suffer from depression, alcoholism, drug abuse and severe obesity. By reducing the risk factors that lead to abuse, Healthy Families America programs are reducing the incidence of abuse.

⊙ **Arizona (Davenport):** Only 3.3% of program participants versus 8.5% of comparison group members had substantiated reports of abuse.

⊙ **Florida (Edwards):** Ninety-nine percent of participants in Healthy Families Jacksonville had no reports of child maltreatment for the 12 months following the target child's birth. The goal was 95%.

⊙ **Florida (Nelson):** In FY 00-01, the maltreatment rate among program participants was 14 out of 875 (1.6%) cases. Maltreatment estimates for Pinellas County during that same time period were 4.9%.

⊙ **Florida (Williams):** Ninety-eight percent of children had no verified indication of child maltreatment within 18 months following successful program completion.

⊙ **Georgia:** Scores on the Child Abuse Inventory, an assessment tool, indicate program parents were significantly less at risk for abuse than parents who did not receive services.

⊙ **Hawaii (Breakey):** Of 1,738 high-risk children served, four children (0.2%) were hospitalized for maltreatment. Among 2,728 families who screened positive but were not served by the program, 38 children (1.4%) were hospitalized for maltreatment, a rate 5.89 times the rate for those served by the program.

⊙ **Hawaii (McCurdy):** Families receiving program services had significantly fewer substantiated cases of abuse or neglect (3.3%) compared to 6.8% from the control group. Between enrollment and 12 months of participation, there was also a significant reduction in scores that measure parental child abuse potential.

⊙ **Iowa:** With 826 families on the caseload in FY '00, 775 (93.8%) had no reports for child maltreatment.

⊙ **Maryland (Klagholz):** Healthy Families Maryland has only had a total of two indicated reports (both for neglect) out of 254 families served in its four years of program operation (.008 or 8 per 1,000 children).

⊙ **New Jersey:** From 1996-99 only 45 of 1,331 (3.4%) Healthy Families New Jersey families had substantiated reports of abuse or neglect. Having 96.6% of families free of child abuse and neglect exceeds the goal of 85%.

⊙ **Oregon:** The 1999 incidence rate of child abuse was lower for participating families (13 per 1,000 children age 0-2) than for non-served families in the same counties (25 per 1,000 age 0-2).

⊙ **Virginia (Galano 2):** All programs equaled or excelled the statewide goal of having no child abuse or neglect reports for 95% of families who received services for at least 12 months.

⊙ **Virginia (Barrett):** From October 1993 to March 1997 only 2% of participating children had a substantiated report of child maltreatment (and all were for neglect).

[1] This report highlights findings from 18 studies conducted in 11 states over the past decade. The study designs range from pre-post analysis to statewide comparison and randomized trials.

Healthy Families America Helps Ensure That Children are Ready to Learn[1]

Healthy Families America promotes healthy brain development.
Home visitors help new parents provide children with experiences that stimulate healthy brain development. Educating parents about ways to engage their child in play and stimulate their minds is a benefit to both parent and child. Parents develop a strong, nurturing bond and children are more cognitively, emotionally, socially, and behaviorally ready to enter school.

⊙ **Georgia:** Parents in Healthy Families America programs were more likely to have organized their children's home environment to promote optimal development and to provide their children with age appropriate play materials.

⊙ **Oregon:** 76% of higher risk participants read or looked at picture books with their year-old child at least three times a week.

⊙ **Virginia (Galano 1):** Home-visited families provided higher optimal levels of stimulation than families in the control group after both one and two years of participation in the program.

Participating children receive early developmental screenings.
Early identification of developmental delays is an important step in ensuring children get the best start in life. Healthy Families America staff are trained to utilize validated measures to determine if children are progressing at an appropriate pace. When necessary, referrals for educational services are facilitated.

⊙ **Arizona (Davenport):** Ninety-five percent of children were functioning at age-appropriate developmental levels at 48 months of age.

⊙ **Michigan:** Total child development scores were significantly better in the home-visited group than the control group.

⊙ **New York:** Ninety-nine point five percent of the sample received developmental screening and 92% of the participating children fell within the normal range of development. For children whose development was assessed as deviating from the norm, 95% were referred for services.

⊙ **Oregon:** Among higher risk families in the program, age-appropriate development is evident in 89% of children. Of those children who fall outside the normal development range, 93% received services.

[1] This report highlights findings from 18 studies conducted in 11 states over the past decade. The study designs range from pre-post analysis to statewide comparison and randomized trials.

Healthy Families Advisory Committee Members Burleigh/Morton

Members:	Affiliation
Andrea Werner	Community Action
Connie Schwartz	Bismarck Burleigh County Public Health/Baby and Mothers Beyond Birth Education
Constance J. Keller	Prevent Child Abuse
Cyndee McLeod	United Tribes Technical College
Diane Zainowsky	Adult Abuse Resource Center
Jennifer Laabs	Morton County Social Services/Health Tracks
Joce Koch	Custer District Public Health
Jodi Benz	St. Alexius Hospital
Jody Bettger-Huber	Healthy Families
Karen Schrieve	Bismarck Burleigh County Public Health/Optimal Pregnancy Outcome Program
Ken Gerhardt	Morton County Social Services
Linda Reinicke	Child Care Resource and Referral
Lori Bergquist	Medcenter One Hospital
Melanie Krentz	Medcenter One Hospital
Michelle Hougen	Bismarck Early Childhood Education Program
Paula Condol	Medcenter One Dakota Children's Advocacy Center
Paula Flander	Bismarck Burleigh Public Health/ Director
Robert Sanderson	Lutheran Social Services
Shannon Spotts	Women, Infants, and Children (WIC) Special Supplemental Nutrition
Sherri Doe	Burleigh County Social Services
Tara Huss	St. Alexius Hospital
Vanessa Hoines	North Dakota State University Family Extension
Weisz, Rita L.	West Central Human Services

Healthy family program

without this program I think I would be lost! Thanx to the great people I have more confidence in being a Mother. they have came in the middle of the night to help me when I was crying to so much pain I couldn't move. without the program I don't think I would have throw those nights. They have helped me grow as a person and I will be forever greatful. I have met some great people in this program. for fellow Mothers I would recomend this program, they help with any gestion or personal problem that comes up!

Alicia Bradley

Dear Sir or Madam,

I have been with Healthy Families for several months and they have been very supportive and helpful.

With my support Worker's help I have managed to keep my sobriety and sanity.

Healthy Families connected me with programs in the Community so I was able to give my family a Christmas.

I received food, toys and a new bed for my son.

I hope Healthy Families is around for many more years because I know that there are many more families that could use the support and benefit from their knowledge.

Shanna DeCotea

Healthy Families Evaluation Information

This information is gathered every 4 months and entered into the database.

- Regular well-child visits to a medical practitioner for children participating in the program.
  Data Collection: Parents will be asked if the child is current on check-ups, contact the clinic if the parent is uncertain, and document check-ups every four months.
  Evaluation Methodology: Family Compliance in completing well-child visits will be tabulated and compared with the American Academy of Pediatrics guidelines.
- Up-to-date immunizations for children participating in the program.
  Data Collection: Parents will be asked if the child is current on immunizations, document the status every four months, and review immunization records through the statewide-computerized record of immunizations for North Dakota children.
  Evaluation Methodology: The immunization status of program children will be compared with that of children in the general population.
- Utilization of formal and informal community supports by program participants.
- Data Collection: We will document family utilization of community supports every four month and conduct an
- Evaluation Methodology: Families will be monitored for consistency and frequency of community support use
- Enhancement of parenting skills in the areas of understanding normal child development and use of alternative methods of discipline for program participants.
  Data Collection: We will administer the Ages and Stages Development Questionnaire and Parent-Child Attachment Assessment to document parenting skills and to evaluate family competency.
    - Ages and Stages evaluates the child's development in Communication, Gross and Fine Motor skills, Problem solving and Personal-Social. Scores indicate if there appears to be a delay and allows for referrals to be made.
    - Parent Child Attachment Assessment indicates the attachment the parent has to the child. A score of 32 or higher indicates adequate attachment and 32 or lower suggests that attachment needs improvement. **Our families consistently score 38 or higher.**

  Evaluation Methodology: Behaviors of program parents will be measured over time using the referenced tools.
- Fewer referrals of program families for mandated Child Protection Services.
  Data Collection: The number of program families referred to Child Protection Services will be calculated by cross checking referrals of program families with referrals from the general population.
  Evaluation Methodology: The percentage of program families referred to Child Protection for services required will be compared with referrals form the general population

Supportive Testimony by Prevent Child Abuse North Dakota

For

Health Families Legislative Testimony

RE: HB1012

Same given to House and Senate

Submitted by: Constance J. Keller

Program Services Manager

Prevent Child Abuse North Dakota

Mr. Chairman and Members of the Committee, thank you for allowing me the opportunity to provide supportive testimony for the North Dakota Healthy Families home visiting program serving the counties of Burleigh and Morton.

My name is Constance Keller. My education includes a Bachelors and Masters of Science in Nursing with a specialty in Community Based Nursing. Throughout my 23 year career, I have worked in the private sector, local, state and federal levels advocating and promoting programs for families. Previously, at the state level, I served as the Director for the Optimal Pregnancy Outcome Program, North Dakota Sudden Infant Death program and as the North Dakota Home Visiting Coordinator and Committee chairperson. Currently, I serve as the Program Support Manager for Prevent Child Abuse North Dakota. Our mission is committed to a safe and nurturing environment, free from abuse and neglect, for all children.

We do this through:

- Public Awareness and Education
- Training and Technical Assistance
- Coordination of Services
- Strategic Partnerships
- Advocacy

We are a chapter of Prevent Child Abuse America, the nation's leading child abuse prevention organization. Prevent Child Abuse America launched Healthy Families America in 1992 in partnership with Ronald McDonald House Charities. Healthy Families is a research proven program that focuses on three equally important goals:

- To promote positive parenting
- To encourage child health and development
- To prevent child abuse and neglect

These goals remain constant from site to site. But, because of the flexibility of the Healthy Families program model, the programs:

- Are tailored to meet the specific and expressed needs of the families and communities they serve
- Adhere to proven best practice standards that ensure the highest quality of service delivery to families.
- Are implemented on the local level by public and private partnerships

With additional funding for Burleigh and Morton counties, our state would be have much needed resources to Healthy Families Home Visit community-based efforts to help prevent child abuse and neglect and to help promote healthy child development.

As noted in Janelle's testimony, **"We all pay for our failure to prevent child abuse."**

Prevent Child Abuse America released an economic impact study that conservatively estimates the cost of child abuse and neglect to the United States at a startling ***$103.8 billion*** each year. The report, ***Total Estimated Cost of Child Abuse and Neglect in the United States,*** documents the pervasive and long-lasting effects of child abuse on children, their families, and society as a whole. Child abuse and neglect is a public health issue that has never received adequate funding. This year alone, the federal government will invest

approximately $4,500 in research for every American with cancer or HIV/AIDS, but only $10 in prevention research for every reported case of child abuse and neglect.

The data in this report shows that a greater investment in prevention activities, such as Healthy Families, will decrease both the short and long-term costs to society.

Please remember:

- The first three years of a child's life are crucial for healthy cognitive, physical and emotional development, and abuse or neglect during this developmental stage can lead to permanent disabilities.
- Many new or expectant parents lack knowledge about parenting, do not have family or social support, or are unaware of important community resources.
- Parents in the aforementioned circumstances may be more likely to abuse or neglect their children, or to suffer from stress or depression that can lead to problems in relating to their children and others.
- Voluntary home visiting programs, such as Healthy Families America , improve family functioning by providing parents with the parenting advice and support they need and by assisting them in accessing helpful resources in their community.
- Voluntary participation in home visiting programs, such as Healthy Families America, has been shown to reduce the likelihood of child abuse and neglect and to result in a number of other benefits to children and families, including fewer emergency room visits, increased well-child visits, and higher immunization rates.

- Research has found that prevention programs, particularly home visiting programs, are cost-effective because they reduce the public costs associated with child protective services, healthcare, special education, loss of productivity, and the criminal justice system.

On behalf of Prevent Child Abuse America and our national network of 43 state chapters and over 400 Healthy Families America sites, I urge you to make the prevention of child abuse and neglect a priority this legislative session. Please consider amending the Department of Human Services budget to allow for additional funds for the Healthy Families Program serving the counties of Burleigh and Morton.

"Healthy Families America is a smart investment. If you want the biggest bang for your buck, you focus on childhood, on the things in childhood that will allow a child to have the best chance they can have."

- Bruce Perry, M.D., Ph.D., Chief of Psychiatry, Texas Children's Hospital

Date: January 27, 2009
Re: Funding for Healthy Families Programming
By: Jean Schafer, Principal, Fort Lincoln Elementary, Mandan, ND

- 40% of students enter kindergarten with language and math skills typical of two, three and four year olds. ~ Almost half of incoming students are one to three years behind their "average" peers on the first day of school. High performing five year olds enter kindergarten with language and math skills typical of eight year olds-they have made eight years of progress during their five preschool years at home. It is common to find within a kindergarten classroom a five-year range in children's literacy-related skills and functioning.
- Public schools create a year of growth during each year for most students.
- The focus of 21st century education reform is primarily to catch up the 40% of students who enter kindergarten behind, then stay behind year after year.
- The achievement gap has its origins in a child's early years, in the home. The home is really the child's first classroom.
- Between birth and age five is the most leveraged opportunity for schools and parents to prevent children from falling behind.
- When parents become skillful in preparing their children to enter kindergarten with age appropriate pre-literacy and pre-math skills, the achievement gap that haunts public schools will be greatly diminished.
- Parent/child education programs that focus on prenatal/birth to three or five years of age have been shown to significantly impact the achievement gap with children entering kindergarten.
- Children whose families participate in programs such as the Healthy Families Program, which teach parenting and healthy child development greatly impact this achievement gap. These children are exposed to far more language and interaction because of this parent/family education. These children enter school with millions more words in their vocabulary.
- Parent/child education programs are cost effective. School districts spend an additional $4,000 or more for each student in the lowest two quartiles every year. The number of students needing this level of intervention could be dramatically reduced. The cost of parent/child education programs are often far less per year than this per child amount, and the child(ren) in these programs benefit by coming to school better prepared to learn.

References

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Healthy Families Legislative Testimony

Re: HB 1012

Submitted by: Janell Regimbal

Senior Vice President of Children and Family Services

Lutheran Social Services of North Dakota

Mr. Chairman and Members of the Committee, thank you for allowing me the opportunity to testify here today. My name is Janell Regimbal. I serve in the capacity of Senior Vice President of Children and Family Services of Lutheran Social Services of North Dakota, a multi-service, comprehensive human service agency offering a variety of programs statewide. I am here today to ask for consideration of legislative support to **amend the Department of Human Services budget to allow for the addition of $200,000 for the Healthy Families Program currently serving Burleigh and Morton counties.**

We are proud to be a part of the collaborative effort that first brought the valuable prevention effort of Healthy Families to the northeastern region of North Dakota in April of 2000. Healthy Families is a ***voluntary*** home visiting program that serves highly challenged families beginning either prenatally or at birth until the child reaches age 3. The service is provided at no cost to the families. The ultimate goal of Healthy Families is to prevent child abuse and neglect and the long-term effects that it causes.

Research tells us that the first three years of life are a period of incredible growth in all areas of a baby's development. The trauma of abuse and

neglect on the other hand has lasting implications for this development. Given the critical importance of the first three years of life for brain development and its implications going forward, it is important to note that children from birth to age three continue to be the age group most likely to be victims of maltreatment. Most maltreated babies are under age one and more than 1/3 were harmed during their first week of life.

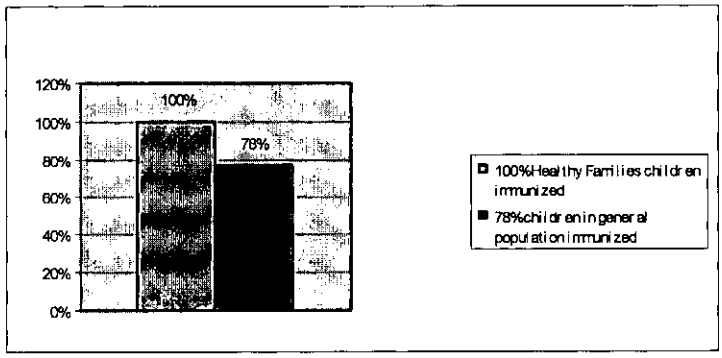
It is because of these issues that community conversation began in 1998 by leaders in the Grand Forks area centered on imagining what we could do throughout our region to create a promising future for ourselves and our children and to help create families where children can grow and thrive without maltreatment. After researching several models of child abuse and neglect prevention, the committee chose the Healthy Families America (HFA) model because of the documented success it has had in other states as well as the technical assistance available to implement the project. After several years of services provision, we too, found this program to be very successful here in North Dakota.

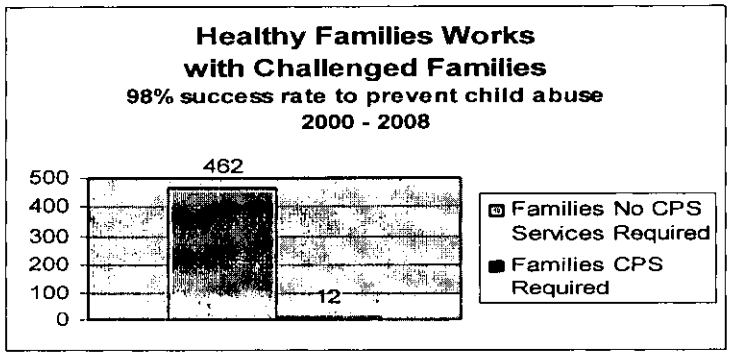
The Bush Foundation recognized this success and assisted us to expand the program to now also serve families in Burleigh and Morton counties. This expansion became a reality in July of 2008. As a committee of service professionals across a broad spectrum including health care, human services, education and corrections as well as parents, we strongly believe that these positive outcomes experienced over the past eight years demand serious consideration for replication. While private foundation dollars can be the spark needed to begin these expansion efforts, we must have additional support to sustain these efforts.

Healthy Families is an effective way of addressing abuse and neglect – by effectively intervening before it occurs. Healthy Families reaches out to high-risk parents during pregnancy and immediately after a child is born to offer voluntary home visiting services. Weekly home visits provided by highly trained paraprofessionals support families' progress in three areas that are critical to preventing child abuse and neglect:

1. Teaching parenting skills
2. Educating on healthy development
3. Teaching tactics to reduce family stressors

While this program tracks a variety of outcomes that help measure the programs success in areas that reflect a child's well being, two such numbers are especially profound. Here is a sampling of two of the outcomes tracked since the beginning of the North Dakota program:





We all pay for our failure to prevent child abuse. We pay as taxpayers for the high cost of prisons, children in foster care, for increased special education needed for the scars left behind from abuse already experienced.

All young children should be given the opportunity to succeed in school and in life just as all parents should receive the support they need to nurture their children's development. While vulnerable children may have greater challenges to overcome, we should not assume that those challenges can only be addressed with services later in life. Instead, we should invest in programs where our investment can have the biggest payoff by working to prevent problems or delays that become more costly to address as they grow older, not to mention the cost of trauma to the individual suffering its direct impact.

I and others whose written testimony I have also provided, as well as all those indicated as serving on our two local advisory committees where these programs operate, thank you for your time and hope that you will join with us in taking this proactive approach to a very serious and costly problem here in North Dakota. Please stand with us in a commitment to our state's children and families, as we know that strong families are the greatest asset of strong communities.

A

HEALTHY FAMILIES BUDGET

	2009-2010		2010-2011	
INCOME				
United Way (Pending)	5,000		7,000	
Bush Foundation (Secured)	150,000			
Private Foundations (Pending)	24,122		18,069	
Basin Electric Power Cooperative (Secured)	10,000			
Individual Donors (Pending)	5,000		6,000	
Department of Human Services (proposed)	15,333		184,667	
Total Income		**$ 209,455**		**$ 215,736**
EXPENSES				
Personnel				
Program Director	4353		4484	
Site Manager	49,775		51,268	
Clerical Support	500		515	
Family Support Worker (2 .5 FTE)	46,111		47,494	
Supervision	3,068		3,160	
Employee Benefits	26,543		27,339	
Total Personnel Related Expenses		$ 130,350		$ 134,260
Other Expenses				
Occupancy	21,597		22,245	
Travel Expenses	11,330		11,670	
Training	5,000		5,150	
PhoneService	1,273		1,311	
Post., Supplies, Equip, Print.	13,197		13,593	
Other	567		583	
Total Other Expenses		52,964		54,552
Agency CAP (.1426)		23,665		26,924
Total Expenses		**$ 209,455**		**$ 215,736**

See testimony of Agnell Reginbal for attachments B-E, F

Burleigh/Morton Counties Collaborating Agencies

- BURLEIGH COUNTY SOCIAL SERVICE CENTER
- MORTON COUNTY SOCIAL SERVICE CENTER.
- CHILD CARE RESOURCE AND REFFERAL, (CCR&R).
- PREVENT CHILD ABUSE NORTH DAKOTA
- WEST CENTRAL HUMAN SERVICE CENTER
- BISMARCK-BURLEIGH PUBLIC HEALTH (BBPH).
- BURLEIGH EARLY CHILD EDUCATION PROGRAM (BECEP)
- ST. ALEXIUS HOSPITAL
- MEDCENTER ONE HOSPITAL
- UNITED TRIBES/FACE PROGRAM
- ADULT ABUSE RESOURCE CENTER
- NDSU EXTENSION
- LUTHERAN SOCIAL SERVICES OF ND
- CUSTER DISTRICT PUBLIC HEALTH

Testimony
Amendment to HB 1012 – Department of Human Services
Senate Appropriations
March 4, 2009

Chairman Homberg,I am submitting written testimony in support of amending the Department of Human Services budget to allow for the addition of $200,000 for the Healthy Families Program currently serving Burleigh Morton counties.

The Healthy Families Program has been serving Burleigh/Morton counties since last summer. This program provides voluntary supportive services for parents and their children. The purpose of the Healthy Families Program is to reach parents early in their child's life, either prenatally or immediate after birth and up to age three, to prevent child abuse and neglect. This is accomplished through home visits by well trained workers who offer one-on-on education and support in parenting skills, healthy child development and strategies for reducing stress within the family. These early intervention efforts are proven to reduce the incidence of child abuse and neglect.

The work provided by Healthy Families is of great benefit and a frequent source of referral for social service agencies. We speak often about supporting prevention services, particularly in the area of child welfare. Healthy Families is an excellent prevention program that works and I urge your support.

Shari Doe
Director
Burleigh County Social Services
415 E. Rosser
Bismarck, ND 58501
08does@nd.gov
701-222-6622

G

The Village Family Service Center

FAMILY GROUP DECISION MAKING/INTENSIVE IN-HOME

FGDM is a strength based decision making process that brings family members, friends, service providers, and others together to create a care or protection plan for the permanency and/or reunification of children.

FGDM gets its strength and support from the belief that the tools for solving many family problems can be found within the parameters of the family itself.

Professionally trained FGDM facilitators are housed in regional Village sites throughout North Dakota. Facilitators travel to all areas of North Dakota to meet with conference participants and facilitate family meetings. On average, a facilitator spends about twenty six hours preparing for a family conference. Preparation time is influenced by the degree of conflict management and negotiation that takes place prior to a conference and the travel time across ND. Average Conference Length is 4.3 hours with conferences often occurring on weekends.

Intensive In-Home is a long term service with remarkable outcomes and great demand.

Target Population:
Children aged 0-18 and their families across the entire state of North Dakota.
Served by FGDM from March 2006-Dec 2008:
- Families- 235 Children-327
- 48% of the children resided in ND regional cities, 52% of the children lived in rural cities and towns
- 40.9 % children served been from ND minority populations including 23.7% Native American
- 40% of the children have had one or both parents incarcerated during their lifetime

Risk factors: abuse, neglect, supervision issues, substance abuse, lack of family involvement, divorce, incarceration, unstable living conditions, developmental/physical/mental health disabilities.

Goals of Programs:
Decrease the risk of placement/preventing placement and increased family placements
Build family connections
Increase father and father family involvement
Improve child wellbeing

Outcomes:
At intake, 69.2% of the children referred had a child protection report that either required or recommended services in the past year. 6 months post conference the number of child protection reports decreased to 14.8%. 2 years post conference there had been child protection reports in only 9.5% of the cases.

94.7% of the time one or both parents participated in the conference. 50.2% both mother and father participated. Often, paternal relatives participate even when the father does not, increased father and paternal family involvement is an important outcome. At 90% of the conferences, at least one relative participated, increasing family connections.

At the time of the initial conference, 62.5% of children were living with either parents or relatives. The family plan developed at the conference shows that in 84.3% of the cases participants planned for the children to live with parents or relatives. At six months post conference 83.6% of the respondents indicated that children were living either with parents or with relatives resulting in 21% fewer children being placed in foster care.

Estimated Cost Saving:
Using above outcomes, a 21% reduction in foster care placements of 327 FGDM children would mean 69 children were not placed in county/state care. If therapeutic foster care had been used @$1,111 per month per child times the 69 FGDM children, the cost would have been $76,659 per month ($459,954 for 6 months). If

residential/group home care had been used @ $1,715 for those 69 children the cost would have been $332,442 per month ($1,994,652 for 6 months). FGDM saves ND monetarily and is priceless for its children and families.
FGDM Funding:

2006-2009 Partnership between the ND Department of Human Services, the Village Family Service Center an the Bush Foundation to implement FGDM/expanded IIH across the state of North Dakota.

- Bush Foundation contribution- $1,162,131 for 2006-2008 and $661,968 from 2008-2009 funding 11 FTE's
- ND Department of Human Services contribution- $234,880 for 2006-2009 funding 3 FTE's
- Village contribution- $38,500 for 2006-2009

The Bush Foundation Funding will end in September 2009

The Department of Human Services submitted a 2009 OAR which was rejected. This OAR was for $2,342,810 of general funds, $238,295 of Federal funds and $18,077 from other funds for the next biennium.

Projected July 2009- June 30, 2011 FGDM/IIH Budget

Salaries: Coordinator/statewide supervisor, Facilitators, FBS therapists, Case Aides- 15 FTE's	$1,030,000
Benefits	$288,400
Contract Staff	$40,000
Supplies	$6,500
Telephone	$40,000
Postage	$22,000
Occupancy/rent	$65,000
Equipment/supplies	$20,000
Printing/publications/dues	$12,500
Mileage	$140,000
Advertising/marketing	$12,000
Depreciation	$4,000
Family conference expenses	$60,000
Professional liability	$12,000
Miscellaneous	$7,200
Administration costs	$175,960
Total costs (for 2 years)	$1,935,560

SENATE APPROPRAITIONS COMMITTEE

I AM SANDI ZALESKI OF THE STATEWIDE CHILD SERVICES AGENCY, THE VILLAGE. Thank you for giving me this opportunity to clarify the available funding for the Family Group Decision making Program.

The program partnership for this program began between the Department of Human Services, The Village and the Bush Foundation. IT WAS DEVELOPED WHILE SENATOR RICHARD BROWN WAS ON OUR BOARD. The fiscal contribution of the Bush Foundation has been $1,824,099 since 2006. The Department of Human Services contributed $234,880 in each of the last biennium.

In the Department of Human Services current budget for 2009-11, the amount of $234,880 has been designated for Family Group Decision Making. This amount will fund ONLY 2.6 FTE's.

This program will not be able to serve the entire state on the amount that has been designated for 2009-11. The Village has developed this program across the state. We have facilitators, case-aides and supervisors in all 8 human service region totaling 15 staff. We cannot continue serving kids and families statewide with only 2.6 FTE's.

Unless more funding is designated, Family Group Decision Making will not exist in the entire state. PLEASE AMEND HB 1012 ADD $1,9 MILLION AS NEEDED TO MAKE THE BUDGET ABLE TO SUPPORT SERVING CHILDREN AND FAMILIES STATWIDE.

Please ADD this funding WHICH WILL REPLACE THE BUSH FUNDING AND KEEP THE PROGRAM WHOLE. THIS IS NO PROGRAM EXPANSION.

This program will save the state money by reducing the states out of home placement costs.

THANK YOU.

Presented by Tim Mathern, 3.9.09 due to weather not permitting Sandi to attend.

Family Group Decision Making

THE village
FAMILY SERVICE CENTER

Five-year-old Chase and 7-year-old Craig lived in a world of methamphetamine and strangers. Their mother, Missy, and her friends used meth and drugs in front of them, and strangers were in and out of the house at all hours of the day and night. Whether they were with their mother, or a stranger she left them with, nobody paid much attention to whether Chase and Craig had eaten, bathed, gone to bed at a decent hour, or in Craig's case, made it to school.

The county removed Chase and Craig from the home and placed them in a foster home. For the 10 months they were there, it seemed as if the situation was working out well for the boys. The social worker visited the foster home on a Thursday and thought everything was fine. The very next day she received a call that the foster mom was leaving amid claims of domestic violence, and that someone had to pick up the boys.

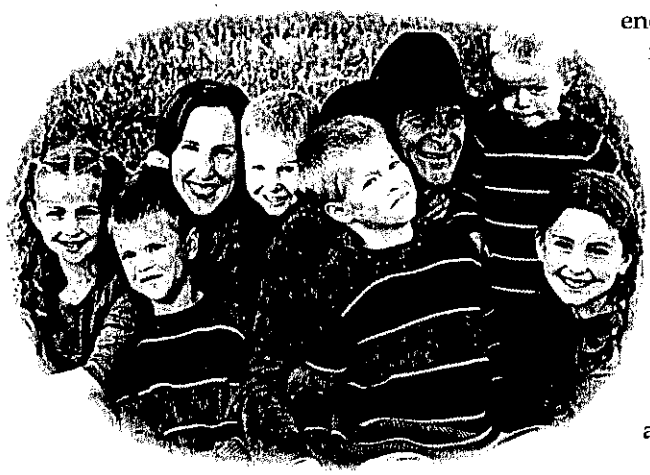
Chase and Craig were taken in by their mother's cousin, Troy, and his wife, Jana. Jana said, "At that time the boys had, and still do have, very challenging behaviors. Chase had rage attacks and would get violent. I had to restrain him 42 times in the first 60 days he was with us."

The situation was extra challenging because of the family connection. The boy's grandparents were committed to helping Missy get her act together so the boys could move back in with her. Jana could see that Missy wasn't showing up for meetings or making the changes she needed to make, but didn't feel she could share that information with the boys' grandparents. Confidentiality laws also prevented the social worker from sharing any of that information with the grandparents.

When the case was referred to Family Group Decision Making, the goal was to bring the situation to some kind of conclusion. After the first family group conference, Jana thought it was a total sham. "Everyone else in the family supported her getting her kids back no matter what the cost. After a 6-hour meeting, we left with a plan to support the mom so she could have the boys back with her." Jana was convinced the plan would fail and that they'd have to start all over at the next meeting.

Jana said, "I realize now that needed to happen. An outside person monitored Missy and it became very clear she didn't follow through with the plan. At the second meeting, the rest of the family could see what was really going on and how she was duping them. Family Group Decision Making was so helpful because it allowed us to put everything on the table and for everyone to know what was going on. We were able to invite all the friends and family, and everyone could see that the mom was not doing her part."

At the second meeting, Missy agreed to terminate her parental rights if the Solhjem's would adopt the boys. "We came back and had the next meeting and said we'd adopt, and then we laid out some contact limits. We were able to negotiate through FGDM so the expectations were all on the table. The grandparents were kind of in the dark and so weren't able to help make informed decisions about the boys. The family conferences helped them to see what was going on and to come to the realization that they wanted us to adopt. It helped our decision a lot to know that the birth grandparents would be very supportive."



"Without FGDM, I definitely think we would have ended up in a court battle. The grandparents would have forked over a ton of cash in order to fight the county. I also believe that if the mom had a good attorney, she would have won and got the boys back. They would have been in a cycle. If they went back to their mom we didn't know if we could take them back because of the additional damage that would be done."

Chase and Craig are now 8 and 10 and have been adopted by Troy and Jana. They have regular contact with their birth grandparents who live only two miles away. They are in school, eat and bathe regularly and have a regular bedtime. Most importantly, they are in an environment free of meth and other drugs.

P

TESTIMONY – PROTECTION AND ADVOCACY PROJECT

HOUSE BILL 1012 (2009)

HOUSE APPROPRIATIONS COMMITTEE -- HUMAN RESOURCES DIVISION

Honorable Chet Pollert, Chairman

January 27, 2009

Chairman Pollert, and members of the House Appropriations Committee Human Resources Division, I am Bruce Murry, a lawyer with the North Dakota Protection and Advocacy Project (P&A).

INTRODUCTION

P&A strongly supports the Governor's 2009 budget for the Department of Human Services. If HB 1012 were approved, P&A believes the Department would have adequate resources to address all of its current activities. HB 1012 contains many insightful reforms and initiatives that would deliver great outcomes for the investment. HB 1012 could also shift resources to address all or most of the constructive criticisms that follow.

PEOPLE WITH DEVELOPMENTAL DISABILITIES

"All persons with developmental disabilities have a right to appropriate treatment, services, and habilitation for those disabilities. Treatment, services, and habilitation for developmentally disabled persons must be provided in the least restrictive appropriate setting." North Dakota Century Code §25-01.2-02.

This statute was part of the resolution of the ARC vs. Olson lawsuit. North Dakota's Developmental Disabilities (DD) Waiver does not serve all persons covered by this mandate. P&A must report the state is not in compliance with NDCC § 25-01.2-02.

P&A has assertively advocated for individuals with significant DD but not "mental retardation" (MR)[1] to receive services under the DD Waiver. States and CMS build all waivers around eligibility for institutional care. North Dakota bases its

[1] A consensus is forming that the term "Intellectual Disability" will replace "MR" eventually. However, "ID" is not yet defined in state or federal law.

DD waiver upon Intermediate Care Facilities for people with MR (ICF/MR). ICF/MR is the basis of all or most DD waivers in the country.

Nationally, people who functionally have similar skills to a person with MR are eligible for ICF/MR services. For example, someone with severe symptoms of Autism Spectrum Disorders might have adaptive behaviors similar to a person with MR. Thirty years ago, the state would have institutionalized many of these people. They should be eligible for a DD Waiver. However, the Waiver agreement with CMS mentions a computerized screening program. The computer program requires a cognitive impairment for DD Waiver services. The Administration on Developmental Disabilities told P&A this requirement was North Dakota's idea. P&A acknowledges the Department disagrees and cites pressure from CMS. P&A appealed whether the computer program can carry the force of law in North Dakota. Our Supreme Court ruled that the DD Waiver agreement with CMS, including the computer program, carries the force of law as though it were in the Administrative Code. Therefore, people who would have been institutionalized thirty years ago now cannot get into the DD Waiver. We have not legally tested whether they can receive ICF/MR services under the Medicaid State Plan, as no clients have wanted more restricted living.

The 1999 US Supreme Court Olmstead decision ruled that states must offer institutional services in less restrictive settings. North Dakota needs to be sure its services to people with DD offer a reasonable alternative to institutions. Therefore, the Department should continue to seek new waivers to serve people with DD but not MR, such as the Children's Medically Fragile Waiver (2007) and the Autism Waiver (2009). The Department should continue to explore with CMS and the Administration on Developmental Disabilities whether the existing DD Waiver must include the cognitive impairment requirement. Active Treatment under a DD waiver continues to be the best way to serve people who could qualify for ICF/MR services. Meeting the terms of Olmstead, the ARC vs. Olson, and NDCC § 25-01.2-02 would require amendments to this budget. P&A can provide amendment language promptly if you so desire.

People with DD have a legal right to adequate services, which in turn require adequate staff. DD providers report turnover rates among their staff as high as 45%.

Such instability violates the legal rights of some people with DD. Similarly, failure to include critical care needs of people with DD violates their legal rights. Please renew this OAR in the final version of HB 1012.

P&A calls upon the Department to redouble its commitment to the State Developmental Center Transition to the Community Taskforce initiative. The Department and the Taskforce have committed to a census of 67 in 2011. The 2005 and 2007 Legislative Assemblies dedicated funds to this end. We should all expect adequate movement from institutionalization to the community.

You might wish to ask the State Council on Developmental Disabilities or the Governor's Olmstead Commission to study the adequacy of DD services, and report to the Legislature. P&A is represented on both bodies, but cannot speak for their time or resources to undertake these tasks.

PEOPLE WITH DISABILITIES DUE TO MENTAL ILLNESSES

P&A believes more funding is needed for community-based mental health services. We applaud and support the additional funding in the Department of Human Service's (DHS) budget for transitional living (TL) services for youth. There is no question that these funds are needed to properly serve this age group. This is a positive step towards increasing community-based supports and services to an adequate level for individuals needing mental health services.

Additional dollars also need to be provided for community-based services for adults. Individuals with mental illness are on waiting lists to get into transitional living placements and supported housing across the state. In the North Central Region, a waiting list is not kept for the transition living facility only because a lack of other community placements has essentially converted the TL facility into long term housing. There are also waits for some individuals in need of psychiatric and psychological services. JoAnn Hoesel testified in her overview of the Division of Mental Health and Substance Abuse that the Division continues its transition to a recovery approach in service delivery. Recovery cannot take place without an adequate continuum of placements and supports to move individuals towards health and integration into the community.

One cost-effective component of the recovery approach is training of peers to support those in treatment. Outcome measures for this program have been extremely favorable, including a 50% decrease in hospitalization rates. The existing funding for peer support services is provided through the Human Service Centers. Federal funding could become available for this program through an amendment to the State Plan. Funding for peer support services, while requested, was not included in the Governor's budget. We recommend that funding be provided to DHS to fund this critical component of an effective, person-centered recovery approach. Such funding might be effective starting at about $65,000 per region.

PEOPLE WITH ADULT ONSET DISABILITIES

The Senate Human Services Committee is hearing several policy initiatives, including one for people with moderate-to-severe brain injury.
In an effort to reduce the fiscal impact of the proposal, that committee is considering relying upon existing programs rather than dedicating money to services for people with brain injury.

The House Human Services Committee is considering a policy initiative to support more informal services to people with Alzheimer's disease and other dementias. This initiative relies upon existing services.

The Department of Human services has secured enhanced FMAP funding under the Money Follows the Person project for people to move out of institutions. However, the project does not create new permanent services.

These policy initiatives and the future balance of long term care in this state all rely upon strong Medicaid personal care (state plan) and SPED programs. Please maintain the health of these programs to delay the need for institutional care for many North Dakotans.

Thank you very much for your time and attention. I would be happy to answer any questions or provide any supplemental information.

TESTIMONY – PROTECTION AND ADVOCACY PROJECT
HOUSE BILL 1012 (2009)
SENATE APPROPRIATIONS COMMITTEE
Honorable Ray Holmberg, Chairman
March 9, 2009

Chairman Holmberg, and members of the Senate Appropriations Committee, I am Bruce Murry, a lawyer with the North Dakota Protection and Advocacy Project (P&A).

P&A strongly supports the Governor's 2009 budget for the Department of Human Services. If HB 1012 were passed as introduced, P&A believes the Department would have adequate resources to address all of its current responsibilities. HB 1012 contains many insightful reforms and initiatives that would deliver great outcomes for the investment. Please amend HB 1012 to include sufficient resources for the suggestions that follow:

I. State Developmental Center & Community Services.
II. Mental Health Peer Support.
III. Aging & Disability Resource Center.
IV. Home & Community Based Services to Avoid Premature Nursing Facility Placement – Personal Care & Guardianship.

I. STATE DEVELOPMENTAL CENTER & COMMUNITY SERVICES

"All persons with developmental disabilities have a right to appropriate treatment, services, and habilitation for those disabilities. Treatment, services, and habilitation for developmentally disabled persons must be provided in the least restrictive appropriate setting." North Dakota Century Code §25-01.2-02. P&A calls upon the Department to redouble its commitment to the State Developmental Center Transition to the Community Taskforce initiative. The Department and the Taskforce have committed to a census of "67 in 2011." The 2005 and 2007 Legislative Assemblies dedicated funds to this end. We should all expect adequate movement from institutionalization to the community. In the

process, our community system of services must be funded adequately to respond to individual needs with quality personnel.

II. MENTAL HEALTH PEER SUPPORT

One cost-effective component of the recovery approach is training of peers to support those in treatment. Peers include people who are successfully recovering from similar mental health situations. Outcome measures for this program have been extremely favorable, including a 50% decrease in hospitalization rates. The existing funding for peer support services is provided through the Human Service Centers. Federal funding could become available for this program through an amendment to the State Plan. Funding for peer support services, while requested, was not included in the Governor's budget. We recommend that funding be provided to DHS to fund this critical component of an effective, person-centered recovery approach. Such funding should be effective starting at about $75,000 per region.

III. AGING & DISABILITY RESOURCE CENTER.

Many good publicly funded services exist to help people stay in the community as long as possible. The single biggest obstacle is helping people who are still funding their own care to spend their money effectively. People then expend their savings and need public assistance sooner. An Aging and Disability Resource Center would help people direct their own resources more effectively.

At an Aging and Disability Resource Center (ADRC), a real person would help North Dakotans navigate the long term care maze. Assessments could be synched to collect compatible information, reducing needless paperwork. Social service agencies could cooperate while resolving issues of turf, blame, or workload. An ADRC could conduct outreach to ensure people know whom to contact in their area. No agency – counties, DHS, Centers for Independent Living, Senior Centers, P&A, etc. – would be a wrong door. Please fund a pilot regional ADRC effort near the Governor's request of $600,000.

IV. HOME AND COMMUNITY BASED SERVICES (HCBS) TO AVOID PREMATURE NURSING FACILITY PLACEMENT

HCBS – ALLOW HIGHER PERSONAL CARE SPENDING LIMITS

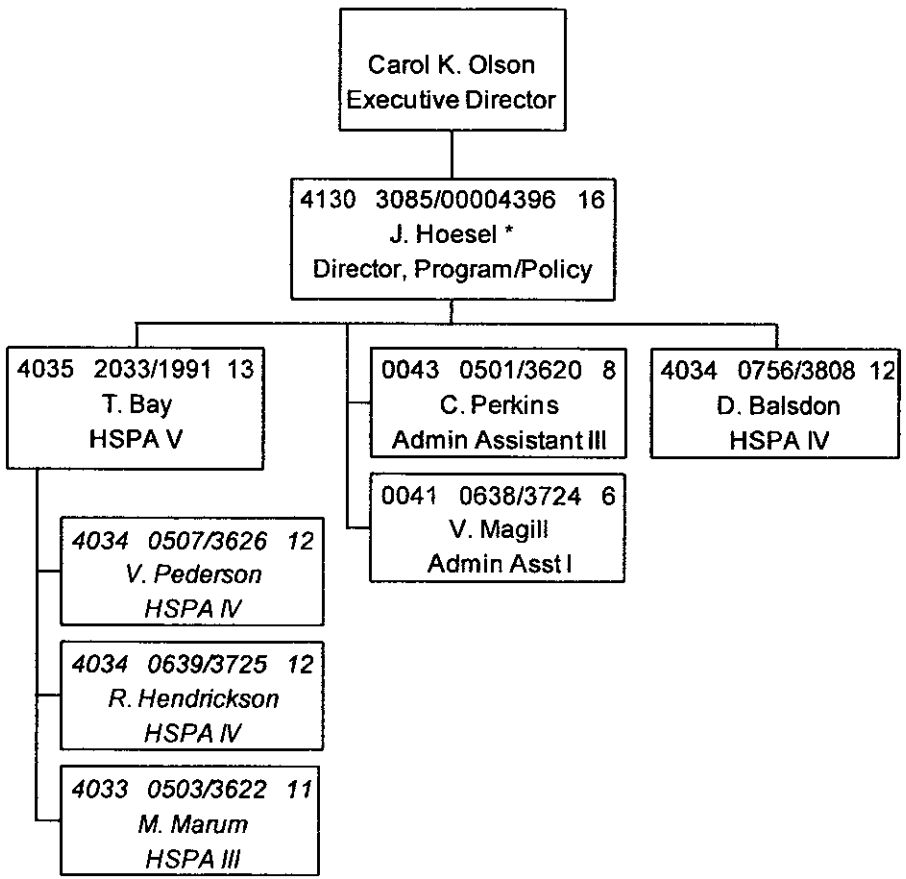
Current personal care services under Medicaid are limited to eight hours of personal care per day. People who need this level of service are likely to enter a nursing facility at a higher daily rate than the average. The Governor has proposed a new limit of about ten hours per day of services when necessary to prevent moving to a nursing facility. Please ask DHS to compare 10 hours QSP services to the corresponding level of acuity at a nursing facility. P&A believes this higher-level HCBS is cost effective and promotes quality of life.

HCBS – GUARDIANSHIP

Guardianship, carefully used as a last resort, is an important tool to extend someone's independence. For people who acquire disabilities as adults, DHS has only $40,000 to obtain guardianships (non-DD). This funds only eight guardianship petitions per year, and pays nothing toward ongoing guardianship costs. P&A asks the Senate to fund guardianship services by amending HB 1012 to include half of the amount recommended in SB 2028 (2005, Interim Criminal Justice Committee – Chapter 410 of 2005 Session Laws), as introduced, or about $350,000. Any intermediate increase would also help protect people who cannot protect themselves.

Thank you for your attention. I am happy to answer any questions, now or before the Subcommittee.

North Dakota Department of Human Services
Developmental Disabilities



* FTE located under MH/SA

2007 - 2009 Budget:
7 FTEs

Revised 1/7/09

B

Testimony
House Bill 1012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
January 13, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, I am JoAnne Hoesel of the Department of Human Services. I am here today to provide you an overview of the Developmental Disabilities Division (DD) for the Department of Human Services.

Programs

The Developmental Disabilities Division is made up of 7 FTEs who are responsible for the needs assessment, staff training, development of policy, quality assurance, compliance with federal oversight agency rules, and service monitoring functions relating to the provision of home and community-based services for individuals who have a developmental disability, as well as children who are at risk of developmental delays.

Staff interact regularly with the developmental disability staff at the regional human service centers, the Developmental Center, federal agency representatives, school systems, universities, consumer advocates, and a variety of public and private entities who play a part in the delivery system and monitoring of services.

Developmental Disability services are funded through the Medicaid state plan, three Medicaid Home and Community-Based Waivers, Part C of IDEA, and general funds.

Caseload / Customer Base

In SFY 2008, 5,185 individuals received developmental disability case management through the human service centers,

1,836 individuals received family support program services, including family subsidy, infant development, and family support,

2,131 individuals received residential and/or day services,

9,282 Right Track screenings were completed for infants and toddlers birth to three years of age at risk for developmental delays.

Note: The funding for the DD case management is contained in the regional human service center budgets. The community-based services for individuals and families are budgeted in the Long-Term Care section of the budget. Right Track Services are budgeted in the operating line of the budget.

Customer Base

According to the latest report from the University of Minnesota on residential services for persons with Developmental Disabilities, Status and Trends through 2007:

- The national average rate of placement in residential settings for persons with Intellectual Disabilities (ID)/Developmental Disabilities (DD) in 2007 was 145.1 persons per 100,000 of the general population. North Dakota ranked number one with 313.6 per 100,000 state residents.

- Nationally, the combined average Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Home and Community-Based Services (HCBS) utilization was 198.0 per 100,000 of the population. North Dakota ranked number one with 645.3 persons per 100,000 state residents.

- In North Dakota, there are 1,112 private provider settings which serve persons with 1 – 3 people; 38 settings which serve 4 – 6 people; 62 settings that served 7 – 15 persons; and only 2 settings serve 16 or more people.

- There were 1,112 people served in settings of 1 – 3 people, 214 were served in settings for 4 – 6; 501 were served in settings of 7 – 15, and 62 were served in settings for 16 or more persons.

Major Program Trends

Consumer Choice – The Division continues its 'self-directed supports' approach which allows families to manage their own services. The Division is proposing to add this feature for some

services in the traditional DD waiver which is currently being reviewed by the Centers for Medicare and Medicaid Services (CMS). Similarly, CMS also requires states to move toward increased portability of funds and increased service access in waivers based on consumer choice.

Developmental Center Transition - Transition efforts from the Developmental Center continue with collaboration between the regional human service centers, the One Center, advocates, DD providers, Medical Services, and the Division. One challenge is the DD providers' inability to find staff to serve the individuals in communities. The Department is working with DD providers to fully identify barriers to transition and the transition committee will use the data to address the challenges from a system view.

Services for young children with DD – Caseload growth continues in the number of young children with developmental disabilities needing support, which has put pressure on the family support budget.

Increased federal accountability requirements and oversight – CMS has placed greater emphasis on providing evidence of compliance with the six health & welfare assurances required in the waivers. CMS has become more prescriptive, requires more state reporting, and requires more oversight of providers on the part of the state.

DD Home & Community-Based Services Waiver Renewals - North Dakota's DD waiver renewals were submitted January 1, 2009 and are being reviewed by CMS. The renewed waivers will be effective April 1, 2009. The waiver submittals are the culmination of on-site visits by CMS, numerous CMS phone calls, numerous work groups including providers and advocates, and tracking the ebb and flow of federal regulatory decisions in Congress and CMS. CMS requires states to formalize their quality framework and track, trend, and train within the DD system.

DD/MI – Individuals with both a developmental disability and a mental illness continue to challenge the system, especially adolescents and those in transition to adult services. Either the youth are too low functioning for the mental health system or too high functioning for the developmental disabilities system. The Department is currently studying options for integrating treatment services.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase/ Decrease
Salary and Wages	860,672	965,013	104,341
Operating	4,400,076	4,971,878	571,802
Grants	816,403	464,125	(352,278)
Total	6,077,151	6,401,016	323,865
General Funds	2,440,426	2,806,110	365,684
Federal Funds	3,636,725	3,594,906	(41,819)
Other Funds	0	0	0
Total	6,077,151	6,401,016	323,865
FTE	7.00	7.00	0.00

The Salary and Wages line item increased by $104,341 and can be attributed to the following:

- $87,001 in total funds is to fund the Governor's salary package for state employees. The general fund portion of this increase is $45,737.
- The cost to continue the 4% salary increase for the last year of the 07-09 biennium is $49,827 of which $49,209 is general fund.
- The remaining decrease of ($32,487), of which ($2,959) is general fund is due to divisional restructuring.

Operating expenses show a net increase of $571,802 for a variety of reasons:

- Increase in travel of $88,109, of which $27,037 is general fund, reflects an increase of travel due to more staff travel time devoted to training and regulatory oversight.

- Increase of $46,179 for professional development, of which $1,479 is general fund to support early intervention services.
- Increase of $599,530 in operating fees and services of which $145,950 is general fund. The increases and decreases are as follows:
    - $257,741 increase in the Catholic Charities Guardianship contract which includes a correction of $49,209 in the contract that was omitted last biennium, $37,777 cost to continue year two increases plus $170,755 for the inflationary increase of 7% in each year of the biennium for this contract. This is all general funds;
    - $527,168 increase for Part C which reflects a shift from the grant line to operating fees and services of $449,636 for early intervention services, which is all federal funds;
    - Increase of $34,310 of federal funds for Right Track screenings due to an increase in assessments, which is all federal funds;
    - ($184,039) decrease in our fiscal agent contract, as last biennium was the original self-directed support work and was based on an estimate. This request reflects actual usage, of which ($103,354) is general funds;
    - ($35,650) decrease due to restructuring of division.

- Decrease of ($92,432) in various supplies, of which ($1,431) is general funds, the majority is being moved to cover increased travel and the Early Intervention program.
- Decrease of ($77,527) in equipment, of which ($361) is general funds, the majority is being moved to cover increased travel and the Early Intervention program.
- Decrease of ($8,163) in Information Technology communication services, of which ($78) is general funds.
- Decrease of ($11,951) in rent, of which ($4,033) in general funds due to staff being moved out of Prairie Hills Plaza building.
- Increase of $14,730 in printing, of which $2,517 is general funds, the majority being for Early Invention program.
- Increase of $13,327 in professional fees, of which $7,400 in general funds, the majority being for administrative hearings.

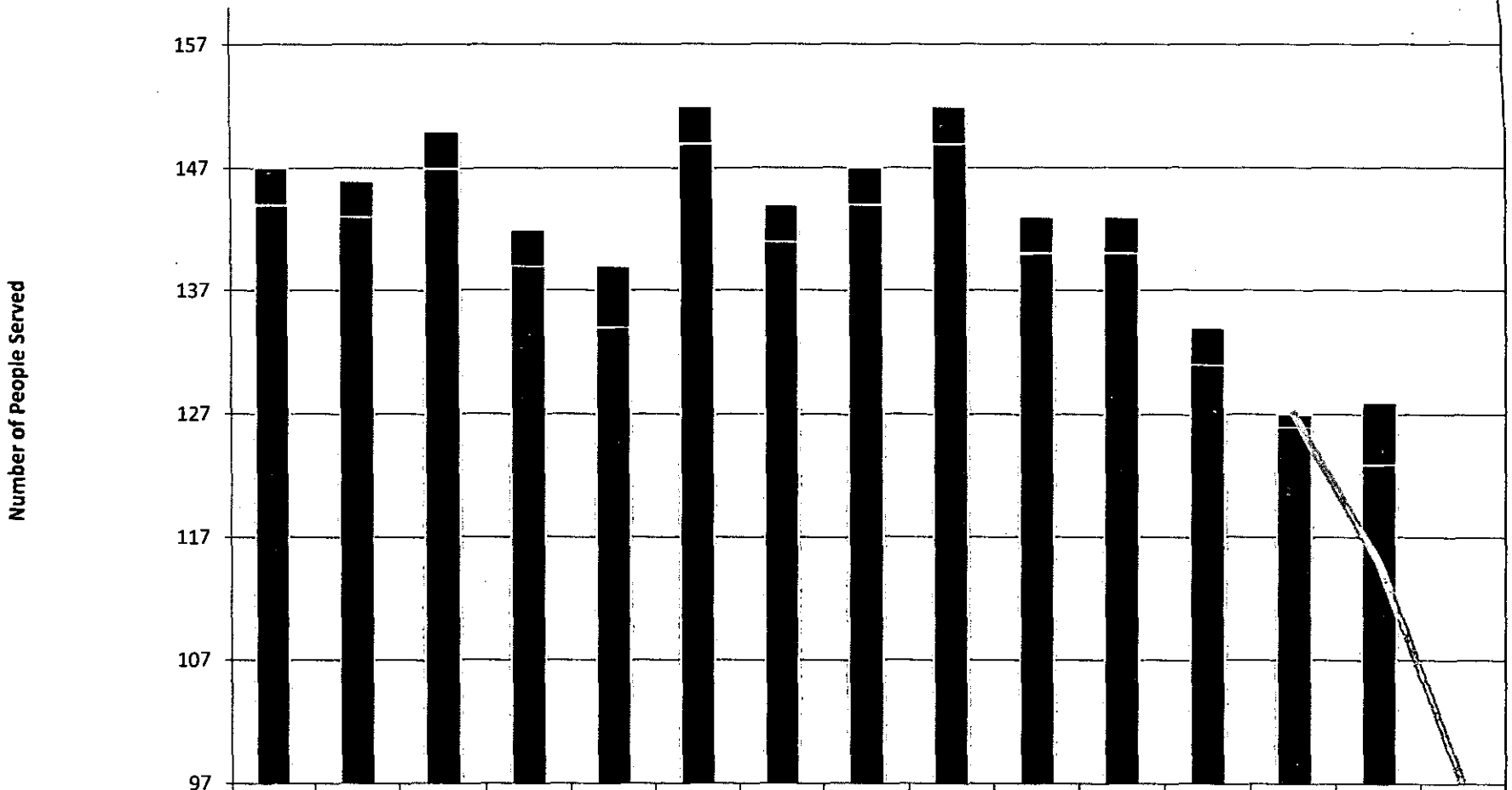
Grants resulted in a net decrease of ($352,278), of which $95,217 is an increase in general funds, for a variety of reasons with the major changes being:

- ($449,636) decrease reflects the shift from grants to operating for the Early Intervention program. This decrease is 100% federal funds. There was also a funding shift of $2,141 from general funds to federal funds.

- Increase of $97,358 in general funds for service payments for individuals who were no longer able to be served by the waiver due to CMS' required eligibility changes in the 05-07 biennium. These funds represent job supports and residential supports for these individuals.

This concludes my testimony on the 2009 – 2011 budget request for Developmental Disabilities Division area of the Department. I would be happy to answer any questions.

Total Population 1995-2008 by 2009 Transition Target



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
NDSH Facility	3	3	3	3	5	3	3	3	3	3	3	3	1	5	
NDDC Population	144	143	147	139	134	149	141	144	149	140	140	131	126	123	
Transition Goals													127	115	97

D

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code		Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-51 DEVELOPMENTAL DISABILITIES DIVISION									
		S101 FULL-TIME EQUIVALENTS (FTEs)		8.000	7.000	0.000	0.000	0.000	7.000
32510	B	511000 Salaries - Permanent		757,768	646,427	285,932	7,717	0	654,144
32510	B	516000 Fringe Benefits		246,390	214,245	100,593	9,623	28,686	252,554
32510	B	599110 Salary Increase		0	0	0	0	49,879	49,879
32510	B	599160 Benefit Increase		0	0	0	0	8,436	8,436
			Subtotal:	1,004,158	860,672	386,525	17,340	87,001	965,013
32510	F	F_1991 Salary - General Fund		360,148	358,016	167,696	46,250	45,737	450,003
32510	F	F_1992 Salary - Federal Funds		644,010	502,656	218,829	(28,910)	41,264	515,010
			Subtotal:	1,004,158	860,672	386,525	17,340	87,001	965,013
32530	B	521000 Travel		141,593	122,111	68,741	88,109	0	210,220
32530	B	531000 Supplies - IT Software		3,392	4,332	3,316	(3,082)	0	1,250
32530	B	532000 Supply/Material-Professional		12,616	54,950	47,843	(44,950)	0	10,000
32530	B	535000 Miscellaneous Supplies		1,757	47,320	39,456	(45,720)	0	1,600
32530	B	536000 Office Supplies		4,688	4,000	2,935	900	0	4,900
32530	B	541000 Postage		696	980	245	420	0	1,400
32530	B	542000 Printing		32,001	19,370	17,852	14,730	0	34,100
32530	B	551000 IT Equip under $5,000		71	3,350	3,332	(3,350)	0	0
32530	B	552000 Other Equip under $5,000		0	130,300	130,296	(70,300)	0	60,000
32530	B	553000 Office Equip & Furniture-Under		1,145	4,477	2,945	(3,877)	0	600
32530	B	582000 Rentals/Leases - Bldg/Land		75,013	48,805	20,867	(11,951)	0	36,854
32530	B	601000 IT - Data Processing		726	792	448	8	0	800
32530	B	602000 IT-Communications		436	491	205	(171)	0	320
32530	B	603000 IT Contractual Services and Re		0	8,000	6,000	(8,000)	0	0
32530	B	611000 Professional Development		62,201	43,045	27,021	46,179	0	89,224
32530	B	621000 Operating Fees and Services		3,094,711	3,903,903	1,774,997	599,530	0	4,503,433
32530	B	623000 Fees - Professional Services		550	1,700	0	15,477	0	17,177
32530	B	625000 Medical, Dental and Optical		0	2,150	1,593	(2,150)	0	0
			Subtotal:	3,431,596	4,400,076	2,148,092	571,802	0	4,971,878

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code		Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-51 DEVELOPMENTAL DISABILITIES DIVISION									
32530	F	F_3991 Operating - General Fund		1,031,947	1,794,713	767,481	178,480	0	1,973,193
32530	F	F_3992 Operating - Federal Funds		2,399,649	2,605,363	1,380,611	393,322	0	2,998,685
			Subtotal:	3,431,596	4,400,076	2,148,092	571,802	0	4,971,878
32560	B	712000 Grants, Benefits & Claims		543,465	816,403	173,844	(352,278)	0	464,125
			Subtotal:	543,465	816,403	173,844	(352,278)	0	464,125
32560	F	F_6991 Grants - General Fund		269,068	287,697	133,271	95,217	0	382,914
32560	F	F_6992 Grants - Federal Funds		274,397	528,706	40,573	(447,495)	0	81,211
			Subtotal:	543,465	816,403	173,844	(352,278)	0	464,125
			Subdivision Budget Total:	4,979,219	6,077,151	2,708,461	236,864	87,001	6,401,016
			General Funds:	1,661,163	2,440,426	1,068,448	319,947	45,737	2,806,110
			Federal Funds:	3,318,056	3,636,725	1,640,013	(83,083)	41,264	3,594,906
300-51 DEVELOPMENTAL DISABILITIES DIVISION			**Other Funds:**	0	0	0	0	0	0
			SWAP Funds:	0	0	0	0	0	0
			County Funds:	0	0	0	0	0	0
			IGT Funds:	0	0	0	0	0	0
			Subdivision Funding Total:	4,979,219	6,077,151	2,708,461	236,864	87,001	6,401,016

Developmental Disabilities

Detail of Budget Account Code 621000 - Operating Fees & Services

Operating Fees & Services	Amount	General	Federal/Other
Acumen contract	228,000	117,242	110,758
Years of Service awards	1,450	538	912
Corporate guardianship contract	1,784,137	1,784,137	0
Right Track contracts	1,734,310	0	1,734,310
Part C contracts	754,136	0	754,136
Public notices of meetings	1,400	0	1,400
Total Operating Fees & Services Budget Account Code	4,503,433	1,901,917	2,601,516

Developmental Disabilities

Detail of Budget Account Code 582000 - Rentals/Leases

Rentals & Leases	Amount	General	Federal/Other
Staff located at Prairie Hills Plaza - $14.05 per sq foot	35,754	16,048	19,706
Miscellaneous booth rentals	1,100	0	1,100
Total Rentals & Leases Budget Account Code	36,854	16,048	20,806

D

North Dakota Department of Human Services
Medical Services Division
Long-Tem Care Continuum

Developmental Disabilities (DD) Grants
HB 1012

Overview of Services for People with Developmental Disabilities

Adult Education Transition Services (AETS)

Refers to services provided to students 18 - 21 years of age who are eligible for developmental disabilities case management services and can benefit from residential and/or day services provided in the developmental disabilities system while they are still in school. This is a joint initiative between the Department of Public Instruction and the Department of Human Services. Services include Medicaid HCBS waiver residential and day services (day supports; extended services).

Congregate Care

Specialized group residential facility which provides programming for elderly individuals with mental retardation which will assist in the maintenance of the individual's current level of functioning. The health and medical conditions of the individuals are stable and they do not require continued nursing or medical care.

Day Supports

A day program to assist individuals in acquiring, retaining, and improving skills necessary to successfully reside in a community setting. Services may include assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; provision of social, recreational, and therapeutic activities to maintain physical, recreational, personal care, and community integration skills; and development of non-job task-oriented prevocational skills such as compliance, attendance, task completion, problem solving, and safety; and supervision for health and safety.

Extended Services

Supports provided for individuals employed in the community. Supports are provided as needed for each individual by a job coach. Initial job placement and

stabilization and training is provided through the Supported Employment Program and Extended Services is the long term follow up.

Family Subsidy

A program that reimburses a family for excess expenses related to their child's disability. Family Subsidy offers support to enable a family to keep their child in their home when lack of financial support would make it very difficult for the family to keep the child at home. The child may be eligible for Family Subsidy through age twenty-one.

Family Support Services

Family centered services which are provided for an eligible client in order for the client to remain in an appropriate home environment. Family Support Services provides: (a) short-term Respite Care when a specialized trained care giver is needed in order to meet the individual's needs. Respite Care is provided when the parents/primary care givers are absent, and can be delivered in the family home or in another location; (b) In-Home Support provides a specialized trained care giver to work with the parents/family when additional help is needed to meet the individual's needs; (c) Family Care Option is out-of-home support which is provided in a licensed family home.

Intermediate Care Facility for the Mentally Retarded (ICF/MR)

Group residential facility licensed as a certified health care facility for individuals with mental retardation and related conditions. A responsible direct care staff is on duty and awake on a 24-hour basis when clients are present. Each client receives a continuous active treatment program which includes training, health services and related services that help him/her function with as much self determination and independence as possible.

Infant Development

A home-based, family-focused service that provides information, support and training for families to assist them in meeting their child's needs. A child may be eligible for Infant Development up to age three.

Individualized Supported Living Arrangement (ISLA)

Residential service which provides support to individuals living in a home owned or leased by the individual. Services may include training and assistance in personal care, budgeting, shopping, laundry, etc. Levels and amounts of support may vary depending on the individual's needs. The individual is responsible to pay for room and board.

Minimally Supervised Living Arrangement (MSLA)

Community waiver group home or community complex setting which provides training in community integration, and social, leisure, and daily living skills.

Specialized Placement

Refers to a residence for people who are diagnosed as both mentally retarded and mentally ill and whose individualized programs address residential, psychosocial and psychiatric development prior to entry into less restrictive settings. Services are provided at one 5-bed and one 6-bed group home operated by Pride, Inc. in Bismarck.

Supported Living Arrangement (SLA)

Residential service which provides support to individuals living in their own home or apartment setting. Services may include instruction in budgeting, shopping, laundry, etc. Support is provided on an intermittent basis and is generally less than 20 hours per month. Individuals receiving SLA services generally need less support and assistance than individuals receiving ISLA.

Title XIX County Waivered Services

Refers to select services offered through the Aged & Disabled waiver service network to persons with developmental disabilities and included in the MR/DD Medicaid waiver. Services include homemaker; adult day care; adult family foster care; respite care for adult foster care provider; and county case management.

Transitional Community Living Facility (TCLF)

Community waiver group home which provides training for individuals in community integration, social, leisure, and daily living skills in a group environment.

Self-Directed Supports

The purpose of the program is to provide assistance for families with a member who requires long-term supports and services, or to individuals who require long-term supports and services, so that the individual may remain in the family residence or in their own home. Eligibility is limited to those individuals who require long-term supports at a level typically provided in an institution.

E

DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES GRANTS BUDGET
09/11 CASELOAD CHANGES

Program	07/09 Appropriation		Ending 07/09 Caseload per April '08 Spenddowns	07/09 Reprojection After April '08 Spenddowns	Ending 07/09 Caseload	Beginning 09/11 Caseload	Ending 09/11 Caseload	09/11 Net Growth	09/11 High School Graduates		09/11 Other Caseload Changes		09/11 New Growth
	Beginning 07/09 Caseload	Ending 07/09 Caseload							August 2009	August 2010	August 2009	August 2010	
AETS	4	4	4	0	4	4	4	0					
Congregate Care	49	49	43	0	43	43	43	0					
Day Supports	953	975	985	12	997	1,028	1,058	61	22	22	9	8	
Extended Services	285	290	290	(5)	285	285	290	5		5			
Family Subsidy	513	513	423	0	423	448	448	25				25	
Family Support Services:													
• In Home Support	317	336	340	0	340	341	360	20					20
• In Home Sup. SCHIP	117	140 (476)	133 (473)	0	133	134	157	24					24
• Family Care Option	16	17	12	0	12	13	14	2					2
• Family Care Option 3	26	38	21	0	21	21	30	9					9
ICF/MR - Adult	252	252	236	0	236	236	244	8				8	
ICF/MR - Children	78	78 (92)	83 (94)	0	83	83	83	0					
ICF/MR - Children SCHIP	14	14	11	0	11	11	11	0					
ICF/MR - PH	121	121	122	0	122	122	122	0					
Infant Development	671	809 (1,153)	642 (900)	0	642	646	738	96					96
Infant Development SCHIP	298	344	258	0	258	259	282	24					24
ISLA	754	784	740	4	744	775	805	61	22	22	9	8	
MSLA	181	181	187	5	192	192	192	0					
Specialized Placement	11	11	11	0	11	11	11	0					
SLA	136	136	138	0	138	138	138	0					
Title XIX Co. Waivered	36	36	36	0	36	36	36	0					
TCLF	168	174	167	0	167	167	167	0					
Self-Directed Supports	240	312	312	(199)	113	115	157	44					44

B

Testimony
House Bill 1012 – Department of Human Services
House Appropriations - Human Resources Division
Representative Pollert, Chairman
January 13, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, I am Andrea Peña, Executive Director of the North Dakota State Council on Developmental Disabilities. I am here today to provide you an overview of the Council's budget request.

Programs

The State Council on Developmental Disabilities administers the federal Developmental Disabilities Act Basic State Grant allocated to North Dakota. The Council directs this funding toward projects and activities that advocate policies and support programs which promote choice, independence, productivity, and inclusion for North Dakotans with developmental disabilities.

Program Trends

For the 2009-2011 biennium, the Council intends to continue to award grants to state and local private, nonprofit agencies and organizations. Activities under these grants need to address at least one of four areas of emphasis identified as priorities in the Council's federally approved five-year plan. These priority areas include: Education and Early Intervention; Employment; Community Supports; and Quality Assurance. More specifically, grant-funded activities under these priority areas are intended to assist persons with Developmental Disabilities to:

- have access to services available in the community which affects their quality of life;
- obtain and keep employment consistent with their interests, abilities, and needs;
- reach their educational and developmental potential; and
- have the information, skills, opportunities, and supports needed to live free of abuse, neglect, exploitation, and violation of their human and legal rights.

Under its federally approved five-year plan for 2007-2011, the Council is responsible for tracking and annually reporting performance data on 26 outcome measures to the federal Administration on Developmental Disabilities. Among other performance outcome data, the Council reported the following accomplishments for FY 2007:

- 116 people were trained in inclusive education.
- 99 parents/guardians were trained in their child's educational rights.
- 109 people were trained in employment.
- 1,155 people were trained in formal/informal community supports.
- 22 buildings/public accommodations became accessible.
- 376 people received training in quality assurance.
- 55 self-advocates and family members were active in systems advocacy about quality assurance.
- 534 people were trained in leadership, self-advocacy, and self-determination.
- 1,230 public policymakers were educated about issues related to Council initiatives.

- An estimated 62,294 members of the general public were reached by Council public education, awareness, and media initiatives.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / Decrease
Salary and Wages	177,742	150,373	(27,369)
Operating	49,825	55,054	5,229
Grants	763,517	812,514	48,997
Total	991,084	1,017,941	26,857
General Funds	0	0	0
Federal Funds	991,084	1,017,941	26,857
Other Funds	0	0	0
Total	991,084	1,017,941	26,857
FTE	1.4	1.0	(.4)

The DD Council's budget includes a request for 100 percent federal funding.

The Salary and Wages line item decreased by $27,369 which can be attributed to:

- FTEs have been reduced from 1.4 to 1.0 due to an in-kind allotment of administrative support provided to the Council by the Department of Human Services.
- The Council's Executive Director retired in 2008 and the new Executive Director's salary is less than the former director's.
- A $13,311 increase for the Governor's proposed salary package.

The Operating line item increased by $5,229, which can be attributed to:

- Additional travel costs for the new Executive Director to travel for federal programmatic training and technical assistance purposes.
- A slight increase to adjust for higher fuel costs.

The greatest share of the Council's proposed budget continues to be allocated to the Grants line item:

- The grants line item increased by $48,997 due to carry over monies from a grantee in the previous biennium who did not fulfill their contractual obligations. Due to unmet contractual goals, the money was not allocated to the organization and will be transitioned to another qualifying organization.

This concludes my testimony on the State Council on Developmental Disabilities 2009-2011 budget request. At this time I would be happy to answer any questions from the committee.

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
March 3, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, I am Andrea Peña, Executive Director of the North Dakota State Council on Developmental Disabilities. I am here today to provide you an overview of the Council's budget request.

Programs

The State Council on Developmental Disabilities administers the federal Developmental Disabilities Act Basic State Grant allocated to North Dakota. The Council directs this funding toward projects and activities that advocate policies and support programs which promote choice, independence, productivity, and inclusion for North Dakotans with developmental disabilities.

Program Trends

For the 2009-2011 biennium, the Council intends to continue to award grants to state and local private, nonprofit agencies and organizations. Activities under these grants will need to address at least one of four areas of emphasis identified as priorities in the Council's federally approved five-year plan. These priority areas include: Education and Early Intervention; Employment; Community Supports; and Quality Assurance. More specifically, grant-funded activities under these priority areas are intended to assist persons with Developmental Disabilities to:

- have access to services available in the community that affect their quality of life;
- get and keep employment consistent with their interests, abilities, and needs;
- reach their educational and developmental potential; and
- have the information, skills, opportunities, and supports needed to live free of abuse, neglect, exploitation, and violation of their human and legal rights.

Under its federally approved five-year plan for 2007-2011, the Council is responsible for tracking and annually reporting performance data on 26 performance outcome measures to the federal Administration on DD. Among other performance outcome data, the Council reported the following accomplishments for FY 2007:

- 116 people were trained in inclusive education.
- 99 parents/guardians were trained in their child's educational rights.
- 109 people were trained in employment.
- 1,155 people were trained in formal/informal community supports.
- 22 buildings/public accommodations became accessible.
- 376 people received training in quality assurance.
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- 1,230 public policymakers were educated about issues related to Council initiatives.

- An estimated 62,294 members of the general public were reached by Council public education, awareness, and media initiatives.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget	House Changes	To Senate
Salary and Wages	177,742	(27,369)	150,373	-	150,373
Operating	49,825	5,229	55,054	(4,446)	50,608
Grants	763,517	48,997	812,514	-	812,514
Total	991,084	26,857	1,017,941	(4,446)	1,013,495
General Funds	0	0	0	0	0
Federal Funds	991,084	26,857	1,017,941	(4,446)	1,013,495
Other Funds	0	0	0	0	0
Total	991,084	26,857	1,017,941	(4,446)	1,013,495

FTE	1.4	(.4)	1.0	-	1.0

Budget Changes from Current Budget to Executive Budget:

The DD Council's budget includes a request for 100 percent federal funding.

The Salary and Wages line item decreased by $27,369, which can be attributed to:

- FTEs have been reduced from 1.4 to 1.0 due to an in-kind allotment of administrative support provided to the Council by the Department of Human Services.
- The former executive director retired in 2008 and the new executive director's salary is less than the former director's.

- A $13,311 increase for the Governor's proposed salary package.

The Operating line item increased by $5,229, which can be attributed to:

- A slight increase in travel costs for the new executive director to travel for initial training and technical assistance purposes.

The greatest share of the Council's proposed budget continues to be allocated to the Grants line item:

- The grants line item increased by $48,997 due to rollover monies from a grantee in the previous biennium who did not fulfill their contractual obligations and the money was not allocated to the organization.

House Changes:

The House reduced 50% of the department-wide travel increase. The Council's share of this decrease is $4,446 in federal funds.

This concludes my testimony of the State Council on Developmental Disabilities 2009-2011 budget request. At this time I would be happy to answer any questions from the committee.

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
March 4, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, I am JoAnne Hoesel of the Department of Human Services. I am here today to provide you an overview of the Developmental Disabilities Division (DD) for the Department of Human Services.

Programs

The Developmental Disabilities Division has 7 FTEs and provides management, monitoring, and oversight of the MR/DD Medicaid waivers. The Division is responsible for providing technical assistance, staff training, and developing policy for the Developmental Disability System and assures that early intervention services are delivered to children between the ages of birth to three who are at risk of developmental delays.

Developmental Disability services are funded through the Medicaid state plan, three Medicaid Home and Community-Based Waivers through the Centers for Medicare and Medicaid Services (CMS), Part C of the Individuals with Disabilities Education Act (IDEA) through the Office of Special Education Programs (OSEP), and general funds.

Caseload

In SFY 2008,

- 5,185 individuals received developmental disability case management through the regional human service centers,
- 1,836 individuals received family support program services, including family subsidy, infant development, and family support,
- 2,131 individuals received residential and/or day services, and
- 9,282 Right Track screenings were completed for infants and toddlers birth to three years of age who are at risk for developmental delays.

Note: The funding for the DD program management is contained in the regional human service center budgets. The community-based services for individuals and families provided by private DD providers are budgeted in the Long-Term Care section of the budget. Early Intervention Services are budgeted in the operating line of this Division's budget.

Customer Base

According to the latest report from the University of Minnesota on residential services for persons with Developmental Disabilities, Status and Trends through 2007:

- The national average rate of placement in residential settings for persons with Intellectual Disabilities (ID)/Developmental Disabilities (DD) in 2007 was 145.1 persons per 100,000 of the general population. North Dakota ranked number one with 313.6 per 100,000 state residents.

- Nationally, the combined average Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Home and Community-Based Services (HCBS) utilization was 198.0 per 100,000 of the population. North Dakota ranked number one with 645.3 persons per 100,000 state residents.

- In North Dakota, there are 1,112 private provider settings which serve persons with 1 – 3 people; 38 settings which serve 4 – 6 people; 62 settings that served 7 – 15 persons; and only 2 settings serve 16 or more people.

Major Program Trends

Increased federal accountability requirements and oversight

The Centers for Medicare and Medicaid Services (CMS) came to North Dakota in 2007 and completed an intense quality review of the DD Medicaid waivers. The review's purpose was to prepare the State for the upcoming DD waiver renewals and bring all states into a uniform renewal process. CMS is placing intense emphasis on documentable evidence of compliance in six health

& welfare assurance areas required in the waivers and is more prescriptive in how states arrive at compliance. CMS requires more reporting and more oversight. This is a change for the Division, the regional human service centers, and the private DD providers.

DD Home & Community-Based Services Waiver Renewals
The DD waiver renewals were submitted January 1, 2009 and are being reviewed by CMS. The renewed waivers will be effective April 1, 2009. Multiple work groups, meetings, and documents have been prepared for the renewal and the regional centers and providers have been included in all aspects of the process.

CMS requirements include increased and documented consumer choice of services, movement toward portability of funds, formalization of the quality framework, incident investigation and reporting, and the ability to track, trend, and train within the DD system.

Developmental Center Transition – Efforts to transition individuals from the Developmental Center continue with collaboration between the regional human service centers, the One Center, advocates, DD providers, Medical Services, and the Division. One challenge that continues to challenge these efforts is difficulty finding staff to serve individuals in communities. The Department is surveying DD providers and regional staff for individuals referred statewide to identify barriers to community

placements. The transition committee will use this data to address the challenges and identify specific strategies.

Services for young children with DD – Growth continues with the number of young children with developmental delays needing support. This has put pressure on the family support budget.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase/ Decrease	2009 - 2011 Budget	House Changes	To Senate
Salary and Wages	860,672	104,341	965,013	(10,522)	954,491
Operating	4,400,076	571,802	4,971,878	(67,710)	4,904,168
Grants	816,403	(352,278)	464,125	0	464,125
Total	6,077,151	323,865	6,401,016	(78,232)	6,322,784
General Funds	2,440,426	365,683	2,806,109	(38,190)	2,767,919
Federal Funds	3,636,725	(41,818)	3,594,907	(40,042)	3,554,865
Other Funds	0	0	0	0	0
Total	6,077,151	323,865	6,401,016	(78,232)	6,322,784
FTE	7.00	0.00	7.00	0.00	7.00

The Salary and Wages line item increased by $104,341 and can be attributed to the following:

- $87,001 in total funds is to fund the Governor's salary package for state employees. The general fund portion of this increase is $45,737.
- The cost to continue the 4% salary increase for the last year of the 07-09 biennium is $49,827 of which $49,209 is general fund.

- The remaining decrease of ($32,487), of which ($2,959) is general fund is due to divisional restructuring.

Operating expenses show a net increase of $571,802 for a variety of reasons:

- Increase in travel of $88,109, of which $27,037 is general fund, reflects an increase of travel due to more staff travel time devoted to training and regulatory oversight.
- Increase of $46,179 for professional development, of which $1,479 is general fund to support early intervention services.
- Increase of $599,530 in operating fees and services of which $145,950 is general fund. The increases and decreases are as follows:
    - $257,741 increase in the Catholic Charities Guardianship contract which includes a correction of $49,209 in the contract that was omitted last biennium, $37,777 cost to continue year two increases plus $170,755 for the inflationary increase of 7% in each year of the biennium for this contract. This is all general funds;
    - $527,168 increase for Part C which reflects a shift from the grant line to operating fees and services of $449,636 for early intervention services, which is all federal funds;
    - Increase of $34,310 of federal funds for Right Track screenings due to an increase in assessments, which is all federal funds;

- ($184,039) decrease in our fiscal agent contract, as last biennium was the original self-directed support work and was based on an estimate. This request reflects actual usage, of which ($103,354) is general funds;
- ($35,650) decrease due to restructuring of division.

- Decrease of ($92,432) in various supplies, of which ($1,431) is general funds, the majority is being moved to cover increased travel and the Early Intervention program.
- Decrease of ($77,527) in equipment, of which ($361) is general funds, the majority is being moved to cover increased travel and the Early Intervention program.
- Decrease of ($8,163) in Information Technology communication services, of which ($78) is general funds.
- Decrease of ($11,951) in rent, of which ($4,033) in general funds due to staff being moved out of Prairie Hills Plaza building.
- Increase of $14,730 in printing, of which $2,517 is general funds, the majority being for Early Invention program.
- Increase of $13,327 in professional fees, of which $7,400 in general funds, the majority being for administrative hearings.

Grants resulted in a net decrease of ($352,278), of which $95,217 is an increase in general funds, for a variety of reasons with the major changes being:

- ($449,636) decrease reflects the shift from grants to operating for the Early Intervention program. This decrease is 100% federal funds. There was also a funding shift of $2,141 from general funds to federal funds.
- Increase of $97,358 in general funds for service payments for individuals who were no longer able to be served by the waiver due to CMS' required eligibility changes in the 05-07 biennium. These funds represent job supports and residential supports for these individuals.

House Changes:

The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $3,455 - general fund and $7,067 - federal funds for at total of $10,522.

The House reduced 50% of the department-wide travel increase. Developmental Disabilities' share of this decrease is $40,511 total funds; $7,536 – general fund.

In Operating Fees and Services, the inflationary increase for the contract with Catholic Charities for guardianship services was reduced from the 7% & 7% increase to 6% & 6% resulting in a general fund decrease of $27,199.

This concludes my testimony on the 2009 – 2011 budget request for Developmental Disabilities Division area of the Department. I would be happy to answer any questions.

K

Testimony
House Bill 1012 – Department of Human Services
House Appropriations Committee – Human Resources Division
Representative Pollert, Chairman
January 26, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, thank you for the opportunity to provide comment on House Bill 1012 – Department of Human Services' budget request for the 2009-2011 biennium.

My name is Dianne Sheppard. I am Executive Director for The Arc, Upper Valley in Grand Forks and an official spokesperson for The Arc of North Dakota. Our mission is to ensure that children and adults with intellectual disabilities (such as mental retardation, a term seldom used anymore) have the supports, benefits, and services they need, and are accepted, respected and fully included in their communities.

The North Dakota Department of Human Services' budget is a good budget. However, there are several critical areas that were identified as an OAR, but failed to be included in the budget or where funded at a lower level than needed.

We are asking you to fund these important areas of need:

1. The North Dakota legislative effort to increase direct support staff wages and benefits is commendable and should be continued. This biennium, community service providers are budgeted to receive increases of 7% in 2009 and 7% in 2010.

   DD Provider Wage Equity and Benefit Increase - A $2.00 per hour increase and a 3% increase in benefits.

   For thousands of people with disabilities of all ages, direct support professionals are the key to living successfully in their home communities.

Direct support professionals assist people with disabilities with medications, preparing and eating meals, dressing, mobility, and handling daily affairs. In 2008, North Dakota's direct support staff reached a statewide average wage of $9.77 per hour for this very demanding, often difficult work. Many workers find that they can earn higher hourly wages, and receive better benefits, in far less demanding jobs. As a result, people with disabilities experience continuous turnover of direct support workers or they find themselves unable to get workers at all. Unable to obtain adequate assistance, people with disabilities find their health and safety at risk.

A well-trained, adequately compensated workforce is essential to providing the necessary supports and services to our constituents, who constitute a very vulnerable population. Higher wages reduce employment turnover and is correlated with an increase in the quality of services.

We realize this is a big request; however, it is needed to turn the tide on staff turnover and eliminate the gap between wages paid to private employees and wages paid to public employees in the state.

General Funds	$14,194,510
Federal Funds	$24,189,780
Total Funds	$38,384,290

2. <u>DD Staffing to Meet Critical Needs</u>

As people age, often times their health care needs increase. When individuals do not receive the level of health care necessary to maintain their health, they are more susceptible to catastrophic events: falling and breaking a bone, developing infections, depression and other mental health issues, etc. Staffing increases have not been available from the DHS to adequately address the increased needs that people have when they age. Additional funding is required to provide for these complex behavioral and medical care needs.

General Funds	$2,336,365
Federal Funds	$3,981,551
Total Funds	$6,317,916

3. **Personal Needs Allowance -ICF/MR – for individuals who reside in an ICF/MR facility the budget will increase the allowance from $50 to $60 per month, this is not enough.**

We are asking you to increase the Personal Needs Allowance from $50 to $75 per month for people living in an ICF/MR facility. The importance of the Personal Needs Allowance for people living in an ICF/MR facility cannot be overstated; it directly impacts the quality of life of a majority of residents.

Residents need this allowance to fulfill various personal needs such as clothing, individual preferences on personal care items, social support (telephone, stationery, etc.) and occasional outings. In our consumer-oriented society, it is important for residents to have an adequate monthly Personal Needs Allowance to be able to participate on the most basic level. This is particularly true for residents who are isolated and have no family or friends to purchase personal items.

4. **North Dakota continues to over-utilize public and private institutions and large group homes.**

Large Group Homes: The 8 bed group home model that was favored when the DD system was being created back in 1980 is now outdated, and has been for quite some time. North Dakota has not changed with the times---while other states have---making our system an antique. What plans are in place to bring our system out of the 80's and into the current decade?

Institutions: We are asking you for a commitment to steadily reduce reliance on and ultimately close the North Dakota Developmental Center at Grafton.

Most professionals, family members and persons with intellectual and developmental disabilities believe that large group settings are no longer acceptable living arrangements because of the difficulty of personalizing services. Virtually every credible research study supports the assertion that people are well served in small community settings, including those with behavior issues, or people with complex medical needs.

As such, institutional placement cannot be justified on the programmatic needs of the people who are forced to reside in an institution in order to receive services. The long-term future of services to persons with intellectual and developmental disabilities in North Dakota is in community settings.

North Dakota's rate of utilization of its state-operated Developmental Center exceeded the comparison states (Idaho, Montana, South Dakota, and Wyoming) by a factor of two to one. An analysis revealed that since the District Court dismissed the *Arc v. Sinner* case in 1990 and closed the Court Monitor's office, the reduction in the census of the North Dakota Developmental Center slowed down dramatically, in fact, from 1995-2004 the census at the Developmental Center actually increased from 140 to 146 persons. North Dakota has recently reduced the census at Grafton from 146 persons in 2004 to 130 persons in 2008.

The Transition to the Community Task Force, chaired by Alex Schweitzer, Superintendent of the Developmental Center, has put together a transition goal for July 1, 2011 for a maximum of 67 people residing at the Center. This is a reasonable goal and should be supported with a budget that will meet that goal.

The closure of a state institution can generate savings for state government over time because it:

1) Eliminates the high fixed cost of operating a state-owned facility, originally built for many more residents than live there at the time of closure;

2) Shifts some fiscal responsibilities from state government tax revenues to federal Supplemental Security Income (SSI);

3) Increases the likelihood that individuals will engage in productive employment in a local community because they now live closer to employment markets;

4) Utilizes less costly social, educational, religious, and recreational resources in the community rather than the relatively expense, specialized services provided in the institution; and,

5) By renting/leasing residences, the expensive institutional capital construction and remodeling costs necessary for most institutions to remain open and certified for receipt of federal reimbursement are avoided.

North Dakota has a healthy budget surplus, and this would be the ideal time to invest in our community service delivery system. People are confined to the Developmental Center in Grafton in part because of the lack of appropriate resources in the community. We are having problems downsizing large group homes because of the lack of appropriate resources in the community. When the state has the resources to provide those services in the community and fails to commit the money, it is difficult to conclude that the state has a real commitment to community services and the least restrictive environment as required by state and federal law.

Attached are two reports where you will find information on the structure, financing, and quality assurance of residential and community services, and 10 key issues associated with the potential closure of the Developmental Center at Grafton.

Developmental Disabilities in North Dakota: 2009
Executive Summary

Funding for this report was provided by the North Dakota State Council on Developmental Disabilities.

I would be happy to answer any questions you may have.

Thank you.

Dianne Sheppard
Executive Director

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Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations Committee
Senator Ray Holmberg, Chairman
March 4, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, thank you for the opportunity to provide commentary on House Bill 1012 – Department of Human Services' budget request for the 2009-2011 biennium.

My name is Dianne Sheppard. I am Executive Director for The Arc, Upper Valley in Grand Forks, and an official spokesperson for The Arc of North Dakota. Our mission is to ensure that children and adults with intellectual disabilities (such as mental retardation, a term seldom used anymore) have the supports, benefits, and services they need, and are accepted, respected and fully included in their communities.

The North Dakota Department of Human Services budget relative to developmental disabilities and community services is a good budget. We would like to see it adopted as presented along with other critical items that were identified as an OAR, but failed to be included in the budget or where funded at a lower level than needed. We would also like you to tighten-up the Amendment to Section 25-04-05 – Qualifications for admission to state facility.

<u>Please consider the following</u>:

1. The North Dakota legislative effort to increase direct support staff wages and benefits is commendable and should be continued.

   This biennium, DD community service providers were budgeted to receive increases of 7% in 2009 and 7% in 2010. We are asking you to approve these increases.

In addition, we are asking you to approve a pass-through raise of $2.00 per hour and a 3% increase in benefits for DD community service providers.

For thousands of people with disabilities of all ages, direct support professionals are the key to living successfully in their home communities. Direct support professionals assist people with disabilities with medications, preparing and eating meals, dressing, mobility, and handling daily affairs. In 2008, North Dakota's direct support staff reached a statewide average wage of $9.77 per hour for this very demanding, often difficult work. Many workers find that they can earn higher hourly wages, and receive better benefits, in far less demanding jobs. As a result, people with disabilities experience continuous turnover of direct support workers or they find themselves unable to get workers at all. Unable to obtain adequate assistance, people with disabilities find their health and safety at risk.

A well-trained, adequately compensated workforce is essential to providing the necessary supports and services to our constituents, who constitute a very vulnerable population. Higher wages reduce employment turnover and is correlated with an increase in the quality of services.

We realize this is a big request; however, it is needed to turn the tide on staff turnover and eliminate the gap between wages paid to private employees and wages paid to public employees in the state.

General Funds	$14,194,510
Federal Funds	$24,189,780
Total Funds	$38,384,290

2. **DD Staffing to Meet Critical Needs**

Staffing increases have not been available from the DHS to adequately address the increased needs that people have when they age.

As such, we believe people are being admitted to the Developmental Center instead of receiving the support they need to stay in the community.

As people age, often times their health care needs increase. When individuals do not receive the level of health care necessary to maintain their health, they are more susceptible to catastrophic events: falling and breaking a bone, developing infections, depression and other mental health issues, etc.

Additional funding is required to provide for these complex behavioral and medical care needs.

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4. **North Dakota continues to over-utilize public and private institutions and large group homes.**

Large Group Homes: We are asking that plans be developed to bring our system out of the 80's and into the current decade.

The 8 bed group home model that was favored when the DD system was being created back in 1980 is now outdated, and has been for quite some time. North Dakota has not changed with the times---while other states have---making our system an antique.

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As such, institutional placement cannot be justified on the programmatic needs of the people who are forced to reside in an institution in order to receive services. The long-term future of services to persons with intellectual and developmental disabilities in North Dakota is in community settings.

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persons. North Dakota has recently reduced the census at Grafton from 146 persons in 2004 to 130 persons in 2008.

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4) Utilizes less costly social, educational, religious, and recreational resources in the community rather than the relatively expense, specialized services provided in the institution; and,

5) By renting/leasing residences, the expensive institutional capital construction and remodeling costs necessary for most institutions to remain open and certified for receipt of federal reimbursement are avoided.

5. **Amendment – Section 25-04-05. Qualifications for admission to state facility.**

Admissions and readmissions to the Developmental Center is a long standing problem. The language changes as proposed, are not helpful.

There are two different issues raised.

First, there needs to be a prohibition against admitting anyone to the Developmental Center if the person can be served in any existing community program, or if a community program can be established to serve the needs of the person recommended for admission.

Second, there is a fundamental conflict in allowing the Developmental Center staff to make the determination as to admission. In most cases, Developmental Center staff will conclude that the person is eligible for admission because the Center needs admissions to survive. There should be a screening process at the regional level first, since the regional staff has better knowledge of what programs are in the community and might prevent admission to the Center. The regional staff should include representatives from the DD community service providers and an advocate from the North Dakota Protection and Advocacy Project and a member of the individual's family and the person being considered. Regional staff should be involved in the identification of services that might be needed and are missing at the community level. If they determine that Developmental Center admission should be considered because of the absence of services in the community, regional staff could then get involved in the expansion or creation of programs that might help to prevent admissions.

Preventing admissions through the statute is a good first step, but adequate funding for community services is the long term answer.

Conclusion:

North Dakota has a healthy budget surplus, and this would be the ideal time to invest in our community service delivery system. People are confined to the Developmental Center in Grafton in part because of the lack of appropriate resources in the community. We are having problems downsizing large group homes because of the lack of appropriate resources in the community. When the state has the resources to provide those services in the community and fails to commit the money, it is difficult to conclude that the state has a real commitment to community services and the least restrictive environment as required by state and federal law.

Attached are two reports where you will find information on the structure, financing, and quality assurance of residential and community services, and 10 key issues associated with the potential closure of the Developmental Center at Grafton.

Developmental Disabilities in North Dakota: 2009
Funded by North Dakota State Council on Developmental Disabilities

Closing the North Dakota Developmental Center: Issues, Implications, Guidelines

I would be happy to answer any questions you may have.

Thank you.

Dianne Sheppard
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DEVELOPMENTAL DISABILITIES IN NORTH DAKOTA: 2009

EXECUTIVE SUMMARY

A report on the structure, financing, and quality assurance of residential and community services

David Braddock, Ph.D.
Richard Hemp, M.A.

Department of Psychiatry
University of Colorado

January 2, 2009

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The executive summary of study results is presented in two parts. The first provides findings and recommendations specific to the structure and financing of residential and community services. The findings/recommendations pertain to: 1) utilization of institutional and 7+ person group home settings; 2) accessing federal funding for expanding Home and Community Based Services; and 3) continuing the enhancement of wages and benefits for community services staff.

The second part of the executive summary provides an overview of the quality assurance component of the study. Quality assurance challenges in North Dakota include deficiencies on critical standards in accreditation surveys conducted by The Council on Quality and Leadership in Supports for People with Disabilities and Medicaid ICF/MR survey/certification reviews. Although North Dakota has continued to perform generally well in terms of national and regional comparisons, the State faces significant continuing challenges in providing services in integrated environments, connecting participants to natural supports, promoting participation in community living, and insuring health and safety.

In summary, this analysis of the structure, financing, and quality assurance of North Dakota's intellectual and developmental disabilities service system has identified continuing issues as well as some recent advances. Although North Dakota has made some progress during 2006-08, much remains to be done. To be addressed are continued reliance on public and private institutional settings and large group homes. This is manifest in the State's over-utilization of federal-state funding for Intermediate Care Facilities/Mental Retardation (ICFs/MR), and its comparative underutilization of the federal-state Home and Community Based Services (HCBS) Waiver program. North Dakota's rate of utilization of its state-operated developmental center exceeded the comparison states (Idaho, Montana, South Dakota, and Wyoming) by a factor of two to one. North Dakota has recently slightly reduced the census at Grafton from 146 persons in 2004 to 130 persons in 2008. The State, however, had previously increased the census of persons with I/DD at Grafton during 1995-2004. Census reduction at Grafton has plateaued since the April 15, 1990, closing of the Court Monitor's office.

A key issue is the fact that the Accreditation Council is accrediting the North Dakota Developmental Center even though the facility does not comply with the

Council's community integration standards. In fact, compliance with the Court Order of 1989 was tied to compliance with "ACDD standards." The Arc of North Dakota and other organizations representing disability interests in North Dakota should reconsider whether failure to enforce compliance with the Council's integration standards represents appropriate practice for individuals with I/DD currently residing at the North Dakota Developmental Center at Grafton.

Part I
Structure and Financing of Residential and Community Services

Total I/DD Spending Increases Negligibly in North Dakota During 2006-08

1. ***Total I/DD spending essentially plateaued during 2006-08, when adjusted for inflation.***

   - Total adjusted I/DD spending increased only one percent during 2006-08. However, 16+ public and private facility spending declined nine percent during this period. Community spending increased by three percent.
   - North Dakota's fiscal effort also increased negligibly (1%) during 2000-08. Institutional fiscal effort declined nine percent, and community services fiscal effort for persons in 1-15 person settings increased three percent.

Over-Utilization of Institutional 16+ Person Settings and 7+ Group Homes Continues

2. ***North Dakota continues to over-utilize public and private 16+ institutions and 7+ group homes as well. Resource commitments should be enhanced for smaller, family-scale settings for six or fewer persons.***

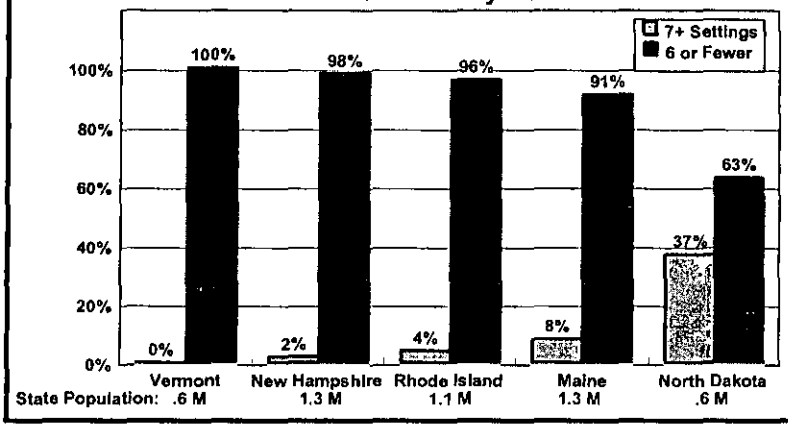
   - During 2006-08, the average daily census of residential settings for 16 or more persons declined by from 325 to 293, a 10% reduction.
   - The decline was made up of a nursing facility reduction of seven persons (- 6%), a decline of seven persons at the North Dakota Developmental Center at Grafton (- 5%), and a decline of 20 persons in private 16+ residential settings (- 27%).
   - During 2007-08, however, the census of 16+ residential settings increased by four persons. Grafton reduced its population by three persons, but nursing facilities increased by six persons and the Anne Carlsen Center ICF/MR increased by one person.

- Persons in 7+ group settings declined by 16 persons (- 3%) during 2006-08. This entailed a reduction of eight persons in 7+ ICFs/MR (- 3%) and a reduction of eight persons in group homes (- 4%).
- After the momentum of the 1980-93 Arc lawsuit diminished, census reduction at the North Dakota Developmental Center at Grafton stalled, and actually increased during 1995-2004.

North Dakota ranked 9th nationally in 2006 in state-operated institutional utilization per 100,000 of the general population among the 41 states that still financed state-operated institutions. Nursing facility utilization in North Dakota also ranked 9th highest nationally. Only New York ranked higher than North Dakota in 7-15 person facility utilization. (North Dakota ranked 2nd nationally.) North Dakota also significantly lags the dominant national trend in the proportion of resources dedicated to six or fewer person settings, ranking 44th in 2006.

Figure 1 compares North Dakota on utilization of six or less and 7+ person measures to four New England states with roughly the same state general population as North Dakota which in 2008 had a 0.6 million general population. North Dakota's proportion of I/DD spending committed to larger settings of seven or more persons was four times that of each of the New England comparison states in 2006.

Figure 1
Percentage of Spending for 6-Person or Fewer Residential and Community Services: FY 2006

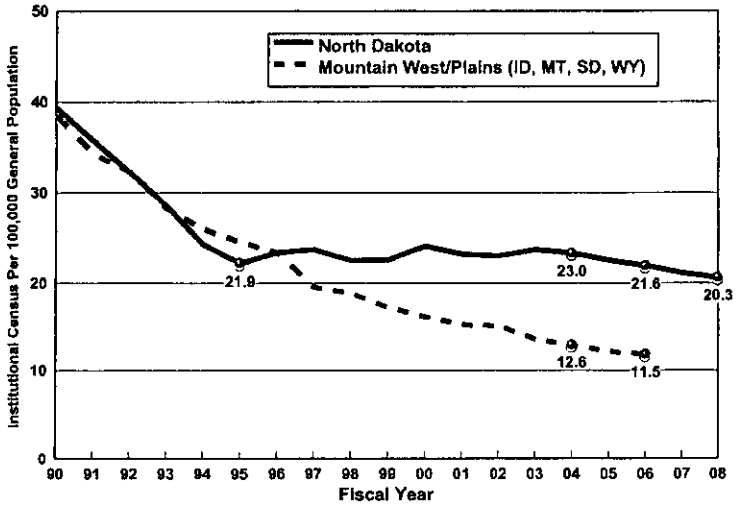


The Mountain West/Plains states are an even more useful comparison group of states than the New England region. These four states include: South Dakota (0.8 million population), Wyoming (0.5 million), Montana (1.0 million), and Idaho (1.5 million). Each of these states, like North Dakota, also has one remaining institution. Their 2006 I/DD institutional censuses were 77 (MT), 90 (ID), 88 (WY), and 162 (SD),

compared to 137 in North Dakota. Although South Dakota's census in 2006 was larger than North Dakota's, all four of these comparison states had lower institutional utilization rates per capita (per 100,000 of the state general population).

The four mountain west/plains comparison states diverged significantly from North Dakota in institutional utilization in 1997, as shown in ***Figure 2***. In 2006, North Dakota's institutional utilization rate exceeded the aggregate of the four comparison states by 88% (21.6 vs. 11.5). Moreover, each of the four comparison states committed a considerably larger share of total I/DD spending to six-person or fewer residential and community services (91-100%) compared to only 63% in North Dakota. North Dakota's utilization rate for state-operated institutional care has been essentially stable during 1995-2008. However, there was modest census reduction in North Dakota during 2004-08.

Figure 2
Institutional Census Per Capita in North Dakota and the Mountain West/Plains States: 1990-2006



On a highly positive note, in 2007 North Dakota received $8.9 million for a "Money Follows the Person" grant from the Centers for Medicare and Medicaid Services (CMS). Effective June 2008 through September 2011, the grant is designed to move approximately 110 persons with mental and physical disabilities from nursing facilities and ICFs/MR to community-based settings. In the case of individuals with I/DD, this involves movement of 30 persons from ICFs/MR (Lipson et al., 2007; North Dakota Department of Human Services, 2008).

Home and Community Based Services Waiver Expansion is Recommended

3. ***Although HCBS Waiver spending in North Dakota surpassed ICF/MR spending in 2007, the State still lags behind most states in Waiver spending. Expansion of the HCBS Waiver should continue.***

- The HCBS Waiver in North Dakota was the means by which much of the progress in developing new six person or fewer residential settings and providing family support funding was accomplished during 2006-08.
  - The census of six person or fewer residential settings increased by 222 persons during 2006-08 (19%).
  - Private ICFs/MR for six or fewer persons increased by 22 persons during 2006-08 (17%); six person or fewer group homes increased by 106 persons (101%), and supported living increased by 95 persons (10%).
- Also during 2006-08, North Dakota's adjusted HCBS Waiver spending increased 10%, and the number of Waiver participants increased by 123 persons (4%).
- Total adjusted ICF/MR spending during 2006-08 decreased by 11%, and the number of ICF/MR recipients increased by eight persons (1%), primarily due to an increased number of persons in six person/fewer private ICFs/MR, coupled with declines in the Developmental Center and in 7+ person ICFs/MR.
- Due to the 2006-08 Waiver spending increase and the ICF/MR spending reduction, North Dakota's HCBS Waiver spending surpassed ICF/MR spending for the first time in 2007.
- Waiver spending per participant, adjusted for inflation, declined from $19.8 thousand in 2006 to $19.1 thousand in 2008 (- 4%).

In 2006, North Dakota ranked 38th among the states in federal-state Waiver spending as a percentage of total I/DD spending, a decline from the rank of 33rd in 2004. North Dakota HCBS Waiver spending only surpassed ICF/MR spending in 2007. (In 2006, only nine states and DC had failed to attain this benchmark. Four of these states and DC are expected to do so in 2008.) The HCBS Waiver is the principal means of expansion of individual and family support, community residences, and related community support services throughout the State. North Dakota should continue to expand the number of HCBS Waiver participants vigorously.

4. ***North Dakota should consider preparing an application for the HCBS "Supports Waiver."***

Supports Waivers have relatively low dollar caps on the services authorized for each beneficiary, but they have flexibility in the selection of services utilized within the cap, and there is the expectation that unpaid family caregivers will provide significant support to Waiver participants. Currently, 18 states have Supports Waivers emphasizing employment services, support brokers, financial management services, and person-directed goods and services. (Smith, Agosta, & Fortune, 2007). The 18 states are: Alabama, Colorado, Connecticut, Florida, Illinois, Indiana, Louisiana, Missouri, Montana, Nebraska, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, and Washington State. Nationwide Supports Waivers information can be accessed at **http://www.hcbs.org/** (use search term "supports waivers").

Strengthen Programs and Funding in Supported Living, Supported Employment, and Family Support

5. ***Adjusted for inflation, spending for supported living in North Dakota declined from 2002 to 2008. Continuing the growth of this vital program is strongly encouraged.***

Supported Living

- During 2006-08, supported living spending (adjusted for inflation) increased one percent. The number of participants increased by 95 persons, however.

North Dakota is a national leader in the implementation of supported living and personal assistance services. In 2006 North Dakota ranked eighth in the nation in supported living spending and fifth in the number of participants supported per capita (per citizen of the general population). However, total inflation-adjusted supported living spending declined by three percent from 2002 to 2008. Growth in supported living spending continues to be needed in North Dakota to provide residential support services for individuals exiting 16+ person public and private institutions and 7+ person group living arrangements and also some individuals with I/DD completing special education programs.

- The HCBS Waiver financed 100% of supported living and supported employment spending, and 94% of family support spending in North Dakota in 2008.

6. ***Programs in supported employment and family support should continue to be strengthened.***

Supported Employment

- Supported employment spending, adjusted for inflation, declined by seven percent during 2006-08. However, the number of workers supported increased by 85 workers (a 28% increment).

North Dakota's spending for supported employment in 2008 remained below its adjusted 1996 level. The HCBS Waiver finances 100% of supported employment spending. The Balanced Budget Act of 1997 authorized Waiver-reimbursed supported employment services. Despite this Waiver support, adjusted overall spending for supported employment declined two percent per year during 1997-2008.

Family Support

- During 2006-08, adjusted family support spending increased by 33%, but the number of families supported declined by three percent.
- Adjusted cash subsidy spending declined 43% during 2006-08, and there was a reduction of 59 families supported.
- Non-subsidy family support spending, adjusted for inflation, increased by 15% during 2006-08 and the number of families supported increased by 39.

Implications of Closing the North Dakota Developmental Center at Grafton

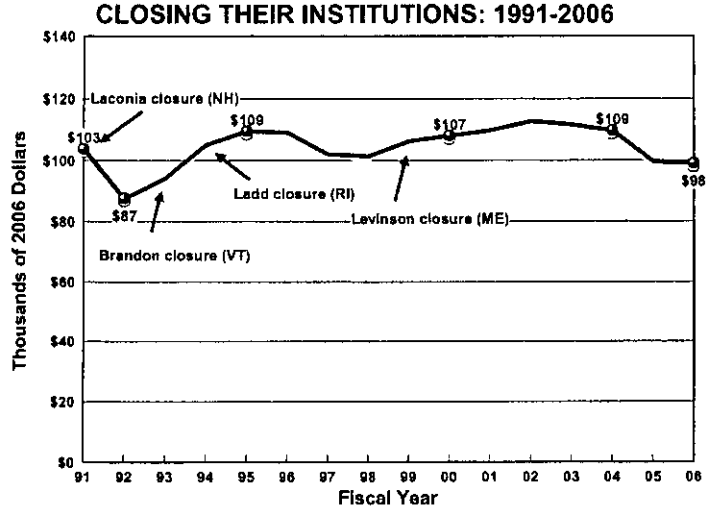
7. What are the implications of possibly closing the North Dakota Developmental Center at Grafton?

Four New England states (Maine, New Hampshire, Rhode Island, and Vermont) offer historical perspectives on post-closure costs of providing community services in lieu of institutional care. These states closed their I/DD institutions during 1991-99. New Hampshire closed Laconia in 1991, Vermont closed Brandon in 1993, Rhode Island closed Ladd in 1994, and Maine closed Levinson in 1999 (Braddock et al., 2008).

We updated through 2006 our previous 1991-2004 analysis of I/DD spending trends after institutional closures in the four New England states (Braddock, 2006). From the dates of the first closure (Laconia in 1991) through 2006, annual spending per statewide residential recipient in the four New England states declined from $103,000 to $98,000 in constant 2006 dollar terms (***Figure 3***). In addition, the number of aggregate

I/DD recipients served in the four states increased by 91% during 1991-06. The number of recipients post-closure increased by 156% in Maine, by 88% in New Hampshire, by 73% in Vermont, and by 47% in Rhode Island.

Figure 3
AVERAGE ANNUAL RESIDENTIAL SERVICES SPENDING FOR I/DD RECIPIENTS IN FOUR NEW ENGLAND STATES CLOSING THEIR INSTITUTIONS: 1991-2006



The closure of a state institution can generate savings for state government over time because it: 1) eliminates the high fixed cost of operating a state-owned facility, originally built for many more residents than live there at the time of closure; 2) shifts some fiscal responsibilities from state government tax revenues to federal Supplemental Security Income (SSI) and, in some cases, to local government sources; 3) increases the likelihood that individuals will engage in productive employment in a local community because they now live closer to employment markets; 4) utilizes less costly social, educational, religious, and recreational resources in the community rather than the relatively expensive, specialized services provided in the institution; and, 5) by renting/leasing residences, the expensive institutional capital construction and remodeling costs necessary for most older institutions to remain open and certified for receipt of federal reimbursement are avoided.

Continue Wage and Benefit Enhancements for Community Staff

8. The North Dakota legislative effort to increase direct support staff wages and benefits is commendable and should be continued.

Wage and benefit deficiencies for direct care staff working with children and adults with intellectual and developmental disabilities is a critical issue across the

country. Higher wages reduce employment turnover and is correlated with an increase in the quality of services. In 2006 and 2007, North Dakota's direct support staff benefited from legislatively sanctioned hourly increases and reached an average statewide wage of $9.77 in 2008. The average direct support wage still lags the North Dakota Developmental Center wage by an estimated $2.00 per hour, and remains three percent below the 2008 U.S. poverty wage for a family of four.

Aging Caregivers Stimulates Demand for Services

9. ***Demand for community I/DD services in North Dakota will continue to be driven by: a) youth aging out of special education; b) individuals in public and private 16+ person institutions seeking alternative placement in community living settings; c) growing supported employment and family support needs; and d) increasing numbers of individuals with I/DD residing with aging caregivers, and requiring residential supports in the future.***

During the 2007/09 biennium, approximately 350 students with intellectual disability, autism and brain injuries will complete special education programs in North Dakota's public schools. An estimated 1,627 individuals with intellectual and developmental disabilities currently live with family caregivers who are aged 60 years or older (see ***Figure 9***, page 16 of the full report). A total of 780 persons in North Dakota currently reside in 7+ person public and private residential facilities. Thus, demand for community and family supports and supported living will continue to grow in the foreseeable future.

Part II
Quality Assurance

Section II of the report analyzed data sets on quality assurance in: 1) Accreditation by The Council on Quality and Leadership in Supports for People with Disabilities; 2) ICF/MR survey and certification surveys; 3) Incidents of substantiated abuse, exploitation, and neglect; and, 4) LRE performance measures for special education districts across the State.

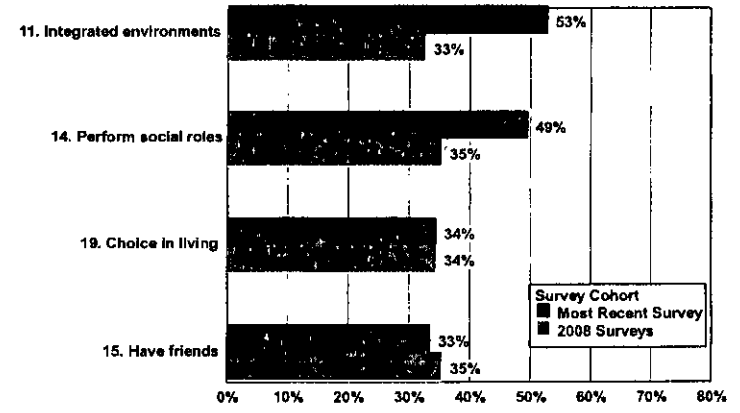
Analysis of Accreditation Results

There were four standards on which both the cohort of North Dakota agencies surveyed in 2008 and the 28 agencies' "most recent surveys" cohort were found deficient on more than 30% of consumers' outcomes/supports (***Figure 4***).

- ***The standards integrated environments, perform social roles, choice in living, and have friends were problematic for more than 30% of the 28 agencies' most recent surveys and for the six 2008 surveys.***

One of these standards, *integrated environments*, was the most problematic for agencies surveyed in North Dakota and also those agencies surveyed nationally by The Council. The standards that proved problematic for North Dakota agencies' participants, in addition to *integrated environments*, were *perform social roles*, *choice in living*, and *have friends*. These standards relate to making connections to other people, choice about with whom time is spent, participation in community environments, and in events such as church, sports, retirement centers, and beauty shops.

Figure 4
NORTH DAKOTA
MOST PROBLEMATIC STANDARDS FOR 28 AGENCIES' RECENT SURVEYS AND 2008 SURVEYS*



*Note: Standards are the four that exceeded 30% deficient for both the most recent cohort of 28 agencies, and for the six agencies surveyed in 2008.

It should be noted that although only six agencies were surveyed in 2008, there was some apparent improvement compared to the cohort of all 28 agencies' most recent surveys during 2004-08 (see ***Appendix 5*** of the full report). These were the standards *integrated environments* and *perform social roles*. There was no difference in the deficiency percentage for *choice in living*; and, for the six agencies surveyed in 2008, there was a slight regression in the standard *have friends*. The North Dakota accreditation

scores in these areas point to a continuing need for the State to expand integrated residential, work, and other support services. Community agencies must also continue to expand opportunities for individuals to interact with people without disabilities.

Analysis of ICF/MR Surveys and Certification

Sixty-eight ICFs/MR in North Dakota, and four units at the North Dakota Developmental Center, were compared to ICFs/MR in CMS Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming) and in the nation as a whole on their surveys in 2006-08 (see ***Appendix 6*** of the full report). "Problematic program and life-safety code requirements" were those on which 10% or more North Dakota ICFs/MR were found deficient, and (simultaneously) on which North Dakota's deficiency percentages were greater than both the regional and national averages.

In 2008, six program requirements and four life-safety code (LSC) requirements were problematic for North Dakota facilities both absolutely (i.e., 10% or more North Dakota ICFs/MR deficient) and relative to the Region and the United States (i.e., deficiency percentage greater than both the Region and the U.S.).

- ***Three program requirement deficiencies related to health and safety.***

  - *Individual medication administration record for each client* (14% North Dakota deficiency)
  - *All drugs administered without error* (21%)
  - *Infection control, active program* (11%)

- ***In addition, three program deficiencies related to the effectiveness of training programs, the interaction of staff with residents of the ICF/MR, and individual program planning.***

  - *Treatment program implemented when Individual Program Plan (IPP) formulated* (36% North Dakota deficiency) (Note: This requirement was a *Condition of Participation* in the Medicaid program.)
  - *Promote the growth, development and independence of client* (21%)
  - *Dine according to developmental level* (32%)

It should be noted that five program requirements were no longer problematic deficiencies in the current study compared to our 2007 study: 1) *treatment risk, can refuse*; 2) *report alleged abuse, neglect immediately;* 3) *individual program planning and*

continuous active treatment; 4) *train for privacy and independence;* and 5) *individual program plan data in measurable terms.*

- ***The four life-safety code deficiencies problematic for North Dakota facilities addressed physical plant health and safety issues.***

- *Corridor doors* (14% North Dakota deficiency)
- *Hazardous areas - separation* (25%)
- *Remote exits* (11%)
- *Other (surveyor did not specify)* (61%)

Review of Trends for Incidents of Abuse, Exploitation, and Neglect

Reports on abuse, exploitation, and neglect from the North Dakota Protection and Advocacy organization are, as previously noted, no longer identifiable by agency or program site. The following is a list of the most frequently cited incidents, across all sites during 1996-2008. It should also be noted that data for 2008 were for a partial year (through August 2008 for the Developmental Center and through May 2008 for other programs). There were seven categories: day programs, group homes, ISLA/SLA, family support, developmental center, supported employment/extended employment (SEP/EP), and community. Some of the reported trends may be an artifact of these missing data (see ***Appendix 8***).

- ***Seven categories of neglect and four categories of abuse were cited 45 times or more during 1996-2008. They are listed in rank order by category.***

Neglect

- *Personal safety* (432 incidents)
- *Medication errors* (366 incidents)
- *Personal care* (265 incidents)
- *Habilitation/discharge planning* (126 incidents)
- *Other* (91 incidents)
- *Failure to provide medical treatment* (68 incidents)
- *Written habilitation plan* (45 incidents)

Abuse

- *Physical* (144 incidents)
- *Verbal* (97 incidents)
- *Restraint/isolation/seclusion* (73 incidents)
- *Threats of retaliation* (48 incidents)

The number of incidents in one category of abuse--*verbal abuse*—increased nearly three-fold from 2006 to 2007 (from 8-22). Moreover, the number of reported incidents based on partial data for 2008 (11) is likely to meet or exceed the number of *verbal abuse* incidents reported for the full year 2007. There were no incidents in four categories of abuse during 2006-08 (*threats of retaliation*, *sexual abuse*, *inappropriate/excessive meds*, or *involuntary/aversive behavior therapy*). Three categories of neglect, *personal safety, medication errors* and *personal care,* have been reported consistently over the years of our analysis, and they continued to increase in 2007. There was a decline in the number of reported abuse incidents for *habilitation/discharge planning*. In addition, there were 50 substantiated incidents of *exploitation: financial* across all sites during 1996-08.

Special Education District Performance Reports

In this 2009 report, as noted, we received North Dakota Special Education District Performance "Report Cards" for 189 districts across the state. There were 156 districts large enough for data to be published (i.e., more than 10 special education students). We calculated summary statistics on Least Restrictive Environment (LRE) placements of special education students across the state.

Regular Classroom:

- Sixteen of the 156 districts reported that 100% of their special education students remained in their regular classroom 80% or more of the day;
- The statewide average regular classroom percentage of participation was 79%;
- Ninety of the districts, in addition to the 16 with 100% regular classroom attendance, exceeded the statewide average;
- The remaining 50 districts that were below the statewide average had student participation rates in regular classrooms ranging from 31-78%; and
- Nineteen districts' students had regular classroom participation rates below 70%.

Separate Classrooms:

- More than half, 84 of the 156 special education districts, reported no LRE placements in separate classrooms (i.e., no students were removed from regular classes for more than 60% of the day);
- The statewide average for use of separate classrooms was 4%;

- For the 72 districts that utilized separate classrooms, rates ranged from 1-18%; and
- Forty-five districts exceeded the statewide average for separate classroom placement rate, and in 16 districts separate classroom usage was 7% or greater.

Separate Facilities:

- Fifty-three of the 156 North Dakota special education districts reported using "public or private separate schools, residential placements, or homebound or hospital placements";
- The statewide average for use of separate facilities was 2%;
- Thirty-nine of the 53 districts were above the statewide average;
- The rates for the 53 districts using separate facilities ranged from 0.7-13%; and
- Fourteen districts had in excess of 5% of their special education students in separate facilities.

Conclusion

The nation is now facing many economic and budgetary challenges. Forty-one states confront budget shortfalls in this fiscal year (FY 2009) and/or the next. The total projected nationwide budget gap in 2009 is $72 billion--12.2% of the states' general fund (McNichol & Lav, 2008). North Dakota is not one of the 41 states projecting fiscal year 2009 or 2010 budget gaps. In fact, in 2008 North Dakota posted a $740 million budget surplus, "a staggering figure for a state that ranks 48th in population and whose general fund budget is about $1.2 billion a year" (Fehr, 2008, p. 1).

> North Dakota's cheery circumstance...can be explained by an odd collection of factors: a recent surge in oil production...; a mostly strong year for farmers...; and a conservative, steady, never-fancy culture that has nurtured fewer sudden booms of wealth like those seen elsewhere...and also fewer tumultuous slumps (Davey, 2008).

North Dakota's fiscal year 2009 began with a $366 million balance, and the State projects an ending 2009 balance of $116 million (National Governors Association, 2008). Moreover, as noted, North Dakota in 2008 lead all states in economic momentum (Federal Funds Information for States, 2008).

North Dakota has responded positively in the past to challenges to improve the capacity and quality of intellectual and developmental disabilities residential and community services. North Dakota has a remarkably strong state budget with which to address pending service needs. In this context, principal priorities for North Dakota in I/DD services are as follows:

1. Continue to prioritize growth of HCBS Waivers, including possibly a Supports Waiver, to finance community residential and related support services;
2. Replace outdated eight-bed group homes with more family-scale individualized living arrangements in community settings;
3. Increase family support and supported employment programs;
4. Continue to enhance wages and benefits for direct support staff; and
5. Steadily reduce reliance on and ultimately close the North Dakota Developmental Center at Grafton. Develop appropriate individualized community residential services and supports such as Individualized Supported Living Arrangements (ISLA) and similar options. Analysis revealed that since the District Court dismissed the *Arc v. Sinner* case in 1990 (Chronology, 1990) and closed the Court Monitor's office, the reduction in the census of the North Dakota Developmental Center at Grafton slowed down dramatically. In fact, from 1995-2004 the census at the Developmental Center actually increased from 140 to 146 persons.

Quality Assurance Challenges

North Dakota agencies and facilities compare reasonably well to others in the region and across the nation. However, quality assurance data analyzed in this report reveal significant and recurring problems in key areas, and at individual facilities. The accreditation standards *integrated environments* and *perform social roles* were problematic for nearly 50% of all consumers in agencies' most recent surveys. Deficiencies for ICFs/MR included *individual medication administration records, administering drugs without error*, and *infection control.* Incidents of abuse, exploitation or neglect including *verbal abuse, personal safety, medication errors*, and *personal care* were also noted. Problematic areas revealed in critical accreditation standards, ICF/MR deficiencies, and in abuse, exploitation, and neglect incident investigation procedures are also priorities for direct support staff and manager training programs.

As noted in our 2007 study, critical accreditation standards in *choice in living, choice in work* and *integrated environments* represent a lack of resources in supported employment and supported living, and the congregate-care orientation of many North Dakota residential settings. The analysis of Medicaid ICF/MR certification requirements also pointed to the need for consumers to be more integrated into local communities. Part I of this report focused on limitations in the structure and financing of services. The findings of the quality assurance component of this study remain, as in our previous

studies, consistent with those fiscal limitations noted. Although modest progress has been achieved in North Dakota during 2006-08, program development and funding challenges in I/DD services in North Dakota remain quite similar to those noted in our study of two years ago.

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TESTIMONY
HOUSE BILL 1012 – DHS Appropriations
Developmental Disabilities - LTC Continuum
House Appropriations – Human Resources Division
Representative Pollert, Chairman
January 26, 2009

Chairman Pollert, members of the House Appropriations Human Resources Division, I am Barbara Murry, Executive Director of the North Dakota Association of Community Providers. I am here today to testify on the developmental disabilities section of the long term care continuum in HB 1012, DHS appropriations.

Today, as a part of NDACP's testimony, you will hear from Sandi Marshall, Executive Director of Development Homes, Inc. in Grand Forks, Jon Larson, Executive Director of Enable, Inc. in Bismarck, and Cindy Vollmer, a parent of a young lady with developmental disabilities.

The North Dakota Association of Community Providers is made up of 26 organizations across the state. We represent approximately 4,500 staff, 3,900 of whom are Direct Support Professionals, or DSP's. We serve approximately 4,800 individuals with developmental disabilities. Services are most often, lifelong. Services may be delivered in an all inclusive service and payment source, such as the Intermediate Care Facility for the Mentally Retarded (ICF/MR) group homes, or through Home and

Community Based Waiver services, which includes Individualized Supportive Living Arrangement (ISLA), some group home settings, In-Home Family Support Services, and others.

Ninety-nine percent of the typical provider funding comes through the Department of Human Services. In addition to people with developmental disabilities, many Providers serve other populations, including people with mental illness, traumatic brain injury, the elderly, children and families, and people with substance abuse. Twelve providers are licensed as agency QSP's. This means that Provider's are paid primarily with Medicaid dollars. In DD, Providers receive referrals from the Department of Human Services Developmental Disabilities Program Management System. Services are funded through individual contracts with the DD Division or through purchase of service agreements. Rates are set by the DD Division and are not subject to provider control as market conditions change.

<u>Providers are requesting support for five main areas.</u>

I will address inflationary increases, wage equity, benefits, and critical staffing needs. Jon Larson will follow up with comments on ISLA, Transition to the Community, and the Personal Needs Allowance. Attachment (A) is NDACP's platform, with the dollar amount from the corresponding OAR, if there was one developed.

1. <u>The first is an inflationary increase of 7% each year of the biennium</u>. This increase is contained in the Governor's budget. The cost is a total of 28.5 Million dollars, of which 10.5 Million is in General Funds. We are a very staff intensive industry. Approximately 80% of provider costs fall in the area of salary and benefits. Providers pass along wage increases in one of several ways.

   a. The most common method is to give all staff the full percentage increase allocated by the Legislature in base pay, this year proposed at 7%.
   b. Some providers use a merit pay methodology. They may, for example, give out 5% to all staff, retaining the remainder for merit pay for high achievers.
   c. Some providers have a set pay schedule within their company and the base hourly salary increases on that schedule.

Providers have had significant compression within their pay scales. During 2002, 2003, & 2004, there were no inflationary increases. Attachment (B), developed by DHS. That may mean that staff who have worked at an agency for five years, six years, or seven years, respectively, all make the same wage. The longevity difference in other years may be as little as $.10 per hour.

The 7% increase would apply to all areas within the provider budget. This includes the 33% benefits, insurances, gas, etc. Providers typically give out wage increases, based on the increase granted by the legislature, before funding benefit increases. Providers use the base reimbursement to develop a pay scale for their organizations.

To give us a representative sample, one of our largest providers calculated the average wage at their organization for DSP's, regardless of longevity. The average DSP wage is $11.38 per hours. The average DSP reimbursement to Providers by the state is also $11.38, which indicates that all wage increases provided by the legislature are being passed along to staff. Most often, the inflationary increase doesn't cover the cost of rising health benefits. Providers continue to have to reduce health benefits to staff. For this reason, we have asked to have fringe benefits increased from 33% to 36%.

2. <u>Providers are requesting a $2.00 per hour market adjustment / equity increase for all staff in the organizations.</u>

   a. <u>Low Wages</u> - A wage study completed in June of 2008 (Attachment C) shows that the provider starting wage of $9.08 is $2.28 behind our competitors. Attachment (D) shows the percentage of all staff, DSP's and professional, in various wage categories. Twenty-five percent of

provider staff earn less than $10 per hour. Seventy-eight percent of provider staff earn less than $12.49 per hour, and ninety percent of staff earn less than $14.99 per hour.

b. Turnover – Providers are experiencing critical market shortages. Attachment (E). After receiving the 4% inflationary increase and $.60 per hour equity increase from the 2007 Legislature, turnover decreased to 41%, the lowest since we began tracking turnover in 2001-2002. However, with increasing market pressure for employees in North Dakota, the decrease didn't hold and turnover has increased to 48.5% for the first quarter of this year. Approximately 1,600 DSP's left our industry last year. There were approximately 250 vacancies at any point in time. Open shifts must be covered by other staff, incurring significant overtime for providers.

Providers are looking to deal with the critically high turnover on several fronts, in additional to asking the Legislature for increased salary dollars. We continue to develop and offer quality training to staff. Management and supervisory training is coordinated by our Association. Programmatic skill training to DSP's and professional staff is developed at Minot State University through the Center for Persons with Disabilities, who have a

contract with the DD Division for module development and updates. This module training is part of a career ladder established through MSU. Upon completion of the module curriculum, they will complete the special education requirement for the Associate in Science. If they choose, they may apply that coursework to a Bachelor's of Science, as well.

We have also begun discussion with the Department of Commerce to be a part of the Governor's Talent Initiative. We anticipate serving as a Beta testing site and will undertake Talent Pipeline Mapping to develop better methodology to look at where we are recruiting most staff, where they go upon leaving our industry, and where we can make the greatest impact in the system, to reduce turnover.

Profile of staff: Because the organizations located in university towns do hire students, many have the misconception of our industry being one of college students who will leave regardless of our efforts to slow turnover. However, our statistics show that our average staff is significantly older.

3. Critical Needs Staffing – Funding for this concern can be found in an OAR's developed by the Department. The acuity needs of individuals currently living in the community has not been addressed with adequate staffing needs. As you heard in the testimony by Alex Schweitzer, Superintendent of the Developmental Center, new admissions related to

the community's lack of resources continues to be an issue. The Department completed a survey to determine the level of staffing that would be required to meet the critical needs of individuals with significant medical or behavioral concerns. The total cost of this OAR is 6.3 million, of which 2.3 million is general funds. Dan Howell, Executive Director of the Anne Carlson Center for Children will expand on the issue of critical need staffing.

Chairman Pollert, this concludes my testimony. I would be happy to answer any questions.

Attachment A

North Dakota Association of Community Providers

PUBLIC POLICY PLATFORM 2009 – 2011 BIENNIUM

Legislative:

1) Wages, Fringe Benefits and Market Adjustment

7% and 7% Inflationary Increase – DHS OAR

Total	$28.5 million
General	$10.5 million
Federal	$18.0 million

$2.00/hour Market Adjustment – DHS OAR

Total	$38.4 million
General	$14.2 million
Federal	$24.2 million

3% Benefit increase - DHS OAR

Total	$6.4 million
General	$2.3 million
Federal	$4.1 million

Some attachments given to House and Senate

2) ISLA Adjustments
   a. Administration Allocation fix – eliminate disincentive to serve people with high need related costs – in base budget
   b. Increased funding for program capacity
   c. Staff supervision and training not included in funding

3) Critical Need increases in Staffing need to be funded – DHS OAR;

Total	$6.3 million
General	$2.3 million
Federal	$4. million

4) Transition
   a. Placement to the community from the Developmental Center
      $ for 17 total placements in base budget
   b. Transition Age Youth needing additional funding
      $ for 22 placements per year in base budget

5) Personal Needs Allowance - DHS OAR
   (Quoted by Hoeven in pre-election initiatives)

Total	$103,680
General	$38,341
Federal	$65,339

Attachment B

North Dakota Department of Human Services
Medical Services Division
Long-Term Care Continuum

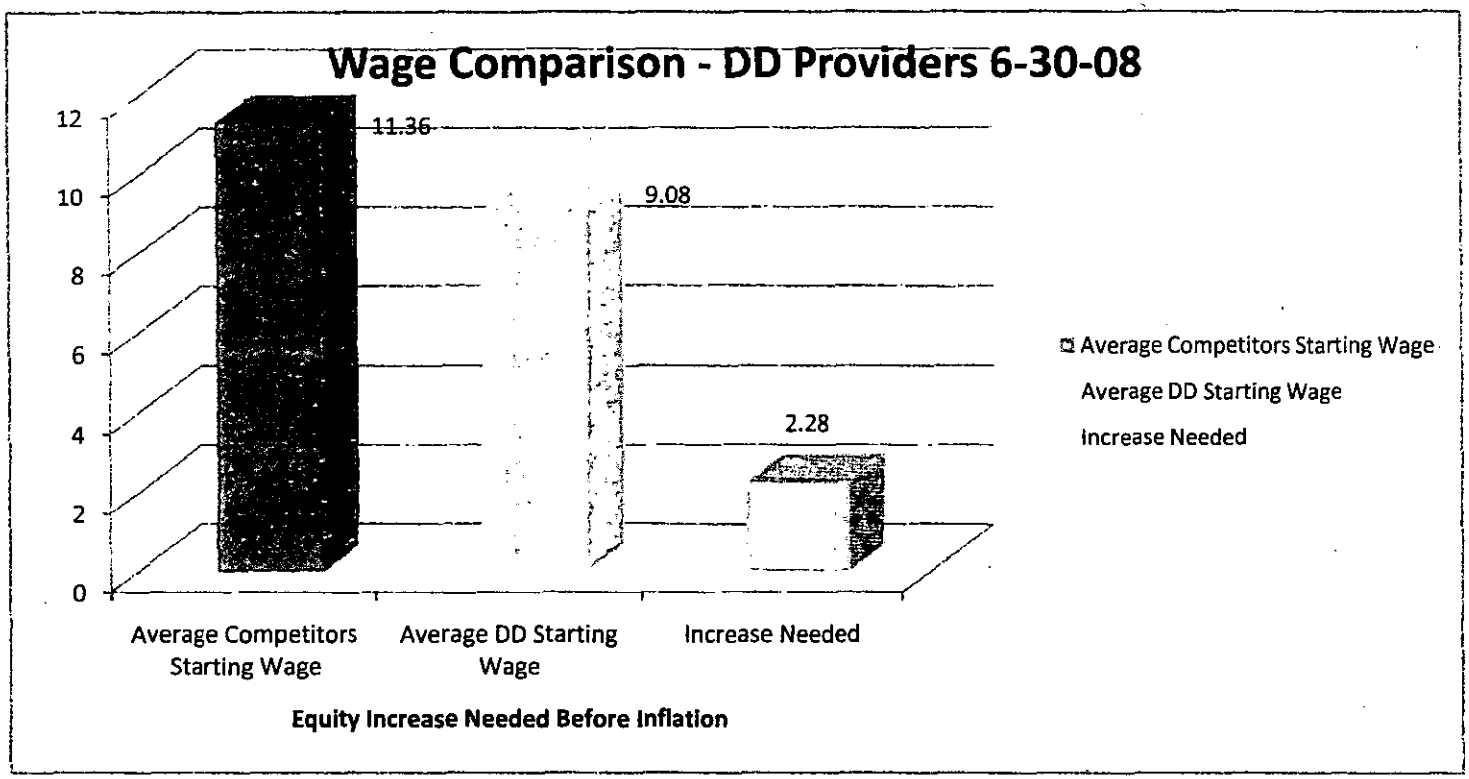
History of Increases to DD Providers

FISCAL YEAR BEGINNING	BIENNIAL COST OF LIVING INCREASE	FRINGE BENEFITS (% of salaries)
July 1, 2008	5%	33%
July 1, 2007	4% plus $0.60*	33%
July 1, 2006	$0.20 * plus 2.65%	33%
July 1, 2005	$0.15 * plus 2.65%	33%
July 1, 2004	no inflation	33%
July 1, 2003	no inflation; $.87 *	33%
July 1, 2002	no inflation **	30%
July 1, 2001	2.2% plus $.10 *	30%
July 1, 2000	2%	30%
July 1, 1999	2% plus $.36 *	30%
July 1, 1998	2.2%	25%
July 1, 1997	2.2% plus $.44 *	25%
July 1, 1996	3.5%	25%
July 1, 1995	3.5%	25%
July 1, 1994	2%	25%
July 1, 1993	2%	25%
July 1, 1992	0%	25%
July 1, 1991	4%	25%
July 1, 1990	2%	25%
July 1, 1989	2%	25%
July 1, 1988	1.6%	25%
July 1, 1987	1.6%	21%
April 1, 1987		
July 1, 1986	4%	21%
July 1, 1985	0%	18%
July 1, 1984	5%	18%

Notes - Biennial Cost of Living Increase:

* $.60 wage increase (July 1, 2007) applicable to professional and direct contact staff.
* $.20 wage increase (July 1, 2006) plus 2.65% inflation applicable to professional and direct contact staff.
* $.15 wage increase (July 1, 2005) plus 2.65% inflation applicable to professional and direct contact staff.
* $.87 wage increase (July 1, 2003) applicable to professional and direct contact staff.
* $.10 wage increase (July 1, 2001) applicable to direct contact staff only.
* $.36 wage increase (July 1, 1999) applicable to professional and direct contact staff.
* $.44 wage increase (July 1, 1997) applicable to direct contact staff only.
** No inflationary increase July 1, 2002 due to budget constraints.

Attachment C



Attachment D

DD Staff only

DD Provider Internal Wage Survey - 23 Providers					
	Under $10	$10.00-$10.49	$10.50-$14.99	$15.00-$19.99	$20.00 or more
Total	904	536	1796	225	132
Percentage	25.16%	14.92%	49.99%	6.26%	3.67%

Category #3 ($10.50-$14.99) Subdivided Based on One Large Provider

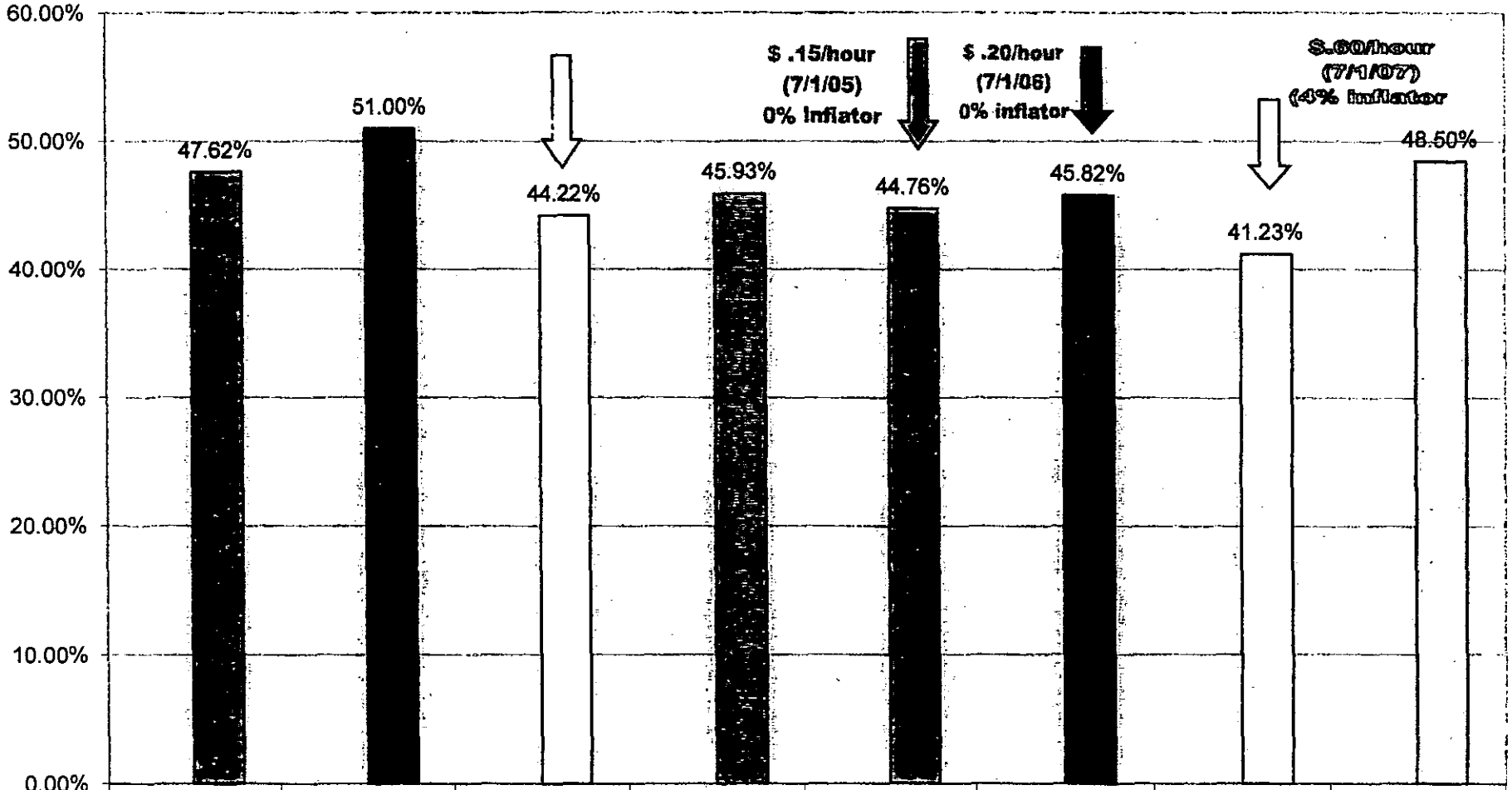
	$10.50-$12.49	$12.50-$14.99
Longevity	3.8	8.94
	1364	513
	37.96%	14.29%

DD Provider Internal Wage Survey - Same Categories as Long Term Care					
Wage	under $10	$10-$14.99	$15-$19.99	$20 or more	
Total	904	2332	225	132	
Percentage	25.16%	64.90%	6.26%	3.67%	

Percentage of staff under $10	25.16%
Percentage of staff under $12.49	78.04%
Percentage of staff under $14.99	90.06%

Attachment E

NDACF TURNOVER
FY 2001 - 2008



	7/1/01 - 6/30/02	7/1/02 - 6/30/03	7/1/03 - 6/30/04	7/1/04 - 6/30/05	7/1/05 - 6/30/06	7/1/06 - 6/30/07	7/1/07 - 6/30/08	7/1/08 - 9/30/08
Series1								
Series2	47.62%	51.00%	44.22%	45.93%	44.76%	45.82%	41.23%	48.50%

f

Testimony on HB 1012
House Appropriations Committee – Human Resources Division
Representative Chet Pollert, Chair
January 26, 2009

Chairman Pollert, members of the Human Resources Division, I am Sandi Marshall, President of the North Dakota Association of Community Providers (NDACP), and Chief Executive Officer of Development Homes, a large non-profit DD provider agency in Grand Forks. Thank you for the opportunity afforded to NDACP to provide information today relative to the needs of our industry, particularly on behalf of both the people we serve and the many citizens of North Dakota that we employ to provide those services.

I have had a unique opportunity in this state to serve in a variety of positions within the community system that serves people with developmental disabilities in North Dakota over the past 32 years, both in state government and in the private sector. These experiences included 18 years with the Department of Human Services, including managing one of the first group homes in the state beginning in the mid-70's, then overseeing the regional DD service development and deinstitutionalization in Grand Forks during the 1980's, and serving as the DD Division Director in the late 80's through mid-90's, a time of reaching major milestones in the development of community services in the state, through the conclusion of the Arc Lawsuit. I am proud of what we created together, and what you supported to bring our services from some of the least supported in the country to ones we can be proud of. As a state, we have accomplished a great deal, but we are now at a pivotal point as we look to the future and move to the next level of community care for all of our citizens with disabilities.

Now, serving on the private provider side, I can truly say that I have gained a new and enormous respect for my colleagues in this industry, and for the immensity of the work involved, and for the many people who provide these services at all levels within our organization. The day to day reality is more than I ever had imagined. This is an industry that serves the most vulnerable people in the state, from the very young to the very old. The sheer responsibility for maintaining safety, while promoting maximum independence in the lives of the people we serve is awesome. We serve people who are some of the most medically fragile in the state, and some who have emotional and behavioral challenges that need constant, intense staff support to be safe from self-harm.

I also have been struck by the amazing dedication of the over 4,500 employees of DD providers across the state who provide care and support, 24 hours a day, 7 days a week. Every day, I see committed staff who work many overtime shifts, or work for more than one provider agency, many, many hours per week, because they care, because they feel a responsibility to cover shifts, and because they need to work more than one job to make a living. As an example, one of our residential managers at DHI works two full-time jobs to get by and support her family, one for our agency and one for another DD provider. Staff holding multiple jobs is a common phenomenon across our industry.

The economic impact of the DD industry is great. By far our largest expense is for our workforce; for salaries and benefits. We purchase in our local communities, and we give back to North Dakota. Additionally, many of the

people we serve work in the communities across North Dakota, and contribute to our local economies, filling a workforce need.

And yet, the crisis our industry faces is the difficulty in maintaining a stable, consistent workforce. While our state has enviable low unemployment, the reality for providers is that we cannot provide a competitive wage that retains our workforce. With low unemployment, we may be able to attract people to our jobs, but once they find out the degree of skill and risk involved, we have a hard time keeping them when they can go to competing businesses and get a job for the same wages with much less responsibility.

Our industry also faces another crisis; and that is potential stagnation. We have people living in institutions who could be served in the community, and people waiting for services who are already in the community. We have increased needs as the people we serve age and lose skills, or as medical conditions deteriorate. However, the current, outdated reimbursement restrictions do not allow for new, critical client needs to be met with increased staffing in a very responsive manner, sometimes resulting in agencies providing for more services than are reimbursed.

So today, we are here to support the provisions in the Department of Human Services' budget that help to address these both of these crises. We are pleased that the budget contains funding for 7% inflationary increases each year of the biennium. This will go a long way towards helping to address ever-rising costs, such as those for health benefits, food, transportation and utilities, and to pass on necessary cost-of-living raises to our employees. Just as our costs of serving clients has been impacted by rising costs of

living, so have those for our employees. Employees have had to pick up a larger share of their medical costs, for example, as health insurance coverage is eroded as a result of the impact of rising premiums on our organizations.

We also urge you to consider funding a catch-up raise of $2 per hour for our employees. Evidence shows that we are behind our competitors and that an increase beyond an adjustment for inflation is necessary in order for this industry to be competitive in the marketplace, and to entice people to stay and make this work not only their passion but their profession.

We support funds that will help providers to break even on the administrative costs of caring for people with high needs in Individualized Supported Living Arrangements. The Department of Human Services budget includes those provisions, and we are grateful for their acknowledgement of these needs. My organization is a large provider of ISLA services, with over 50 individuals in this service, many with complex behavioral and medical needs. Without the proposed reimbursement changes, we would continue to lose money on administration of this service, which we only are able to cover through our charitable gaming revenues.

We also support additional funds to serve people who will transition from schools and from the Developmental Center. The community provider system stands ready to serve these individuals, given increased allocations to our regions to meet their needs.

However, in addition to more slots to serve people in the DD Home and Community Based Waiver programs, new and innovative programs must be

developed to build community capacity. We are operating on service models created in the 1980's. In order to truly stay on course with the national direction of services, we need to embrace technologies and new ways of supporting people in the community that are different than what we have done so far.

One potential way to support innovation in service development and to build community capacity for further deinstitutionalization, would be through the re-establishment of the DD Loan Fund. The availability of very low interest loans could help to support innovative projects that would strengthen our service system, while serving as a one-time funding strategy. As an example, my organization has just been awarded a $720,900 HUD grant to construct a facility to serve 5 young adults with Autism in Grand Forks. The grant covers much, but not all, of the construction costs. A one-time construction or equipment loan or grant could reduce ongoing expenses.

Again, thank you for the privilege of addressing you today, and for your past and continued support. I would be happy to answer any questions you have.

G

Testimony on SB 1012
House Appropriations
Sub Committee on Human Services
January 26, 2009

Chairman Pollert and members of the committee, my name is Jon Larson. I am the executive Director of Enable, Inc, a licensed service provider for people with developmental disabilities in Bismarck and Mandan. I am also here today to testify on behalf of the North Dakota Association of Community Providers (NDACP).

I have been in my present position at Enable for nearly 25 years and during that time I have seen a lot of changes in the developmental disability system. I have seen the system take on what seemed to be an impossible task to create community services for people who at the time we thought would be extremely difficult to serve. We have expanded the service delivery system in creative and flexible ways that serve people's unique needs in a wide variety of community settings. We have provided appropriate community settings for a lot of people who prior to this expansion were institutionalized inappropriately. We have developed a service delivery system in North Dakota that we all can be proud of.

There remains much more to be done. The developmental disability system faces some daunting challenges.

- There are more people in our institutions that need community placement.
- Provider staff turnover continues at an unacceptable rate.
- Workforce shortages make maintaining appropriate staffing difficult.
- Low wages require much of our workforce to take more than one job.
- Health Insurance premium increases are eroding the coverage our staff receives.
- Our reimbursement system needs to encourage more creativity.

DD Providers are working with the Department of Human Services to address these challenges.

Several providers participate on the Transition to the Community Task Force that is chaired by Alex Schweitzer. This task force consists of developmental center staff, case management staff, central office staff, community provider representatives and representatives from advocacy and consumer groups. We have met several times and studied the complexities involved in continuing to place people from the developmental center and established several goals and recommendations. One of our goals is to place people at the developmental center into appropriate community settings. To meet this goal we need to be able to assure that we can continue to have adequate numbers of well trained direct support professionals. We also need to have some changes in our reimbursement procedures to encourage providers to serve people with challenging needs.

Some of these issues were addressed by the Department and are contained in the executive budget and some are contained in optional adjustment requests. We are pleased to see that the governor included a 7% inflationary increase in each year of the biennium. This is necessary to meet the ever increasing cost of doing business and will assist us in meeting the increased cost of gasoline and utility costs, food costs, insurance premium increases, and increased medical supply costs. This inflationary increase will also be used for wage increases for staff.

We are also appreciative of the Departments work on the ISLA administrative reimbursement issue and are glad that it was included in their budget. This change corrects a long standing problem that resulted in a disincentive to serve people with high needs in ISLA settings. The new system will base administrative reimbursement on the needs of the person receiving services by creating five levels of administrative reimbursement instead of two. This should allow providers to cover their administrative cost allocation and minimize the losses that have been occurring in this area. It removes one of the barriers providers have faced in trying to serve people from the Developmental Center in Grafton.

As has been mentioned by others, we also need the increase in wages and benefits that were included in the DHS optional budget requests. This is needed to more adequately pay our staff for the invaluable work that they do. I want to describe for you the "typical" direct support professional employed at our agency.

The average age of our employees is 36 ½ years and the average length of service at Enable is 5.8 years. 80% of our employees are women. I felt it was important to mention this to you so you can understand that we are not simply providing entry level jobs to people. The jobs that we have require extensive training and a lot of dedication from our staff. For most of them this is the career they have chosen. Unfortunately, many of them need to work more than one job to make ends meet.

We have been in front of you before with similar requests and we are appreciative of the support you have provided. I know that one of your questions is what do providers do with the increases we provide? There are a number of factors that a provider must consider when determining wage increases, such as merit, longevity, training, and benefit increases. Each provider may do thing slightly differently but you can be assured that those increases are being used for wages and benefits. Enable has provided the wage increases to our employees as the legislature has designated but one of the issues we continue to struggle with is that the cost of our group health insurance premium consistently increases at a higher rate than our inflationary increase and the result is an erosion of the benefit our employees receive. Last July, our employees received a 5% wage increase but they also had to pay a larger portion of their health insurance premium.

In order to meet the challenges ahead of us we need to provide a competitive wage and benefit package for our staff to attract and retain sufficient numbers of well qualified employees to meet the needs of the people we currently serve and the people who are waiting to be served in the community.

Finally, I would like to voice my support for the increase in the personal needs allowance that was included in the executive budget. The people we serve try to live rich and rewarding lives in the community on a very limited income. Although this increase is very modest it will help with some of their expenses.

Thank-you for this opportunity to testify today. I would be glad to answer any questions you may have.

Jon Larson, Executive Director Enable, Inc.
North Dakota Association of Community Providers (NDACP)

TESTIMONY
HOUSE BILL 1012 – DHS Appropriations
Developmental Disabilities - LTC Continuum
Senate Appropriations
Senator Holmberg, Chairman
March 4, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, I am Barbara Murry, Executive Director of the North Dakota Association of Community Providers. I am here today to give very brief testimony on the developmental disabilities section of the long term care continuum in HB 1012

The North Dakota Association of Community Providers is made up of 26 organizations across the state. We represent approximately 4,500 staff, 3,900 of whom are Direct Support Professionals, or DSP's. We serve approximately 4,800 individuals with developmental disabilities. Services are most often, lifelong. Ninety-nine percent of the typical provider funding comes through the Department of Human Services.

We are requesting your support in a number of areas of this bill. I will be glad to provide more information when you conduct the public hearings before the subcommittee.

1. Inflation and Equity Increases. We are requesting your support for an inflationary increase of 7% each year of the biennium. Providers are also requesting a $2.00 per hour equity increase for all staff in the organizations. We additionally request that you remove the 90th percentile application of the wage increase included by the House, as this will create

significant personnel problems due to wage compression and inequity between 26 different agency pay scales throughout the state.

2. We ask that your support the five level administrative payment structure to providers of ISLA services, as described in Brenda Weisz' testimony. This will increase services to people with the most severe disabilities.
3. Critical Needs Staffing and intense medical needs for children and adults - The acuity needs of individuals currently living in the community has not been addressed with adequate staffing. This results in new admissions to the Developmental Center, at a much higher cost to the state. We ask that you support the funding included in DD grants for this children in family homes and adults served by providers. Critical needs staffing will be addressed further by the Anne Carlson School.
4. We also ask that you support the funding in the Developmental Center budget for increased community placements.
5. We ask that you support the increase to the Personal Needs Allowance in the Governor's budget, and the increase from $50 to $75 which was included by the House for those in ICF/MR services.

Chairman Holmberg, this concludes my testimony. I look forward to the opportunity to expand on these issues before the subcommittee or at another time. I would be happy to answer any questions.

Testimony on SB 1012
Senate Appropriations Committee
March 09, 2009

Chairman Holmberg and members of the committee, my name is Jon Larson. I am the executive Director of Enable, Inc, a licensed service provider for people with developmental disabilities in Bismarck and Mandan. I am also here today to testify on behalf of the North Dakota Association of Community Providers (NDACP).

I have been in my present position at Enable for nearly 25 years and during that time I have seen a lot of changes in the developmental disability system. I have seen the system take on what seemed to be an impossible task to create community services for people who at the time we thought would be extremely difficult to serve. We have expanded the service delivery system in creative and flexible ways that serve people's unique needs in a wide variety of community settings. We have provided appropriate community settings for a lot of people who prior to this expansion were institutionalized inappropriately. We have developed a service delivery system in North Dakota that we all can be proud of.

There remains, however much more to be done. The developmental disability system faces some daunting challenges.

- There are more people in our institutions that need community placement.
- Provider staff turnover continues at an unacceptable rate.
- Workforce shortages make maintaining appropriate staffing difficult.
- Low wages require much of our workforce to take more than one job.
- Health Insurance premium increases are eroding the coverage our staff receives.
- Our reimbursement system needs to encourage more creativity.

DD Providers are working with the Department of Human Services to address these challenges.

Several providers participate on the Transition to the Community Task Force that is chaired by Alex Schweitzer. This task force consists of developmental center staff, case

management staff, central office staff, community provider representatives and representatives from advocacy and consumer groups. We have met several times and studied the complexities involved in continuing to place people from the developmental center and established several goals and recommendations. One of our goals is to place people at the developmental center into appropriate community settings. To meet this goal we need to be able to assure that we can continue to have adequate numbers of well trained direct support professionals. We also need to have some changes in our reimbursement procedures to encourage providers to serve people with challenging needs.

Some of these issues were addressed by the Department and are contained in the executive budget and some are contained in optional adjustment requests. We are pleased to see that the governor included a 7% inflationary increase in each year of the biennium. This is necessary to meet the ever increasing cost of doing business and will assist us in meeting the increased cost of gasoline and utility costs, food costs, insurance premium increases, and increased medical supply costs. This inflationary increase will also be used for wage increases for staff. The House reduced this inflationary increase to 6% and 6%. We hope that you will consider restoring this inflationary increase to the 7% and 7% as provided in the executive budget.

We are appreciative of the Departments work on the ISLA administrative reimbursement issue and we were happy to see it included in the executive budget. This change corrects a long standing problem that resulted in a disincentive to serve people with high needs in ISLA settings. The new system will base administrative reimbursement on the needs of the person receiving services by creating five levels of administrative reimbursement instead of two. This should allow providers to cover their administrative cost allocation and minimize the losses that have been occurring in this area. It removes one of the barriers providers have faced in trying to serve people from the Developmental Center in Grafton.

We also need the increase in wages and benefits that were included in the DHS optional adjustment requests. This is needed to more adequately pay our staff for the invaluable

work that they do. The House funded half of this request by allowing for an increase of $1.00 an hour to 90% of our staff. We hope the Senate will consider adding to this increase.

In an attempt to dispel the myth that we only provide entry level jobs for people, I thought you might find it interesting to hear what a "typical" direct support professional employed at my agency looks like. 80% of our employees are women, the average age of our employees is 36 ½ years and the average length of service at Enable is 5.8 years. The needs of the people we serve in community settings are quite complex and the jobs that we have require extensive training and a lot of dedication from our staff. For many of them this is the career they have chosen. Unfortunately, many of our employees need to work more than one job to make ends meet.

In order to meet the challenges ahead of us we need to provide a competitive wage and benefit package for our staff to attract and retain sufficient numbers of well qualified employees to meet the needs of the people we currently serve and the people who are waiting to be served in the community.

I would also like to voice my support for the increase in the personal needs allowance that was added by the House. This change would allow the people we serve in our ICF/MR group homes to keep $75 a month to pay for personal items, clothing and community activities. The people we serve try to live rich and rewarding lives in the community on very limited incomes.

We have been in front of you before with similar requests and we are appreciative of the support you have provided. We hope that you will consider, in these interesting economic times, to make an investment in the future of some of our most vulnerable citizens.

Thank-you for this opportunity to testify today. I would be glad to answer any questions you may have.

Jon Larson, Executive Director Enable, Inc.
North Dakota Association of Community Providers (NDACP)

F

Amy B. Armstrong
North Dakota Center for Persons with Disabilities (NDCPD)
at Minot State University
North Dakota Medicaid Infrastructure Grant (ND MIG)
Testimony - HB 1012
House Appropriations Committee - Human Resources Division
Representative Chet Pollert, Chairman
Monday, January 26th, 2009

Chairman Pollert and members of the Appropriations Committee - Human Resources Division, I am Amy Armstrong, Project Coordinator for the North Dakota Medicaid Infrastructure Grant (ND MIG) at the North Dakota Center for Persons with Disabilities (NDCPD) at Minot State University. Thank you for the opportunity to present testimony in favor of House Bill 1012. In particular, I would like to express support for the proposed 7% & 7% increase for Qualified Service Providers (QSPs) and other providers as recommended in the Governor's budget; funding for the development and implementation of an Aging and Disability Resource Center (ADRC); and support for increased home and community based services (HCBS) for the elderly and people with disabilities of North Dakota.

There is a plethora of current and past research that supports HB 1012. Attachment A lists various studies and reports that have been issued regarding long-term care and HCBS. These reports contain an abundance of recommendations to drawn upon as North Dakota considers ways to improve its continuum of care system. Several noteworthy themes throughout these reports include *recurring* recommendations for improving access to case management, development of a streamlined single point of access to services or an ADRC; and assuring that consumers have informed options and better access to services, particularly home and community based services and qualified services providers (QSPs).

In addition to these recommendations, it is well documented that ND's seniors and people with disabilities desire of to remain living and working in

their homes and communities for as long as possible. Without the continued and increased support for ND's HCBS, QSPs and DD providers; many ND's will not be able to maintain their independence and community employment.

In 2008, the ND MIG project disseminated surveys and participated in meetings with ND QSPs. QSPs expressed their thoughts, concerns, and recommendations for improving their work. Specifically, concerns and recommendations regarding consistent reimbursement increases; consideration for travel costs; access to affordable health insurance and benefits; and access to training are all important issues to QSPs. Also apparent was the QSPs' dedication to the ideals of home and community-based care.

After careful analysis of past and more current data, including the surveys of QSPs, surveys of other HCBS providers and analysis of state HCBS data; this information was used to develop the report, *At a Crossroad, North Dakota Home and Community Based Services – An Overview and Recommendations,* compiled by Dave Zentner, Consultant for the ND MIG[1]. The recommendations of this report, as highlighted in Mr. Zentner's testimony, also support HB 1012.

Again, I urge the committee to support HB 1012; in particular the proposed 7% & 7% increase for QSPs and other providers, funding for ADRCs, and increased funding for HCBS.

Thank you for your time. I would be happy to answer any questions.

Contact information:
Amy B. Armstrong, Project Coordinator, ND MIG
NDCPD at Minot State University
Email: amy.armstrong@minotstateu.edu
Ph: 1-800-233-1737 or 701-858-3578

[1] Zentner, D., Consultant. (2008). North Dakota Medicaid Infrastructure Comprehensive Employment Systems Grant, *At a Crossroad, North Dakota Home and Community Based Services – An Overview and Recommendations.* Minot, ND: North Dakota Center for Persons with Disabilities, Minot State University.

Appendix A

A List of Studies Regarding Continuum of Care Services in North Dakota

1987

Long Term Care: Issues and Recommendations, 1987, ND Interagency Task Force on Long Term Care

1996

Report of the Task Force on Long Term Care Planning 1996,

1998

Report of the Task Force on Long Term Care Planning 1998,

2000

Report of the Task Force on Long Term Care Planning 2000,

White Paper: Olmstead Workgroup, Nov. 6, 2000

Report of the ND Governor's Task Force on Long Term Care Planning Expanded Case Management, June 30, 2000

2002

A Study of North Dakota's Nursing Facility Payment System Study, Oct. 2002

Needs Assessment of Long Term Care, ND: 2002,

Initial Report & Policy Recommendations, Nov. 2002

Cost Containment Alternatives for ND Medicaid, Nov. 1, 2002

2003

Real Choices in North Dakota, 2003

Informal Caregivers: 2002 Outreach Survey, 2003

Community of Care Baseline Survey, 2003

National Family Caregiver Support Program: ND American Indian Caregivers, June 2003

2004

2004 AARP ND Member Survey: Support Services, June 2004

Senate Bill 2330 Workgroup Final Report, Dec. 2004

2005

Community of Care Olmstead Grant, August 2003 - 2005 Final Report

Final Report Real Choice Systems Change Grant Cultural Model, May 05-06

2006

Home and Community Based Services Planning Project Survey Results, June 2006

ND Real Choice Systems Change Grant-Rebalancing Initiative: Focus Groups and Personal Interviews- Research Report One, June 2006

ND Real Choice Systems Change Grant-Rebalancing Initiative: Hospital Discharge Planner Questionnaire – Research Report Two, Aug. 2006

ND Real Choice Systems Change Grant- Rebalancing Initiative: ND Consumers of Continuum of Care Services Questionnaire – Research Report Three, Dec. 2006

An Overview and Recommendations: Medicaid Services in ND, Dec. 2006

2007

The Economic Impact of the Senior Population on a State's Economy: A Case Study of ND, Jan. 2007

An Overview and Recommendations: Long-Term Care in ND, February 2007

2008

At a Cross Road, North Dakota Home and Community Based Services, Sept. 2008

Report of Questionnaires Administered to North Dakota Individual and Agency Qualified Service Providers, 2008

(For details regarding these reports please contact Linda Wright, DHS - Aging Services Div. or Amy Armstrong, NDCPD at MSU.)

Senate Appropriations
Tom Alexander – Testimony
North Dakota Medicaid Infrastructure Grant (ND MIG),
North Dakota Center for Persons with Disabilities (NDCPD)
at Minot State University
House Bill 1012

Chairman Holmberg and members of the committee, my name is Tom Alexander. I am the Project Director for the ND Medicaid Infrastructure Grant (NDMIG) with the North Dakota Center for Person with Disabilities at Minot State University. I greatly appreciate the opportunity to present testimony on HB 1012.

The purpose of my testimony is to ask you to reinstate a portion of the DHS's OAR for the Peer Support Program into the Human Services Budget. The following information will briefly explain the Peer Support Program and Services.

Peer Support Services refer to support provided *by* people with mental illness *to* others with mental illness. They are consumer-centered services with a rehabilitation and recovery focus. They are designed to promote skills for managing and coping with symptoms while facilitating the use of natural resources and the enhancement of community living skills. *Peer Support Services* are provided by a person who has progressed in their own mental health recovery and is working to assist other people with mental health issues. These individuals are called *Peer Support Specialists*. Because of their life experiences, *Peer Support Specialists* have expertise that professional training cannot replicate. Peer Support Services are an integral piece of current state-wide efforts to create a Recovery-oriented, evidence based, consumer-driven Mental Health system of

care.

Peer Support Specialists provide specific interventions including support and assistance with:

- Identifying individual strengths, resources, preferences, and choices;
- Identifying existing natural supports for development of a natural support team;
- Developing crisis management plans;
- Identifying risk factors related to relapse & development relapse prevention plans & strategies;
- Promoting self-advocacy & participation in decision-making, treatment, & treatment planning;
- Building a natural support team for treatment and recovery; and
- Developing functional, interpersonal, coping, and community living skills that are negatively impacted by the person's mental illness.

In the fall of 2007 NDDHS submitted a proposal to the Substance Abuse and Mental Health Services Administration (SAMHSA) titled, "Transformation Transfer Initiative (TTI)." ND was fortunate enough to be one of ten states selected to be funded for the initiative. The TTI project supported new and expanded efforts to improve the capacity and effectiveness of mental health systems that foster recovery and meet the multiple needs of consumers.

A variety of consumers, stakeholders and professionals were invited in January 2008 to be a part of the TTI – Peer Support Initiative. The purpose of the initial work group was to meet, provide an overview and a timeline for the initiative, form sub-groups, schedule meetings, and complete the Project Management Plan.

The main goal of the Project Management Plan *is "Initiative will prepare people with mental illness to become Peer Support Specialists, using their shared experience to guide others toward recovery."* The management plan also has eleven objectives to accomplish the goal and they include:

1. Develop a Peer Support Initiative Work Group (a.k.a. Stakeholder Committee and/or Steering Committee) and Sub Groups which included:
   - Technical Support and Research
   - Stakeholder
   - Stakeholder-System Partner Training/Peer Support Specialist Training
   - Psychosocial Rehab Centers
   - Peer Support Curriculum
   - 1915i Amendment
2. Conduct Stakeholder Input Meetings
3. Complete an initial Project Management Plan, and update as necessary until project is completed.
4. Design the Research and Outcomes Plan
5. Design Technical Support Plan
6. Develop Peer Support Certification Curriculum
7. Provide Training to Stakeholders within the Mental Health System to educate, inform, and increase readiness for peer involvement in the formal service delivery process.
8. Define the Recovery Principles Approach within the 8 Regional Psychosocial Rehabilitation Centers
9. Complete and submit the 1915i Amendment & Explore Options for Additional Funding
10. Evaluate Project and Submit the Final Report
11. Develop a Training & Employment Plan for Peer Support Specialists.

The management plan was submitted SAMHSA in September of 2008 with all objectives complete. It is important to note that this plan would provide peer support services to Medicaid eligible and non-Medicaid eligible individuals.

Currently, Northwest Human Services Center (Williston) and North Central Human Service Center has a very successful peer support specialist projects funded through the human service center at approximately $65,000. South Central Human Service Center has received $25,000 to begin a Peer Support Specialist program. The $25,000 is a good start but will not sustain the program.

Western Sunrise, Inc., a consumer-run, nonprofit organization in Williston, N.D., is an example of a successful consumer-directed peer support model currently operating in North Dakota. Outcome data for the *Peer Support Program* is extremely favorable. Outcome measures indicate: 50% decrease in hospitalization rates; 50% of consumers gained employment; volunteerism rates increased; and 94% of consumers indicated that their quality of life improved. Many of the consumers in the program began to rely less on other more expensive services.

The existing *Peer Support Programs* are funded through the Human Service Centers. There are options for federal dollars as well. Through an amendment to the State Plan, Medicaid can become a partner in funding *Peer Support Services*. More North Dakotans with a mental illness can benefit from *Peer Support Services* by making the program available state-wide. No one has to live feeling recovery is impossible; *Peer Support Services* makes recovery a reality. Other states have experienced great successes by employing *Peer Support Specialists* to work in multiple settings such as medical, corrections, employment, and housing, as well as other areas where people with mental health needs receive services.

As part of the management plan the ND Department of Human Services submitted an OAR which did not make Governor Hoeven's proposed budget to the assembly.

The DHS, consumers, stakeholders and mental health professionals completed a great deal of work to develop the Peer Support Services Project Management Plan. This work should not go unrecognized. Therefore, I would like to recommend a two-step process to fund this initiative. The first step would include adding an additional $600,000 for the biennium into the 8 regional human service centers budgets, which would provide $75,000 per human service centers for the biennium to provide peer support services to individuals who are not Medicaid eligible. The second step would include the NDDHS to submit a revised state plan amendment to CMS under the Rehab Option and 1915 (b)4 Waiver. This would allow the management plan to be implemented and allow the peer support program to blossom prior to CMS's approval for a state plan amendment.

As of June 2008 the total statewide Severe Mental Illness population was approximately 2,153. It is estimated that about 20% (432) of these individuals would need Peer Support Services. About half of those individuals (216) would receive Peer Support Services for a year and the other half would receive Peer Support Services for 6 months. The total number of individuals receiving this service over a year's time would be approximately 648. It is estimated that a Peer Support Specialist would have about 12 people on their caseload. That would require 36 new Peer Support Specialists thus creating 36 new jobs in ND that currently do not exist. Not only will this program create these new jobs, but it

also creates a system that keeps people who receive Peer Support Services healthy, out of the hospital and potentially employed in their communities. As stated earlier individuals receiving Peer Support Services have a higher rate of gainful employment. This is economic development and a win win situation for ND.

This is a project that needs to be funded for many reasons which were stated earlier. The bottom line is Peer Support Projects work. The current state projects and the national data indicates that as well. This is an opportunity that should not be missed! Thank you for your time and I would be happy to answer any questions that you may have.

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TESTIMONY BEFORE THE HOUSE APPROPRIATIONS COMMITTEE
HUMAN RESOURCES DIVISION
REGARDING HOUSE BILL 1012
JANUARY 26, 2009

Chairman Pollert, members of the committee, I am David Zentner and I was a consultant for Minot State University/North Dakota Center for Persons with Disabilities (NDCPD) North Dakota Medicaid Infrastructure Grant: In May 2008 I completed a report entitled "At a Crossroad, North Dakota Home and Community Based Services". The report was an effort by many stakeholders to provide a guidepost to ensuring that North Dakota will have a continuum of long term care services to meet the needs of our elderly and people with disabilities for the next 20 years.

The number of elderly citizens in North Dakota will increase dramatically over the next decade to about 150,000 by 2020. In addition, the number of individuals over age 85 will increase by 59% in just 15 years. It is imperative that we have a strong home and community based care system to meet the needs of these citizens given that the vast majority of the elderly wish to remain in their own homes and communities as long as possible.

The report presented six recommendations regarding the provision of Home and Community Based Services (HCBS) in North Dakota. It is gratifying to learn that HB 1012 contains many provisions that support the recommendations contained in the report.

The first recommendation concerned the need for a coordinated single point of entry or a no wrong door process into the long term care process. States that have been successful in developing a strong HCBS infrastructure use these tools to ensure citizens have the needed information to make informed decisions regarding care options that are available in their communities. This bill contains funds to develop an Aging and Disability Resource Center that can act as a single point of entry into the long term care continuum.

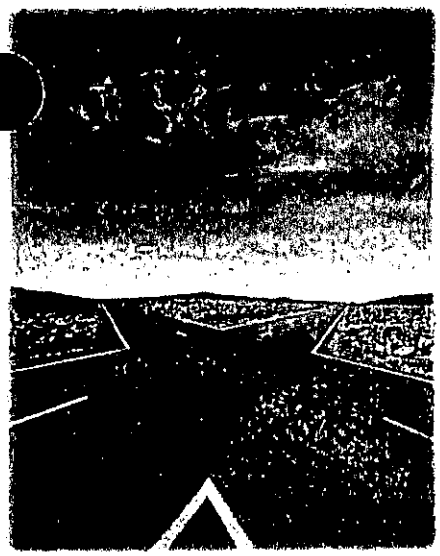
The second recommendation concerned the need for more flexibility in the delivery of HCBS services. This bill contains funds to expand personal care services, reduces the payment schedule for individuals eligible for SPED and provides additional payment for family foster care providers. These provisions will allow for additional flexibility in the delivery of HCBS in our state.

The third recommendation concerned the need for ongoing funding in order to attract and retain an adequate number of care givers to meet current and future needs. This bill does provide increases for Qualified Service Providers and it is important that these individuals and agencies continue to receive yearly increases to ensure an adequate supply of providers. By state law, nursing facilities receive increases each biennium and if we intend to have a strong HCBS delivery process such increases should also be considered for HCBS providers.

The last recommendation in the report concerned the need to increase the medically needy income level. At present a one person household can retain $500 a month to meet their household maintenance needs and a two person household $516 per month. The income level has not been increased since 2003. Individuals who receive Supplemental Security Income payments because they have not have an earned Social Security benefit are allowed to retain their entire check to meet their maintenance needs whereas those who have worked all their lives have much less to meet their needs. If we are going to maintain individuals in their own homes they do need adequate funds to meet their basic needs. This bill contains a substantial increase in the medically needy income levels.

I urge this committee to retain all the provisions put forth by Governor Hoeven to improve the delivery of HCBS for the elderly and people with disabilities citizens of our state.

I would be happy to respond to any questions you may have.



"The demographic time bomb regarding the number of elderly in our state looms large as the baby boomers age and our citizens over 85 increases dramatically ... It is now time to take action to strengthen the availability of HCBS in order to avoid drastic increases in expenditures for long term care services in the very near future."[3]

North Dakota
Medicaid
Infrastructure
Grant

NDCPD
Minot State University
Center of Excellence

Comprehensive Employment Systems

At a Crossroad, A Brief Overview of the North Dakota Home and Community Based Services Report

September 2008

North Dakota (ND) is at a crossroad and needs to decide what direction to take in its effort to provide a continuum of long term care services to the elderly and people with disabilities. By the year 2020, the number of citizens in North Dakota over age 65 will be approximately 150,000 and the number of individuals over age 85 will increase to approximately 24,300, a 59 percent increase in just 15 years.[1]

Today services in North Dakota are provided through a variety of programs that are funded by federal, state and county funds for individuals who do not have the resources to meet their long term care needs. In addition, the AARP Public Policy Institute estimates that in 2006 ND had approximately 56,000 unpaid caregivers that provided the equivalent of $550 million in care.[2] This brief supports the recommendations taken from *At a Crossroad, North Dakota Home and Community Based Services* report.[3] The report delineates the need to ensure that adequate and appropriate services are available to the elderly and people with disabilities in the near future.

To access this document or the full report visit:
www.ndmig.com

NORTH DAKOTA MEDICAID INFRASTRUCTURE GRANT

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Moving Beyond the Crossroad

North Dakota needs to move beyond the crossroad in an effort to provide a continuum of long term care services to the elderly and people with disabilities. The need for policy changes to occur within the HCBS system for people with disabilities and North Dakota's aging population is evident. These recommendations will assist in assuring that consumers receive what they want which is to remain in their homes and live independently for as long as they are able.

The issues surrounding the delivery of continuum of long term care services has been studied and discussed in North Dakota for more than 20 years. The ND demographics clearly show that the need for additional services will increase dramatically as the number of individuals over age 85 grows in the next decade. .Now is the time to take action to strengthen the availability of HCBS in order to avoid a drastic increase in expenditures for institutional long term care services in the very near future.[3]

*Case scenarios are based on a variety of situation that North Dakotan's face in regards to continuum of care services but do not represent specific case's.

[1]Rathge, R., Director. (2002,September). Population projections in North Dakota: 2005-2020. *The Population Bulletin.* Fargo, ND: North Dakota State Data Center- NDSU, *18*, 9.

[2]Gibson, M. & Houser, A. (2007, June). *Valuing the invaluable: a new look at the economic value of family caregiving - research report.* Washington D.C.: AARP Public Policy Institute.

[3]Zentner, D. (2008). *At A Crossroad, ND Home and Community Based Services - An Overview and Recommendations.* Minot, ND: North Dakota Center for Persons with Disabilities, Minot State University.

[4]Armstrong, A. (2006). North Dakota Real Choice Systems Change Grant-Rebalancing Initiative, *Research report one - A report of focus groups and personal interviews conducted in North Dakota's eight human services regions with consumers of home and community based services, elderly nursing home residents, younger nursing home residents, family members of consumers of continuum of care services, and providers of continuum of care services.* Minot, ND: North Dakota Center for Persons with Disabilities, Minot State University.

[5]Armstrong, A. (2008a). [Survey of North Dakota agency qualified service providers]. Unpublished raw data. Minot, ND: North Dakota Center for Persons with Disabilities, Minot State University.

This was developed under the North Dakota Medicaid Infrastructure Grant, Award Number: 1QACMS300054/03; CFDA No. 93.768 from the U.S. Department of Health and Human Services Center for Medicare and Medicaid Services received by the North Dakota Center for Persons with Disabilities. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services and the North Dakota Center for Persons with Disabilities.

Amy B. Armstrong
North Dakota Center for Persons with Disabilities (NDCPD)
at Minot State University
North Dakota Medicaid Infrastructure Grant (ND MIG)
Testimony - HB 1012
Senate Appropriations Committee
Senator Ray Holmberg, Chairman
Wednesday, March 4, 2009

Chairman Holmberg and members of the Senate Appropriations Committee, I am Amy Armstrong, Project Coordinator for the North Dakota Medicaid Infrastructure Grant (ND MIG) at the North Dakota Center for Persons with Disabilities (NDCPD) at Minot State University. Thank you for the opportunity to present testimony in favor of House Bill 1012 as proposed by the Governor.

In 2008, the ND MIG project contracted with Mr. Dave Zentner to complete a report titled "At a Crossroad, North Dakota Home and Community Based Services." I have included a summary of this report with my testimony. This report was an effort by many stakeholders to provide a guidepost to ensuring that North Dakota will have a continuum of long term care services to meet the needs of our elderly and people with disabilities for the next 20 years. This report was developed through careful analysis of past and more current data and reports, including surveys of QSPs, and HCBS providers.

The report contains six recommendations regarding Home and Community Based Services (HCBS) in North Dakota. HB 1012 contains many provisions that support the recommendations contained in this report.

The first recommendation concerns the need for a coordinated Aging and Disability Resource LINK –No Wrong Door process. This process has been successfully implemented in 45 states. A streamlined system for accessing services is important in order to assure that North Dakotans are aware of *all* of their long-term care options and thus are able to make informed decisions about their care. The purpose of an ADRC is not to set up a new bureaucracy, but to help those service agencies and providers that are currently in existence to work together, streamline their work, and make accessing long-term support services a simpler and less confusing process for North Dakotans. Implementing an ADRC will help North Dakotans learn about all of their long-term care options and then make informed decisions about their care. Being able to make informed decisions, means seniors and adults with disabilities are better equipped to make sound financial decisions about their current and future care needs.

The second recommendation concerns the need for more flexibility in the delivery of HCBS. This bill contains funds to expand personal care services, reduces the payment schedule for individuals eligible for SPED and provides additional payment for family foster care providers. These provisions will allow for additional flexibility and availability in the delivery of HCBS in our state.

The third recommendation concerns the need for ongoing funding in order to attract and retain an adequate number of in-home caregivers to meet current and future needs. HB 1012 provides increases for Qualified Service Providers. It is important that these individuals and agencies continue to receive yearly increases to ensure an adequate supply of providers. It is also important that

QSPs be included in the $1.00 "wage pass-through" currently recommended for DD and Nursing Home providers. If QSPs are not included in this increase, the gap among providers will become wider and potentially cause an increased shortage of QSPs. In 2008, the ND MIG project disseminated surveys and participated in meetings with ND QSPs. QSPs expressed their thoughts, concerns, and recommendations for improving their work. Specifically, concerns and recommendations regarding consistent reimbursement increases; consideration for travel costs; access to affordable health insurance and benefits; and access to training are all important issues to QSPs. Also apparent was the QSPs' dedication to the ideals of home and community-based care.

The fourth recommendation concerns the need to provide incentives to develop, and subsidies for affordable accessible housing with services for low and moderate-income elderly and people with disabilities. ND should consider implementing subsidies for assisted living facilities and other similar congregate settings that would include reasonable limits on the monthly payment. ND should consider tax and loan fund incentives to developers who are willing to build congregate housing that is comfortable but affordable for individuals with moderate and low incomes. It is imperative that ND develops an adequate number of affordable housing options for the elderly and people with disabilities that include apartment and congregate settings. Without affordable housing options, individuals and families will be forced to look to institutional care to meet their long term care needs.

The last recommendation in the report concerns the need to increase the medically needy income level. At present, a one-person household can retain

$500 a month to meet their household maintenance needs and a two person household $516 per month. The income level has not been increased since 2003. Individuals who receive Supplemental Security Income payments because they have not earned Social Security benefit are allowed to retain their entire check to meet their maintenance needs whereas those who have worked all their lives have much less to meet their needs. If we are going to maintain individuals in their own homes, they need adequate funds to meet their basic needs. HB 1012 contains a substantial increase in the medically needy income levels.

It is well documented that ND's seniors and people with disabilities desire of to remain living and working in their homes and communities for as long as possible. Without the continued and increased support for ND's HCBS, QSPs; a streamlined continuum of care delivery system, and affordable accessible housing; many ND's will not be able to maintain their independence *and* community employment. These issues are not only human service and quality of live issues but also economic issues. Increased access to HCBS will help seniors and people with disabilities to stay healthy and delay more costly alternative care. In addition, when they are able to maintain their independence, they are better able to live and work in their communities. I urge this committee to retain all the resources put forth by Governor Hoeven to improve the delivery of HCBS for the elderly and people with disabilities of ND.

Thank you for your time. I would be happy to answer any questions.

Contact information:
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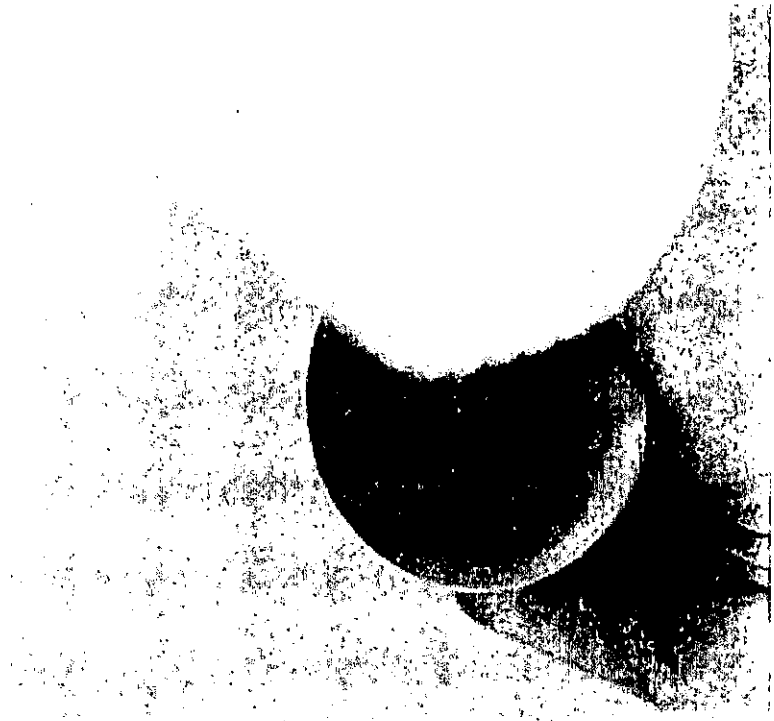
Email: amy.armstrong@minotstateu.edu - Ph: 1-800-233-1737 or 701-858-3578

Some handout given to House on 1-26-09

Recommendation

Ensure that each individual needing long term continuum of care services receives adequate information to make informed decisions regarding how to access available services through the implementation of an assessment/screening tool using a coordinated single point of entry or no wrong door process.

- ND needs to take steps to implement a single point of entry and/or a no wrong door process to ensure that elderly and people with disabilities make informed choices that will allow them to remain in their homes and communities for as long as possible.
- It is imperative that consumers know that a wide array of services are available to both private and public pay consumers.
- A specific process must be implemented before consumers decide whether they will select nursing facility or alternative less restrictive Home and Community Based Services (HCBS) care to meet their long term care needs.



"There are good, qualified, trained people, who are very helpful; unfortunately most of us don't even know where they are."
~Family member[4]

Case Scenario*:

My mother is 83 years old with a variety of health care needs. She currently receives no assistance in her rural home. However, her health is slowly diminishing and she could use help. I live in another state and am not able to care for her. I am not sure where to go to get her help, nor am I completely certain of all her care needs. I am afraid to leave her at home by herself, yet she doesn't have enough money to live in assisted living and 24 hour care is not yet necessary. I went to one place to get help but they told me that she was not eligible. They sent me to someone else. It would be helpful if there was someone that would help with this process rather than send you on again. I have asked her doctor but he was also confused about where to turn stating the system is always changing.

Recommendation

Ensure that long term continuum of care programs and services have the flexibility necessary to ensure that consumers receive the needed services to remain in their communities.

- It is imperative that a simple method be developed that can allow Qualified Service Providers (QSPs) to assist in the distribution of medications without jeopardizing consumer safety.
- Consideration should be given to providing more flexibility to meet consumer needs. Ongoing communication among case managers, ND Department of Human Services staff, and QSPs is important to help address specific issues regarding flexibility of services.
- Consideration should be given to improving the process in which adult foster care-respite care is approved and paid.
- Action should be taken to allow more flexibility in the manner in which HCBS are delivered in ND including the concept of consumer directed care.

"I'd love to be at home but the shots that I get for my Multiple Sclerosis are so expensive, in here [nursing home] I get them for free. I have a house; I'd rather be at home... I have [children] ... still living at home."

~ Younger nursing home resident[1]

Case Scenario*:

I am 72 years old. I took care of my wife for over 2 years. I had to do everything. I did all the cooking, cleaning, laundry, bathed and dressed her, took her to the doctor. I was so exhausted, frustrated, stressed and confused. I needed help but didn't know where to turn. Sharing information is so important because I am not trained and don't have any idea where these services are or what is even available. I found out about some services from one of my neighbors that had used the services. Unfortunately, it wasn't soon enough.

Recommendation

Provide additional ongoing funding in order to attract and retain an adequate number of Qualified Service Providers (QSPs) to meet current and future needs.

- Consideration should be given to some type of a payment differential for QSPs that must travel over a set number of miles, or a set time period in urban areas, in order to ensure that consumers can continue to receive needed services.
- If ND wishes to have the direct in-home care worker staff ready to provide those services to the elderly and people with disabilities of our state they must provide adequate rates to attract individuals and agencies to this profession.
- If ND is serious about putting HCBS on equal footing with nursing facility services, it is imperative that funding for rate increases for these services be considered just as important as nursing facility services. Consideration should be given to providing ongoing yearly rate increases similar to what is provided to the nursing facility industry. Also, some mechanism needs to be developed to provide additional monetary support for QSPs that must travel in rural areas to provide services.

The system is too focused on documentation, financial issues, etc. and less focused on meeting the needs of elderly and disabled clients."

~ Agency QSP[5]

Case Scenario*:

I am 25 years old and live in a rural community. I have found it difficult to find a job here where I don't have to drive to the nearest large city, that provides benefits and pays a decent wage. I have looked at providing personal care services to my neighbors, family members and friends so that they could remain in their home and community, however I could not make a living on the current reimbursement that I would receive as a QSP. It is important to create incentives and adequate reimbursement to attract people to do in-home direct care work. I currently drive 60 miles a day to a job that pays a decent wage, health insurance, retirement, vacation and sick time. If QSP's received adequate reimbursement, provided some health insurance benefits, and reimbursed for some travel expenses; I would consider choosing a career as a QSP in my rural community. This would allow me to work in my community and help care for my fellow community members, which is what I really want to do.

Recommendation

Establish a task force that will make recommendations on how best to encourage individuals and agencies to become QSPs by improving recruitment, retention, training and recognition for this important group of providers.

Approximately 78.8% of agency Qualified Service Providers (QSP) indicated that at some level QSP staff has been requested to provide additional services to clients while in the home, however the QSP was unable to provide the additional services for various reasons most commonly including time, travel, and reimbursement.[5]

- If the number of caregivers does not increase over the course of the next decade, both nursing facilities and HCBS programs will have difficulty meeting the needs of ND's elderly and people with disabilities.
- A task force could provide recommendations to the state for ways to encourage individuals to consider care giving as a career.
- Some changes should also be considered based on the issues raised by QSPs in the recently conducted surveys to improve job conditions and make QSP work more appealing. If there are not sufficient workers in ND, recruitment outside of the state may be required.
- A task force could examine all aspects of this issue and make recommendations that could alleviate the looming shortage of caregivers in ND.

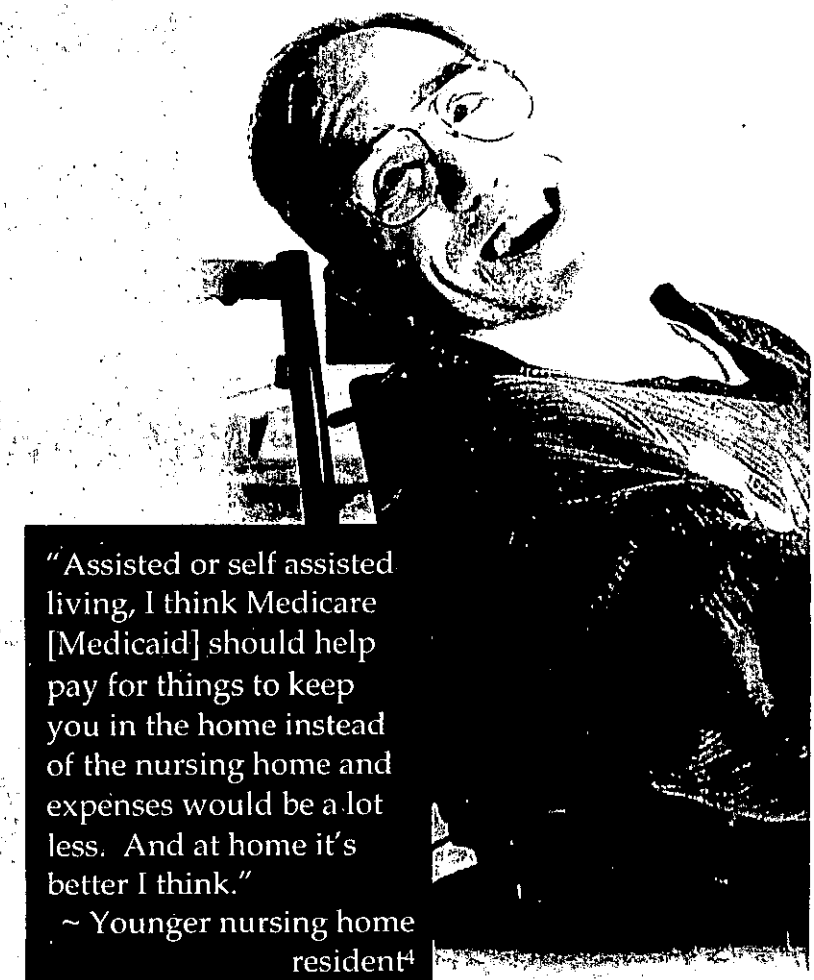
Case Scenario*:

I have been an in-home direct care worker for over 20 years. In a previous state, I would call in my hours for reimbursement, be evaluated once per year by a case manager, had higher wages, and belonged to an association with healthcare and vacation benefits. In ND, I find it very difficult to receive QSP reimbursements in a timely manner, travel time and cost is not reimbursed, I have no healthcare or vacation benefits, and the paperwork is difficult. In addition, training would be very helpful, however it is not reimbursed and it would require me to pay another caregiver, which would put me in a financial deficit. I love my job and know how important it is to the consumers I serve. However, this job is not an easy one and with so many barriers, something must be done in order to make this job more appealing to others.

Recommendation

Provide incentives to develop affordable accessible housing with services for low and moderate income elderly and people with disabilities. Provide housing subsidies for affordable accessible housing with services to low and moderate income elderly and people with disabilities.

- ND should consider implementing subsidies for assisted living facilities and other similar congregate settings that would include reasonable limits on the monthly payment.
- ND should consider tax and loan fund incentives to developers who are willing to build congregate housing that is comfortable but affordable for individuals with moderate and low incomes.
- It is imperative that ND develops an adequate number of affordable housing options for the elderly and people with disabilities that includes apartment and congregate settings.
- Without affordable housing options, individuals and families will be forced to look to institutional care to meet their long term care needs.



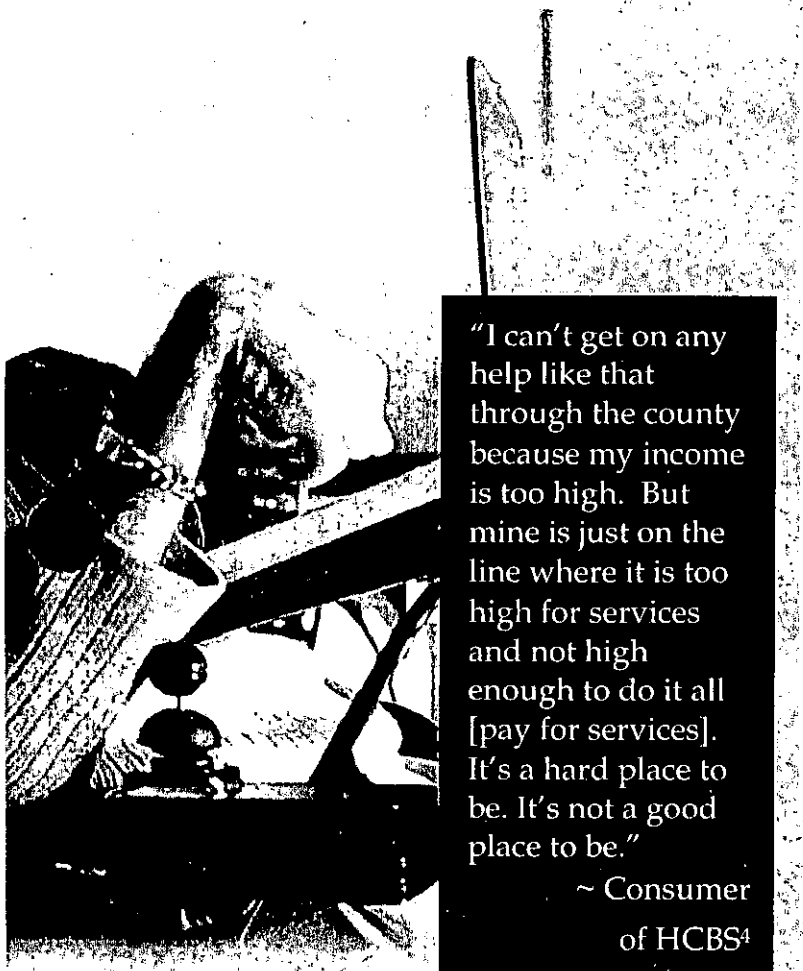
"Assisted or self assisted living, I think Medicare [Medicaid] should help pay for things to keep you in the home instead of the nursing home and expenses would be a lot less. And at home it's better I think."
~ Younger nursing home resident[4]

Case Scenario*:

I am 35 years old with Multiple Sclerosis (MS). I have been looking for an affordable and accessible place to live, however my income level is too high to qualify for assistance using a Section 8 voucher but not high enough to pay for rent and all of my medical expenses. It is extremely difficult to find somewhere to live that would work for my needs, both in terms of accessibility and affordability. My income may decrease as my ability to work decreases and I may need some additional financial assistance and personal care. I wish I had more choices regarding where I live within my limited income.

Recommendation

Increase the Medically Needy (Medicaid) income levels to at least match the amount received by individuals that receive Supplemental Security Income (SSI) and/or permit more access to Service Payments for the Elderly and Disabled (SPED) funding for individuals who would otherwise have a high recipient liability through the Medicaid program.



"I can't get on any help like that through the county because my income is too high. But mine is just on the line where it is too high for services and not high enough to do it all [pay for services]. It's a hard place to be. It's not a good place to be."

~ Consumer of HCBS[4]

- It will be six years or more before deserving elderly and people with disabilities could receive an increase in the amount of money they have available to meet their everyday living expenses. An increase will happen only if the ND Legislature provides additional funding during the 2009 Legislative Assembly.
- While it would be very costly to raise the medically needy income levels to that of Social Security Administration – SSI program, efforts should be made to raise the levels over time with the goal of matching the SSI income levels by the year 2020.
- If raising the medically needy income levels is not financially feasible then consideration should be given to allow the elderly and people with disabilities to receive personal care services through the SPED program even though they qualify for enrollment in the ND Medicaid

Case Scenario*:

In July of 2008, the Social Security Retirement Benefits my wife and I receive is a combined total of $1061 per month. We are eligible for the Medically Needy Program (Medicaid) however, the amount allowed to us as a couple is only $516 per month, plus a $20 disregard. This amount is subtracted from our SSI amount and leaves us with $525 per month in recipient liability. This $525 is used to pay for medical care that we receive. That means that we have only $536 each month to pay for non-medical bills such as, rent, electricity, food, and fuel for our car.

Testimony in reference to House Bill 1012: particularly the Early Intervention Autism Waiver
January 26, 2009

My name is Shannon Grave. I live in West Fargo with my husband Brian and our two children. Our daughter, Janessa, is 9 and our son, Carsen, is 7. While originally from ND, I lived in Minnesota for about 10 years. Our family moved to West Fargo two years ago. This move was prompted and influenced by our son's special needs.

I have been called an "expert" in the area of autism in the context of my professional and educational accomplishments and experiences. This is because I work in the field of mental health providing therapy services in the home, school, and community for children birth to 18 and their families. Many of the families with whom I work have children with a type of autism. I also provide mental health consultation to Head Start. After completion of the Autism Spectrum Disorders certificate program at the University of North Dakota, I was asked to serve as Adjunct Instructor for the Methods for ASD course for graduate students. But I am far from what I would consider an "expert on autism". However, I would define myself as an expert in one context. I am the parent of a seven year old boy with a diagnosed Autism Spectrum Disorder.

Our Journey

Just before my son's second birthday, he showed numerous signs of having an autism spectrum disorder. He was non-verbal and when he needed something he would flap his hands, cry, scream, fold himself in half, drool, and sometimes get so upset he would vomit unless we correctly guessed his need. Every day life was a constant struggle. Given my professional training and experience working with children ages birth to three, I knew something was amiss.

I contacted the Birth to Three program in our town and arranged for an evaluation. Right after he turned two, a team convened to fully assess our son. A licensed psychologist used the term "autism spectrum disorder". We *knew* in our hearts before she even uttered the words. At the time, in Minnesota, a diagnosis of autism would preclude him from receiving services so the private Occupational Therapy we had started would have been discontinued. We had to be very careful who we shared the psychologist's report with, lest we lose the necessary therapies we had begun.

Autism is a pervasive developmental disorder affecting all parts of life

Thus began our journey of intensive, comprehensive treatments and lifestyle alterations. For several months we found ourselves driving one hour in each direction, twice a week for a half hour Occupational Therapy session to address Carsen's sensory based and motor planning differences. This was all paid out of pocket on our part as his parents. In addition to the monetary and time commitments of driving Carsen to OT, we participated in the services provided by the Early Intervention Team. It was our job as his parents to coordinate everything on a day to day basis working to implement all of the recommendations given to us with all of his care givers including his daycare provider. The preparation required to go on the most mundane of outings involved immense effort on our part. We did this all while balancing full-time professional careers and caring for two young children.

Families need support

I am blessed to have a wonderful husband who has encouraged me and truly partnered with me as I continue to pursue my passions and hone my professional skills. Like many families who have children with special needs, my work and home life becomes increasingly intertwined. Many families with autistic children do not have the luxury of living in a two parent home. The divorce rate for families with

an autistic child is disparagingly high. It is significantly higher for families affected by autism than it is for the general population or even for families having a child with another disability. Families need comprehensive systems of support.

Families need information

I had the opportunity to attend graduate school to earn my master's degree in special education with a strong emphasis in autism spectrum disorders. I read everything I could get my hands on with regards to treatments for autism. My husband and I attended any conferences we could afford to attend. Most families do not have the resources to do this. I am blessed to have a professional job that encourages my further specialization in the field of autism. I am blessed to have a supportive life partner. I am blessed to have the financial and intellectual means to pursue higher education. Not all families of children with autism have this. Families need information that is of sufficient depth and breadth. They need information on a variety of research supported methods as well as those that are considered promising so they can be informed, active team members in all aspects of service delivery for their young children.

Waivered services need to be expanded

Since moving to North Dakota, our son has qualified for case management through Developmental Disabilities due to his IQ. This means he has Medicaid as a secondary insurance to the Blue Cross/Blue Shield insurance my husband and I purchase through our employment. He now only requires intermittent short-term therapy services to help us readjust our approaches and refocus our efforts. Through his DD case manager our family receives a small number of respite hours each month. My husband and I use these hours as a "date night" to maintain a strong relationship. We can do this because we know the providers are well trained and that he is safe. Prior to receiving respite, we could not go anywhere as a couple because we could not trust anyone else to provide care for him. Many families who have a child with autism cannot access DD services because their child's IQ is considered to be "too high". This is where the services provided under a waivered system can be very beneficial.

Time is of the essence

Our son has been called a "poster child for early intervention". This is indeed an accurate description of him. I could tell many stories about him in his toddler and preschool years that would likely bring tears to your eyes, but I will instead allow a few pictures to tell the story.

Thank you

I thank you for your time and consideration of this bill. With shocking national prevalence rates, we need to do something now. We know that early intervention is the key to reducing costs as the child ages. By front-loading services, the cost savings will be felt for years to come. This bill to provide waivered early intervention services is a great first step in providing comprehensive care to children and their families. Please do not let your most vulnerable constituents down.

Shannon Grave
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West Fargo, ND 58078
701-200-5421

Public Comment
Human Resources Division of the House Appropriations Committee
January 26, 2009

Chairman Pollert and members of the Human Resources Division:

My name is Mike Ahmann, and I am the executive director of BECEP (Bismarck Early Childhood Program). The Bismarck Public Schools is the Fiscal Agent for this program which provides Infant Development Services to eligible infants and their families in Region VII.

Because, the North Dakota Early Intervention system uses a program called Infant Development, which is part of the DD grants under the Home and Community Based Waiver, I am here today to ask you to support an increase to funding for all DD providers through a 7%/7% provider inflation increase which is included in the Governor's budget proposal. In addition, I would ask you to consider funding towards optional adjustment requests that were not included in the governor's budget: an increase for Infant Development salaries ($1.7 million) and a wage and benefit increase ($2 per hour and 3%) for DD providers.

Because of the scope of the work in Infant Development that needs to be accomplished, several critical components need to be fiscally supported. These include:

- An experienced, highly qualified workforce with knowledge in infant and toddler development, family systems, and assistive technology;
- Adequate supervision and technical assistance for staff;
- A professional development system, both pre-service and continuing skill development;
- Mechanisms to insure that all children in all parts of the state have access to equal services (i.e. travel, technology based communication, contracted staff, etc.)
- A comprehensive quality assurance system.

One of the difficulties that Infant Development has struggled with is having adequate budgets and an appropriate funding mechanism that insures the above noted components are in place. Presently, the Infant Development providers are working with the state office to reconsider options for a funding mechanism. What remains to be true is salaries for professionals such as physical therapists, occupational therapists, speech therapists, and educators in the general market are significantly greater than those that

can be offered in Infant Development. In a market analysis that was conducted, an average starting salary for these professional disciplines was $22.43 an hour. The starting salary range for professionals employed in Infant Development was from $12.98 to $20.21. In addition, working in Infant Development means a twelve month contract, working non-traditional hours (i.e. evenings), and requires vast professional development in the field of early childhood and special needs.

The increase for providers that is presently included in the governor's budget will help Infant Development narrow the gap, but additional assistance towards salary equity is critically needed. Many of the providers experience difficulty in recruiting and hiring experienced professional staff. Service delivery can be diluted and consultation with specific professional disciplines is not always available, especially in the rural areas. There are more demands for supervision due to additional accountability standards and increased caseloads.

Within my programs at BECEP, I pay professionals less in my infant development program who have the same training and experience as their counterparts who work with the same students when they turn age three, due to the different funding mechanisms. This disparity of payment has caused a constant problem in recruitment and retention of these highly qualified professionals for our Infant Development program.

Infant Development services are one of the hidden gems in North Dakota. It's a small program serving 935 infants and toddlers with disabilities across the state. These 935 children are some of the most vulnerable children with special health care needs and disabilities. We are lucky in our state to have maintained state funding support. We have the mechanisms in place to impact children and their families but we need adequate staffing.

Thank you for your consideration of this request for funding and my comments.

Mike Ahmann
806 N. Washington St.
Bismarck, N. Dak. 58501
701-323-4006
mike_ahmann@bismarckschools.org

J

January 26, 2009

Chair Pollert and members of the House Human Resources Division, my name is Tom Newberger and I am the Director for Red River Human Services Foundation in Fargo. Our agency supports approximately 525 people with developmental disabilities in Residential, Day and Social programs. The focus of my testimony today is related to the latter – social programs.

Red River Human Services operates the Activity Center in Fargo. The Activity Center has been operating since the late 1970's and has filled a void for services to people with disabilities. People with disabilities go to the Activity Center to recreate, socialize and to find a place where they can receive services that are not always available to them through our residential and day programs. I have been in this business for 23 years and I have seen where our traditional services come up short and not able to give people a the choices they want. This is where the Activity Center and the LISTEN CENTER play a vital role.

The Activity Center adds meaning to people's lives by being a common place where people come together to learn and develop social skills, friendships and how to access the community. It also acts as a safety net when other support systems have failed. For example, last winter a member of the Activity Center called and said she had been sick to her stomach for 3 days and was out of toilet paper, medicine and nearly out of food. Our staff went to her apartment, bought her the items she lacked and possibly saved her life. While this is an extreme example, it shows what we do for the less fortunate.

More common activities include going camping, to ball games and to the park. These activities add meaning to people lives by getting them involved rather than sitting in a group home that is not staffed adequately. We have 4 group homes in West Fargo each with 5 people living in them for a total of 20 people. Each home usually has 1 DSP in the evenings and it's not possible for the staff to take someone to the park, drop them off, take another person to a movie and work with 3 people at home at the same time. This again is where the Activity Center fills a void by providing staff for these different functions.

The story of the Activity Center is long and winding due to funding constraints. The Activity Center has nearly closed and numerous occasions, most recently 6 years ago when Lutheran Social Services cut the program because of the financial drain. The Activity Center was picked up by Red River Human Services Foundation and we lose $30,000-$40,000 per year operating it. We have operated without state funds and now ask for your support. Our Charitable gaming has filled these losses in the past, but now our charitable gaming is down like the rest of the industry. Please support the Activity Center and the LISTEN Center by funding $50,000 per year per Center or $200,000 for the Biennium. Thank you and I'll be happy to answer any questions.

RED RIVER HUMAN SERVICES FOUNDATION

Business Office:
2506 35th Ave. S., Fargo, ND 58104-8897
701-235-0971 Fax 701-235-1051

Together we can help.

June 9, 2004

The Honorable John Hoeven
Governor of North Dakota
600 East Boulevard
Bismarck, North Dakota 58505

Re: FUNDING SOCIAL AND RECREATIONAL PROGRAMS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

Dear Governor Hoeven:

We, the Board of Directors of Red River Human Services Foundation and L.I.S.T.E.N. Inc, (Love Is Sharing The Exceptional Needs), request that you include in your 2005/2007 biennial budget $200,000 for programs providing social and recreational services for people with developmental disabilities. These funds would support the nearly 400 people who use Red River Human Services Foundation's **Activity Center** in Fargo and the 575 people who use the **L.I.S.T.E.N. Center's Drop-In Program** in Grand Forks.

The **L.I.S.T.E.N. Drop-In** and the **Fargo Activity Center** have existed since the early 1970's. The ARC lawsuit thrust over 600 additional people into these programs ***without any support from the State of North Dakota.*** This has placed a difficult financial burden on these facilities. For example, the LISTEN Center had an attendance level of 3,800 in 1978; today that number is over 14,000. In 1978, 138 people with disabilities were using the Drop-In Program; today that number is over 800 with over 575 having disabilities. There are also 167 children participating. You can see this explosion in attendance has created a very real problem.

The State of North Dakota has done a wonderful job of supporting the social and recreational needs of people with mental illness (MI), but has not funded the same programs for people with Developmental Disabilities. The MI social centers have been funded for approximately 10 years while the DD social centers have struggled to make ends meet for the last 20 years. Evidence of this struggle appeared when Lutheran Social Services decided to terminate its ownership of the struggling Fargo Activity Center. This would have been a real tragedy if it were not for Red River Human Services Foundation who saw the value and need for such a program and decided to continue the program.

You have an opportunity to correct this disparity and continue to provide services to 975 people who see these programs and the services they provide as valuable and necessary. If you would like to discuss our request, please contact Tom Newberger from Red River Human Services Foundation at 701-235-0971 or Charlie Bremseth from the L.I.S.T.E.N. Center at 701-746-7840.

Sincerely,

Red River Human Services Foundation Board of Directors:

Sen. Russell Thane, Chair of the Board

Rep. Ole Aarsvold, Vice Chair of the Board

Steve Dawson, Secretary

Mike Sundquist, Treasurer

Sen. Tom Fischer, Past Chair of the Board

Deanna Bakken, Board Member

Jeanette Plummer, Board Member

Alice Haugen, Board Member

Dick Shorma, Board Member

Chris Christopherson, Board Member

L.I.S.T.E.N. Center Board of Directors:

Peter Johnson, President

Ron Goodman, Board Member

Rob Carolin, Vice President

Alice Hoffert, Board Member

Roger Brockmeyer, Board Member

Bev Koller, Board Member

Duane Goetz, Sec/ Treas

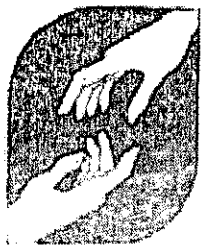
Randy Ensrude, Board Member

Russ Prochko, Board Member

Dave Perry, Board Member

cc: Tom Newberger, C.E.O.
Charlie Bremseth, Listen Center Director
Phyllis Briss, Activity Center Director
Carol Olson, Department of Human Services Executive Director
Gene Hysjulien, DDD

Red River Human Services Foundation



Together We Can Help

Drop-In Center - Grand Forks, ND

Number of participants Grand Forks: 381

Number of ND participants with disabilities: 494

Adults: 343

Children: 100

Attendance: 9,508

Ages served: 3 +

Activity Center - Fargo, ND

Number of participants Fargo: 402

Number of ND participants with disabilities: 402

Adults: 394

Children: 8

Attendance: 6,512

Ages served: 17 +

Reference Point: Northeast Human Services

10-1-08 there were 655 people with DD being in Region IV

Total number of cases served in 1 year 748

Centers for people with Mental Illness (8)

Mountain brook: Grand Forks

Budget: $200,000 biennium

Serve: 204 people.

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TESTIMONY
HOUSE BILL 1012 – DHS Appropriations
Developmental Disabilities – LTC Continuum
House Appropriations – Human Resources Division
Representative Pollert, Chairman
January 26, 2009

Chairman Pollert, members of the House Appropriations Human Resources Division, I am Cindy Vollmer, proud Mom of Amber Vollmer. I'm here today to speak on Amber's behalf. Amber is a delightful 28 year old who lives with a housemate in one half of a duplex. She and her housemate pay rent, split the other household bills, come and go sometimes together but most times separately to different destinations. Amber enjoys meaningful activities during her day, spends leisure time at home, out in the community for entertainment, the church of her choice, recreation, and of course shopping – all the things most 28 year olds do. Like most 28 year olds, she no longer thinks Mom is the center of her universe. She no longer thinks her parents are the most interesting, coolest people to live with.

The thing that makes Amber's life different than most 28 year olds is that she needs full supports to do all the above and all other activities of daily living. Amber needs total help for eating, bathing, dressing, repositioning, mobility, toileting – everything except smiling and enjoying a life independent of her

parents. Her lifestyle did not evolve in the same way as many young people. We have planned and worked closely with her Developmental Disability case managers, community services provider, and prior to her moving away from home, the team at the Anne Carlsen Center in Jamestown. Amber spent her high school years at the Anne Carlsen Center to help prepare her for many things including being away from Mom and Dad, having multiple care providers, and how to communicate her wants and needs in her own way. We utilized their comprehensive services to help prepare her for life in the big world such as many of you prepare your children for college or living on their own. Amber has demonstrated for the past 6 years what a lot of planning, working together, and commitment on our part and most importantly the part of her community service provider team can achieve – a well rounded, successful, meaningful, safe life in her home town. People know Amber, watch out for her, respect her for herself – this is her safety net. This can only be achieved when people who are vulnerable live, work and play in their home community. My biggest concern for many years was what would happen to Amber if I dropped off the face of the planet. She is an only child. Who would care how she was being treated. I sleep better at night these past years because I know that Amber has a circle of support, people who

know her, value her and will make sure that her life will continue to be safe and satisfying even if I'm gone.

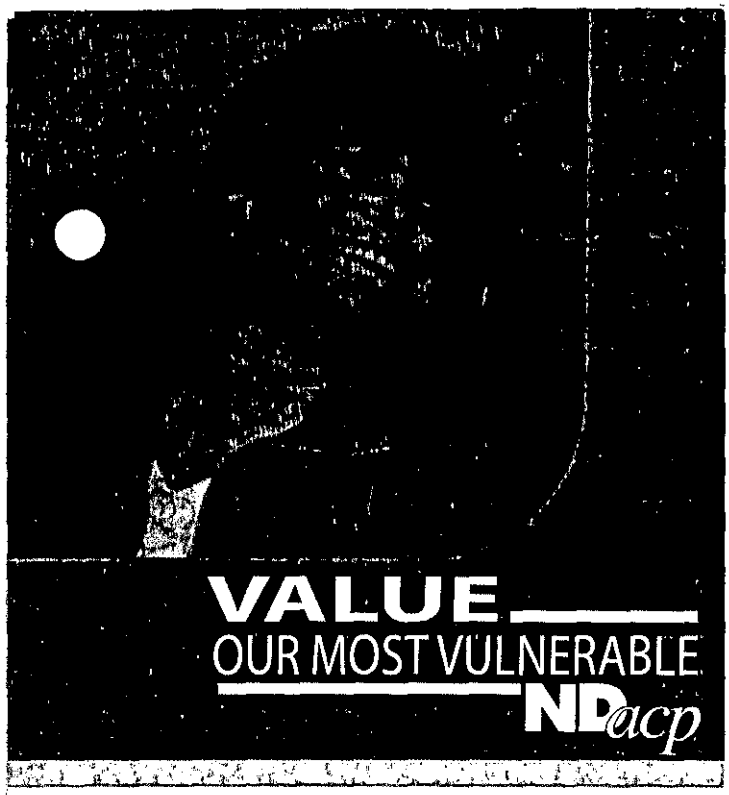
Now with all that said, my main concern and request to you, the folks who make the decisions on where and how state funds will be portioned out, is to consider a substantial increase in funds for wages for direct care community service providers. For many years we have requested an increase in pay for the people that are most critical for the wellbeing and care of our daughter – the direct care providers. These individuals are dedicated, caring and very hard working. Unfortunately, most of them cannot make a career out of direct care service because the pay and/or benefits are so low. They are not making a living wage doing some of the most intense, intimate care for people that cannot take care of themselves. This leads to recruitment and most of all retention problems. Frequent changes in staff seriously affects Amber's emotional health, her care, quality of life and security. It takes time to trust a care provider for help with her most intimate needs, to learn her style of nonverbal communication, her likes and dislikes. When that person leaves it not only seriously impacts Amber's emotional health but her physical and medical wellbeing. Each time a trusted, well trained care provider leaves we must start over. Her quality of care is often affected due the length of time to transfer information and train new staff. This can lead to

misunderstanding of what Amber is trying to convey and as well as many other types of errors. There is also the extra expense and wasted training dollars due to the large, frequent turnover of direct care staff.

We appreciate that past sessions of legislators have upped the pay for direct service providers but the amounts were very small and certainly did not keep up with the cost of living nor provide wages that would entice most people to enter this most valued field of work.

Please consider including a substantial pay increase for direct care workers in this session's budget. We need to acknowledge the work these fine folks do by paying them a fair wage so this will become a chosen field. We need to entice people who have the desire and heart to work in this field by rewarding them with a wage that they can live on, pay their bills and have a well rounded meaningful life so they can help Amber continue to have the same.

Thank you for your time and consideration.



Meet Amber – a young lady from Bismarck who has cerebral palsy and requires a team of caregivers to support her daily activities. In 1988 Amber's family began using In-home Supports to assist her. In 2002 Amber graduated from school and moved into an apartment with support from the ISLA program. This is Amber's home today. Caring staff help Amber with her shopping, laundry, chores and all the simple daily things we take for granted.

Without the qualified and dedicated staff, Amber would not be the happy, social and healthy young lady that she is. She loves living independently and her family credits the outstanding direct support professionals who support her needs each and every day.

Our goal is to provide continuity and consistency for Amber and the thousands of additional people who need daily assistance. Amber and others in the same situation thrive and live fulfilling lives when there is consistency in the care and services provided.

Amber is supported by Enable in Bismarck.

Support an equity and inflationary increase in wages for developmental disabilities employees.

VALUE OUR MOST VULNERABLE

NDacp

North Dakota Association of Community Providers

Support a 7% inflationary increase and a $2.00 per hour equity increase for Employees working with the Developmentally Disabled.

Support a $2.00 per hour equity increase to become competitive with the labor market in North Dakota.

We are more than 4,800 employees in North Dakota living in 80+ communities who provide support services for thousands of people with developmental disabilities. Our average employee is 37 years old and has a family to support.

Our goal is to continue giving quality and consistent support for people with developmental disabilities. Providing competitive wages will enable us to decrease employee turnover leading to better outcomes for the people we support. Current turnover rates for DD providers are nearly 50%.

Hourly Wage Comparison

Average Competitor *(retail, food industry)*	$11.36
Average DD Provider	$9.08
Increase Needed	**$2.00**

Current turnover rates for DD providers are nearly 50%.

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Testimony in Support
HB 1012

Mr. Chairman and members of the committee. Hi, my name is Kris. I am here to give a testimony. I have friends and my friend's name is Rachel. I want her to get a raise for helping me. Thank you.

Kris Langlie

N

Betty Heuchert
ND Independent Qualified Service Providers (QSP's) Testimony
House Appropriations – Human Resources Division
Representative Chet Pollert, Chairman
January 26, 2009

Good Morning Chairman Pollert, and members of the House Appropriations – Human Resources Division: My name is Betty Heuchert from Grand Forks, ND. I have been a full-time independent QSP for almost 10 years. I also am a Nurse Trainer for new QSP's entering the program.

1. **Usage and Availability of Services:** I get referrals from Options Resource Center for Independent Living, County Social Services, physicians, word of mouth and former clients. Other QSP's may advertise in grocery stores, churches and Senior Centers.

   The clients want to remain at home for as long as possible, which is often their biggest goal. However, when a person passes on, or needs institutional care in a nursing facility, it abruptly affects my income. This necessitates the need to always be looking for additional work. I want to continue working full-time as a QSP, however, there needs to be a more consistent way of obtaining referrals. Most QSP's don't get enough work, which means they are forced to eventually find other jobs and quit providing QSP services.

2. **Future Increases:** I would highly support the 7 & 7% increase as recommended in the Governor's Budget for House Bill 1012 for the QSP rate increase. While past increases have helped, future increases would be necessary in consideration of the fact that QSP's are independently employed and receive no benefits such as health insurance, sick time, vacation and mileage reimbursement.

3. **Personal Story:** I'm in this business because most individuals prefer to remain in their own home for as long as possible, where they are happiest. Many elderly and disabled clients have expressed a desire to have as few people coming in and out of their home as possible. They do not want to have to train multiple people to care for them on a regular basis. Clients want to get to know their caregivers and be able to trust them. As us baby-boomers age in ND, the need for QSP's will only increase!

Thank you for the opportunity to share this information and I would be happy to answer any questions you may have.

Sincerely,

Betty Heuchert
1922 Willow Dr.
Grand Forks, ND 58201-8111
701-741-9531

Chairman Pollert, Members of the House Appropriations Human Resources Committee

My name is Diane Melby. I am writing in support of the 7%/7% within HB 1012 for QSP's, which stands for Qualified Service Provider. I have been a QSP for over 25 years and enjoy providing this service to those in need, like a lot of other QSP's. QSP's have experienced a higher cost of living. In order to provide service to the clients in their homes, we need to have a dependable vehicle, and vehicles are costly to maintain. When I first moved to Bismarck this was my only source of income, so with the high cost of living it just wasn't affordable. So I had to look for a second job that would pay for health insurance and other benefits. This required me to work 14-16 hours a day between the two jobs.

If you are single it is impossible to make a living on QSP's wages alone. QSP's also have to provide their own social security tax's at the rate of 15.3 % of their income.

I want you all to think about something today; what if you or a loved one were to become disabled, wouldn't you want to be able to stay in your own home rather then be placed in an institution? There are a lot of young adults who are disabled in some way here in Bismarck alone. No matter what your age is it's always better to stay in your own home. The disabled residents that can stay in their homes also cost the state less in the long run.

So we ask you today for your continued support on HB 1012, so we can retain the QSP's we have and attract others to help us provide services to the disabled residents that live in their homes; and provide QSP's with an adequate income and health benefits. Thank you for your support on HB 1012.

Sincerely,

Diane Melby 6YBZ

Diane Melby
3201 Balters Drive
Bismarck, ND 58501
701-471-0026

P

January 16, 2009

HUMAN SERVICES COMMITTEE TESTIMONY

RE: House Bill 1012

Kimberly Ternes-North Dakota Constituent

Mr Chairman, and members of the committee, my name is Kimberly Ternes voter from Mandan. I want to thank you for this opportunity to add my support to the House Bill No.1012.

I urge your support of the House Bill No.1012. This bill is critical to the Qualified Service Providers (QSP) who provide their time, commitment, services, support and loving care to their recipients. Without the care of the QSP's in North Dakota many of the recipients would be taken from their homes, their quality of life and loved ones and placed in expensive nursing facility which many recipients feel is the last stepping stone in their lives. By making it possible for the recipients to remain in their homes, and rewarding the QSP's adequately financially for their abilities and time, both become winners as well as the State.

I, myself, became a QSP for my son, Scott Thomas, December of 2007. I had to leave my farm home, northwest of Mandan, and move into Bismarck so my husband and I could determine if we could make ends meet on just one of my salaries. Needless to say this was a very hard decision for us to make. My employer did offer the work at home program but there was no adequate internet support for me to work from our farm. I moved into Bismarck, which did offer secured internet service for my work, prior to bringing Scott home. After working in town for 5 months we decided that if I could find just a small second job (babysitting) to help pay for my loss of health insurance, we could

afford to have Scott and I move home to the farm. It has been a financial struggle but the rewards are in having my son home with us receiving the loving care of his family and getting to know his nieces and nephews who find it easier to see their uncle in a home rather than an institutional setting. Scott has prospered also and is off his medication, Nuerontin.

I pray all of you look into your hearts and put yourselves in the QSP's positions. What is the amount you would pay to have your loved ones cared for by loving, caring Qualified Service Providers?

Thank you for your attention to this important issue and your commitment to the aging and disabled members of our great state. I know that you will be guided by your beliefs to make the best decision for all.

Kimberly Ternes

Kimberly Ternes

2895 County Road 140

Mandan, North Dakota 58554

701-220-7681

Time Task Started and ended	Authorized Tasks Provided	Task Category	Units	ADL	Other	Care Not Billing For
5:15 - 8:15	Temp,Pulse/Respiration/Blood Pressure	Other	1		1	Setting up G-tube feeding at night
	Incontinence	ADL	1	1		
	Transferring/Turning/Positioning (to shower gurney)	ADL	1	1		5 G-tube flushes per day
	Dressing/Undressing, Bathing	ADL	4	4		
	Transferring/Turning/Positioning (back to bed)	ADL	1	1		10-20 wiping of Scott's face per day
	Skin care	Other	1		1	due to his drulling
	Teeth, Mouth, Denture Care	Other	1		1	
	Incontinence	ADL	1	1		Giving Scott his vitamins and lactulose
	Exercise	ADL	2		2	3 times per day. (lactulose & vitamin in AM; Xango i
	Transferring/Turning/Positioning (to wheelchair)	ADL	1	1		in the afternoon; Lactulose and prune juice in the
	Mobility (inside)	ADL	1	1		PM
12:00 - 12:30 pm	Mobility (inside)	ADL	1	1		
	Transferring/Turning/Positioning (back to bed)	ADL	1	1		Putting Scott's head back in his head harness; 7-10 t
	Incontinence	ADL	1	1		time a day.
2:30 - 3:15 pm	Communication	Other	1		1	
	Transferring/Turning/Positioning (back to wheelchair)	ADL	1	1		Giving Scott his suppositories daily
	Mobility (inside)	ADL	1	1		
4:15 - 5:15 pm	Mobility (inside)	ADL	1	1		Taking Scott to dental and doctor appts.
	Incontinence	ADL	1	1		
	Transferring/Turning/Positioning (back to bed)	ADL	1	1		
	Exercise	Other	2		2	
	Transferring/Turning/Positioning (back to wheelchair)	ADL	1	1		
7:00 - 8:30 pm	Mobility (inside)	ADL	1			
	Transferring/Turning/Positioning (back to bed)	ADL	1	1		
	Dressing/Undressing (for bedtime)	ADL	1	1		
	Teeth, Mouth, Denture Care	Other	1		1	
	Temp,Pulse/Respiration/Blood Pressure	Other	1		1	
	Incontinence	ADL	1	1		
	Transferring/Turning/Positioning (laying on left side)	ADL	1	1		
10:30 - 11:00 pm	Transferring/Turning/Positioning (repositioned to right side)A	ADL	1	1		
2:00 -2:30 am	Incontinence	ADL	1	1		
	Transferring/Turning/Positioning	ADL	1	1		
	Total		37	26	10	
		ADL-26				
		OTHER-10				
	Hemiroid suppository given					
	Bowel Movement					
	Suppository given					
	Laxative given					

D

Testimony
North Dakota Disabilities Advocacy Consortium
HB 1012
House Appropriations-Human Resources Committee
Chairman Representative Chet A. Pollert

Chairman Pollert and members of the House Appropriations Human Resources Committee, my name is James M. Moench, Executive Director of the North Dakota Disabilities Advocacy Consortium (NDDAC). The Consortium is made up of 23 member organizations concerned with addressing the issues that affect people with disabilities. (See attached list of members).

NDDAC supports House Bill 1012 – The Department of Human Services Budget. We were very pleased with the funding levels proposed in the Governor's budget in most cases and we support those levels with some enhancement that I will detail later in my testimony. First though, let me state that the Department of Human Service's open dialogue with stakeholders and the process used to determine the scope of the requirements and the resources needed to provide human services in North Dakota was the best that our members have witnessed to date and we wish to complement both the Governor and DHS management and staff for their efforts on behalf of the less fortunate in North Dakota.

There is much NDDAC member organizations wish to support in both the number chosen and the Governor's proposed funding levels of the OAR's presented to him by the Department. NDDAC vigorously supports raising the Medically Needy Income Level to 83% of the poverty level. The positive impact of adopting this change on low-income elderly and persons with a disability cannot be overstated. A person who currently is trying to survive on $500.00 per month for shelter, food, utilities, clothing, and transportation etc will be allowed to keep $720.00 per month. A couple would be allowed $969.00 per month for their needs. Not a

princely sum by any standards. The adjustment is long overdue and will change the lives of many North Dakotans.

NDDAC supports increasing Health Steps (also known as S-CHIP) program eligibility to 200% of net income. One of our state's highest priorities must be the goal of health care coverage for all the state's children. The payoff in quality of life from early detection and the later savings on treatment are well documented.

We wish to acknowledge the positive steps in HB 1012 as introduced in three major areas. One, the bill seeks to provide more opportunity for North Dakotans to access Home and Community Based Services and remain in their homes and communities for as long a possible, Second, providing a third tier of personal care expanding the hours a client is eligible for from eight to ten hours and Third, the bill's many enhancement of services for children both at home and in foster care. Revising the SPED fee schedule and providing funding for the Autism Spectrum Disorder Waiver for children up to five (5) years of age are two enhancements that we would especially like to highlight and support. Serving the 30 children projected to be served in the waiver will be most welcome as North Dakota steps up its efforts to combat the growing and perplexing problem of Autism.

While we were pleased that the Department was able to decouple ICF/MR from nursing homes and propose raising the Personal Needs Allowance from $50 to $60. We believe that level is still too low. We urge the Committee to raise the Personal Needs Allowance for those individuals in an ICF/MR to $100.

NDDAC supports funding for the Aging & Disability Resource Center (ADRC) pilot project. The one-stop concept of the ADRC has proven both to enhance services and help clients cut thought bureaucracy in other states.

Due to the shortage of affordable facilities for individual who could remain independent with some reasonably priced services, we would support including the OAR to provide for an assisted living room & board subsidy.

In the area of mental health, we support funding the OAR for Peer Support Services for persons with mental illness. Peer support is consumer-centered with a rehabilitation and recovery focus. Peer support services are provided by a person who has progressed in their own mental health recovery and is working to assist other people with mental health issues. Because of their life experiences, peer support providers have expertise and insights that professional training simply cannot duplicate.

Lastly, we support the proposed 7% & 7% inflation adjustment for Medicaid service providers. Service providers were promised catch-up adjustments during the sessions when budgets were tight. Now seems the time for adopting the adequate reimbursement rates that are needed for DD and QSP service providers to compete in the job market for talent and continue to provide quality services. We would further support up to an additional $2.00 per hour for both DD workers and QSPs.

Thank you for your attention today and we urge your favorable consideration of HB 1012.

NORTH DAKOTA DISABILITIES ADVOCACY CONSORTIUM

2008-09 Membership

1. AARP
2. American People Self Advocacy Association
3. Autism Society of North Dakota
4. Experience Works, Inc.
5. Fair Housing of the Dakotas
6. Family Voices of North Dakota
7. Independence, Inc.
8. Mental Health America of North Dakota
9. Metro Area Transit – Fargo, ND
10. ND APSE: The Network on Employment
11. ND Association for the Disabled
12. ND Association of Community Facilities
13. ND Association of the Blind
14. ND Center for Persons with Disabilities
15. ND Children's Caucus
16. ND Consumer & Family Network
17. ND Federation of Families for Children's Mental Health
18. ND IPAT Consumer Advisory Committee
19. Protection & Advocacy Project
20. Senior Health Insurance Counseling/Prescription Connection
21. The Arc of Bismarck
22. The Arc of Cass County
23. The Arc of North Dakota

1-16-09

Example for 3rd Tier Personal Care

A 49 year old female was injured in a car accident 15 years ago. She is a quadriplegic (paralyzed from the chest down) and lives in her own home. She is totally dependent on her motorized wheelchair and controls the movement of the chair with a cheek control device. She can swallow and breathe on her own.

The individual scored a 3 on a scale of 0 to 3 in all ADL's (activities of daily living) which includes bathing, dressing/undressing, eating, toileting, transferring in/out of bed/chair. A score of 0 means able to do without help and a 3 means unable to do.

The individual scored a 2 (unable to do) in the following IADL's, (Instrumental activities of daily living); meal preparation, housework, and laundry.
She scored a 1 (with help) in the following IADL's; shopping, taking medication, transportation, money management, and telephone/communication.

The client is receiving the maximum units of personal care of 960 units per month under the Medicaid State Plan.

Her QSP's bathe her daily, frequently turn her to prevent skin breakdown, and assist her at mealtime, and with transferring her from the bed to her wheelchair. This is a primary role of the QSP and the majority of their approved units are assigned to these tasks.

The individual is never left alone and lives with her elderly father who is unable to carry out the bathing, transferring and turning tasks due to his own health restrictions. She and her care givers are extremely diligent and cautious about skin care. She did not have any skin breakdowns for the past 3 years, which is evidence of the high quality of care.

In the past 6 months, the individual was hospitalized due to pneumonia and now has to have continuous oxygen. Her physical needs have increased.

The individual would benefit from additional personal care hours now that her condition has changed.

This is an example of a situation that demonstrates the need for the additional hours that would be provided with a 3rd tier for personal care. More units could be allotted for the need for frequent turning to maintain good skin integrity, additional time for assistance with eating etc. The additional 2 hours per day would extend the time in which the individual would be able to stay in her own home versus moving to a nursing facility.

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

	General	Federal/Other	Total
To address critical needs with with enhanced staffing [from OAR priority #5]	$ 438,900	$ 747,957	$ 1,186,857

NOTE: This proposed amendment represents reimbursement to all private DD providers to help partially reimburse them for their losses in caring for critical needs clients. Adequate funding for this critical needs staffing throughout the system is vital to providing adequate care for the state's most vulnerable individuals, all of whom are either medically fragile or behaviorally challenged.

HB 1558 is a Bill that would study and correct this reimbursement disparity so the Center and other DD facilities serving these complex populations would not need to return to the Legislature each session seeking to be covered for some of their losses due to the existing DHS rate setting structure.

Testimony
North Dakota Disabilities Advocacy Consortium
HB 1012
Senate Appropriations
Senator Ray Holmberg, Chairman

Chairman Holmberg and members of the Senate Appropriations Committee, my name is James M. Moench, Executive Director of the North Dakota Disabilities Advocacy Consortium (NDDAC). The Consortium is made up of 24 member organizations concerned with addressing the issues that affect people with disabilities. (See attached list of members).

NDDAC supports House Bill 1012 – The Department of Human Services Budget. We were very pleased with the funding levels proposed in the Governor's budget in most cases and we support those levels with some enhancement that I will detail later in my testimony. First though, let me state that the Department of Human Service's open dialogue with stakeholders and the process used to determine the scope of the requirements and the resources needed to provide human services in North Dakota was the best that our members have witnessed to date and we wish to complement both the Governor and DHS management and staff for their efforts on behalf of the less fortunate in North Dakota.

There is much NDDAC member organizations wish to support in both the number chosen and the Governor's proposed funding levels of the OAR's presented to him by the Department. NDDAC vigorously supports raising the Medically Needy Income Level to 83% of the poverty level. The positive impact of adopting this change on low-income elderly and persons with a disability cannot be overstated. A person who currently is trying to survive on $500.00 per month for shelter, food, utilities, clothing, and transportation etc will be allowed to keep $720.00 per month. A

couple would be allowed $969.00 per month for their needs. Not a princely sum by any standards. The adjustment is long overdue and will change the lives of many North Dakotans.

NDDAC supports increasing Health Steps (also known as S-CHIP) program eligibility to 200% of net income. One of our state's highest priorities must be the goal of health care coverage for all the state's children. The payoff in quality of life from early detection and the later savings on treatment are well documented.

We wish to acknowledge the positive steps in HB 1012 as introduced in three major areas. One, the bill seeks to provide more opportunity for North Dakotans to access Home and Community Based Services and remain in their homes and communities for as long a possible, Second, providing a third tier of personal care expanding the hours a client is eligible for from eight to ten hours and Third, the bill's many enhancement of services for children both at home and in foster care. Revising the SPED fee schedule and providing funding for the Autism Spectrum Disorder Waiver for children up to five (5) years of age are two enhancements that we would especially like to highlight and support. Serving the 30 children projected to be served in the waiver will be most welcome as North Dakota steps up its efforts to combat the growing and perplexing problem of Autism.

While we were pleased that the Department was able to decouple ICF/MR from nursing homes and propose raising the Personal Needs Allowance from $50 to $60. We believe that level is still too low. We urge the Committee to support at least the $75.00 level the House adopted for the Personal Needs Allowance for those individuals in an ICF/MR.

NDDAC supports funding for the Aging & Disability Resource LINK (formally ADRC) pilot project. The No-Wrong-Door

concept of the ADR-LINK has proven both to enhance services and help clients cut thought bureaucracy in other states.

Due to the shortage of affordable facilities for individual who could remain independent with some reasonably priced services, we would support including the OAR to provide for an assisted living room & board subsidy.

In the area of mental health, we support adding funding of the OAR for Peer Support Services for persons with mental illness. Peer support is consumer-centered with a rehabilitation and recovery focus. Peer support services are provided by a person who has progressed in their own mental health recovery and is working to assist other people with mental health issues. Because of their life experiences, peer support providers have expertise and insights that professional training simply cannot duplicate.

Lastly, we support the proposed 7% & 7% inflation adjustment for Medicaid service providers. Service providers were promised catch-up adjustments during the sessions when budgets were tight. Now seems the time for adopting the adequate reimbursement rates that are needed for DD and QSP service providers to compete in the job market for talent and continue to provide quality services. We would further support up to an additional $2.00 per hour for Long Term Care worker, DD workers and QSPs. Long Term Care and DD worker were given $1.00 per hour by the House, QSPs were not included. We believe this oversight must be corrected.

Thank you for your attention today and we urge your favorable consideration of HB 1012.

Developmental Disabilities

3,900 ND Direct Support Professionals

Our economic stability also depends on jobs that don't require shovels!

Investing in the DD Direct Support Professional Workforce will:

- ✓ **Get money quickly into the hands of low wage workers who will spend it locally.**
- ✓ **Stabilize a critical part of our health care infrastructure.**
- ✓ **Ensure that people with disabilities get the care they need.**

TESTIMONY
HOUSE BILL 1012 – DEPARTMENT OF HUMAN SERVICES
HOUSE APPROPRIATIONS – HUMAN RESOURCE DIVISION
REPRESENTATIVE POLLERT, CHAIRMAN
January 26, 2009

Chairman Pollert, members of the Committee, my name is Dan Howell and for the past 9 years, I have had the privilege and honor to be the Chief Executive Officer of the Anne Carlsen Center (ACC) located in Jamestown, North Dakota. I continue to serve in the shadows of our namesake, Dr. Anne Carlsen. Dr. Anne Carlsen, is one of only 36 individuals who have received the prestigious Teddy Roosevelt Roughrider Award. She has been the driving force and inspiration for over 67 years as the ACC has taken on the challenge of caring for the State of North Dakota's most challenging children and now adults with special needs.

I am here today to testify in support in support of HB 1012, as well as Optional Adjustment Request (OAR) #5. Specifically, in OAR #5, the line item addressing DD staffing to meet critical needs. The issues overview summary, which we have handed to you, outlines this OAR request in greater detail for the ACC, as well as other providers around the State of North Dakota. Chairman Pollert and members of the Committee, in my testimony today I wish to cover three (3) items.

During the 2007 legislative session, the ACC made a promise to the North Dakota Legislature. That promise that if indeed providers around the State of North Dakota, as well as the ACC would be recognized financially for serving children, as well as adults with complex special needs that the ACC would explore alternatives for providing care to the State's most voluble.

The ACC began its community-based services for medically complex and behaviorally challenged children and adults in April of 2008. The Board of Trustees of the ACC allocated over $500,000 from our foundation for this new venture. We choose the community of Grand Forks to launch these home and community based services. Within 2009, we will begin offering these services in the Fargo and Bismarck areas. These services consist of two (2) programs: In-home supports and adult day supports. The in-home support program has served 11 clients, and our adult day support program has served 8 clients. Our hope going into these programs was that these programs would be a less costly alternative than providing residential care, as well as providing services close to or in many cases within the communities that the child or adult reside in. These programs today have kept families intact and our in-home support programs in some cases have eliminated or at least delayed the entry into a residential program.

Today, in the gallery is a mother of one of our adult day clients. If you turn to Tab 8 in the packet of materials that was set forth in front of you, you will read the story about Jenny. Jenny is a recent high school graduate who with the support of the ACC has been allowed to stay within her home community of Cooperstown, North Dakota. As Jenny approached her 21st birthday, there were many individuals who believed that Jenny could not stay in Cooperstown, but would need group home and residential placement in a community outside of Cooperstown. Although Jenny would be well taken care and would have a very fulfilling life in another community, Jenny nor her parents wanted her to leave the community of Cooperstown.

With Jenny continuing to live at home, the ACC is now providing a 1:1 day support program where Jenny volunteers in a number of businesses within the community. Jenny is now enjoying a great social network, loves her work opportunities, and on a daily basis is becoming a more independent person with disabilities.

If Jenny were to have gone a residential setting outside the community of Cooperstown, would be approximately $100,000 for her residential care. We are pleased to report that the cost to the State of North Dakota for keeping Jenny in her home community

and being an active part of the community of Cooperstown is a far less costly alternative.

Even though the community support program that we began in April is in its infancy, the early results have shown great satisfaction from parents, as well as clients, and as importantly, the costs of keeping individuals out of other more restrictive environments has been greatly reduced.

Mr. Chairman, as indicated earlier, the ACC supports HB 1012 but specifically is looking for support for OAR #5 and more critically and importantly the line item which is titled DD staffing to meet critical needs.

In 2003, the Department of Human Services wrote a letter to all providers taking a position that due to budget issues there would be no additional staffing enhancements granted. There were some exceptions to this, but for the most part, most providers have not received staffing enhancements to meet the needs of complex individuals under their supervision. Three (3) years ago, the Department asked each provider to look at where the gaps were for critical needs staffing. From that request came the $6,317,916 within that OAR. The ACC is approximately 37.5% of that dollar amount of $2,495,288 in the biennium.

44 of the 52 children on our campus have a behavioral related disorder. 28 of the 44 or 63.7% of the children and young adults are classified at the highest level in our scoring matrix. Children with behavioral support plans have increased 159% over the past 12 years. The ACC uses the Oregon Scoring Criteria, which the Department of Human Services has recognized as an appropriate tool to gauge severity in children with behavioral complexities. In 2003, the average score for a child at the Center was 94, and in 2008 the average score was 133. This represents a 42% increase in severity. All the while, approved fulltime equivalents (FTEs) at the Center rose only 4 FTEs or 4.5%. The ACC staffs today at 114 FTEs for children with behavioral challenges. We are reimbursed for 88.64 FTEs. This 25.36 FTE variance equates to $713,691 per year.

The other population when considering critical staffing needs is children with great medical fragility. The State of North Dakota has adopted the Oregon Scoring Criteria as valid criteria to measure the complexity and acuity of children with great medical fragility. The ACC has 20 students that meet the definition of medical fragility. The average score for a child with medical fragility in 2005 at the ACC was 30.56. In 2008, the average score was 42.6. However, the top 10 children today had an average score of 60.9. That has risen approximately 20% over this past year. The ACC staffs for 28.4 nursing professionals to meet the complex

needs of clients being served. The Department of Human Services reimburses at 21.3 FTEs. It is interesting to note that other states such as South Dakota, Illinois, Florida and Alabama to extinguish acuity and severity in their reimbursement methodologies for medically fragile clients.

The difference in how ACC staffs for medical fragility and what are allocated for reimbursement by the Department is 7.1 FTEs or $473,166 per year.

Mr. Chairman, and members of the Committee, once again the investment that our Board has made for the two programs; the behaviorally challenged program and the medical fragility program, was $1,186,857.

A Wiseman once said, "When there is an elephant in the room it is best to introduce it." The elephant in the room for the ACC is our Foundation. The Center has been blessed and privileged over the past many years to receive generous one time gifts, as well as many end of life gifts towards the care of children at the Center. This has given the Center a unique position, as well as responsibility towards accepting children with great medical and behavioral complexity regardless of adequate reimbursement. Other providers around the State of North Dakota will take children and adults with complex needs, but need to be assured that there is adequate reimbursement for these individuals.

Without adequate reimbursement, it would sadly become a financial hardship on many of these organizations. For providers around the State of North Dakota to adequately serve the growing complexity with respect to the clients that we serve, it is imperative that funding for critical staffing needs is placed in HB 1012.

I also recognize that additional dollars going into the 2009-11 budget may be difficult. Therefore, we are asking support for one-half of the OAR or $3,158,958. Of which $1,168,182 is general funds with the remainder being federal funds.

Mr. Chairman, and members of the Committee, this is the third session that I have come before you to ask for additional funding for medically fragile and behaviorally challenged funding. While I enjoy and respect each and every one of you, I am most certain that our request for enhanced funding at times gets old. That is why we have submitted HB 1556 which is a resolution for an interim study to collect the methodology and calculations for the rating setting structure used by the Department for clients who are medically fragile and behaviorally challenged. This would include children and adults in both the ICR/MR and home and community based setting.

My hope is that systemic change occurs so the ACC finds it no longer necessary to continue to come to the Committee asking

for additional funding for the medically fragile and behaviorally challenged populations.

Mr. Chairman and members of the Committee, I thank you for the job that each of you and at this time, I will answer any questions that you may have.

Thank you.

Dan Howell, Chief Executive Officer
Anne Carlsen Center

Anne Carlsen
CENTER
Nurturing abilities. Changing lives.

House Appropriations

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Prepared for the

2009 North Dakota Legislative Assembly

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Introduction

Anne Carlsen CENTER

The Anne Carlsen Center has a rich tradition of providing compassion and expert care to children and adults with developmental disabilities.

Founded in 1941, our name honors Dr. Anne Carlsen who, despite being born with partial arms and legs, overcame her disability and excelled in her life and career. A former teacher, principal and administrator at the Center, Dr. Anne worked to help individuals with disabilities become as independent as possible and enjoy a higher quality of life. That quest for independence is at the heart of all we do here.

Our highly-trained staff supports individuals and families affected by disabilities and conditions that include: autism, cerebral palsy, traumatic brain injury, and medical fragility. On our Jamestown, N.D., campus, we meet a variety of educational, residential, medical and therapeutic needs. In 2008, we expanded our community-based services to offer more supports to more parts of the state. We are branching out to communities large and small, offering experience, knowledge and hope to children, adults and families.

As we meet these critical needs, we are faced with financial concerns similar to many other organizations that work with children and adults with developmental disabilities. The resources it takes to provide quality care and support are considerable. We look to the state to help adequately fund the care and services ACC provides and address the current gap in funding.

Dr. Anne once said, "Independence is the greatest reward a person can have." We are dedicated to helping that dream become a reality for individuals across the state. By providing individualized services, supports and training, we equip and empower all those we come in contact with. We have a passion for providing choices, guidance and hope in the journey of life.

Anne Carlsen
CENTER
Nurturing abilities. Changing lives.

HISTORY

1922: The Evangelical Good Samaritan Society was granted state licensure of incorporation for a fee of $5.

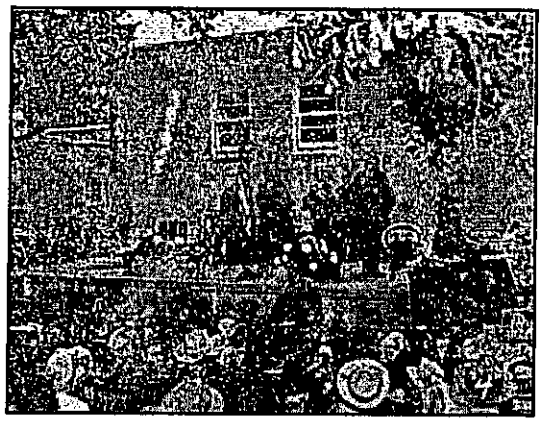
1923: The first Good Samaritan Society home was opened in Arthur, N.D., with 13 residents.

1932: A former Presbyterian college in Fargo, N.D., was offered to the Good Samaritan Society for the Crippled Children's School. Lelend Burgum was superintendent.

1938: Rev. W.B. Schoenbohm joined the Good Samaritan Society as superintendent. Anne Carlsen, a quadruple congenital amputee, joined the staff as a high school teacher.

1940: Lutheran Hospitals and Homes Society purchased the Crippled Children's School and moved it to Jamestown, N.D. Construction began in the fall at Horseshoe Park on six acres purchased for $450.

1941: Despite inclement weather, nearly 1,000 people gathered Sept. 21 to help dedicate the new school. The original building cost $58,000 to construct and was paid for entirely with private donations. It opened its doors to 18 students on Sept. 22. The School included two modern classrooms, a craft room, library, therapy room, dining hall, recreation room, and dormitory for 35 children.



1943: A new sunroom was dedicated Sept. 5.

1946: Anne Carlsen earned her master's degree in education from Colorado State University in Greeley.

The School purchased additional acreage to the east and west of the school.

1948: Anne Carlsen was named the school principal. The School purchased additional acreage to the northwest.

1949: The Easter Seal Wing, dedicated May 29, included three classrooms, rooms for occupational therapy, physical therapy, hydrotherapy, speech correction, storage, and exercise and a dormitory for 32 boys. Additional remodeling provided a junior high school room, a staff dining room and additional medical isolation facilities.

Anne Carlsen completed the doctoral program at University of Minnesota and was named child guidance director of the School.

A summer session called the Cerebral Palsy Training Program and Parents Conference was started in cooperation with the N.D. Easter Seals Society.

1950: Dr. Anne Carlsen was named superintendent after Rev. W.B. Schoenbohm resigned to take a new position in Iowa.

1953: Two classrooms and a laundry unit were added to the growing facility. The School's enrollment climbed to 59.

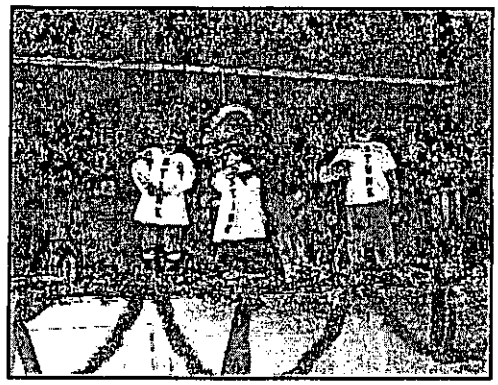
A postgraduate business education course started to offer young people with disabilities a chance to prepare for office jobs. It was discontinued in 1968 when two commercial colleges in the state were on ground level and accessible to those with disabilities.

1955: Students of the high school and commercial department started the first all-school yearbook, the Island Echo.

1958: A Ford Foundation grant for $33,200 and Hill-Burton Funds approved by the N.D. State Health Planning Commission provided money for construction of the industrial arts department, homemaking department, and new kitchen and dining room facilities.

Dr. Anne Carlsen received the President's Trophy as Handicapped American of the Year. The award is given annually to the person who has helped to advance the cause of the employment of the physically disabled.

1962: The new occupational therapy department and all-purpose auditorium/ gymnasium, with a seating capacity of 400, was dedicated in May. The auditorium included a permanent, handicap-accessible stage area.



Today children use the auditorium for physical education class, recreation, and performing in events like their annual Christmas program.

1965: A new heating plant, physical therapy department and speech therapy department with a special classroom for the hearing impaired were added.

1966: North Dakota Governor William Guy honored Dr. Anne Carlsen with North Dakota's highest honor, the Theodore Roosevelt Roughrider Award. The award is given to persons who have brought credit to the state by achieving national recognition in their fields of endeavor.

1968: The new limb and brace department was constructed. A vocational evaluation program, sponsored jointly by the School and the Vocational Rehabilitation Division, started and continued through 1973. The prevocational classroom for students not academically inclined but able to benefit

from further practical training and therapy, was kept as part of the program.

1971: The Crippled Children School dedicated a new modular dormitory designed to house 32 students. Thousands of gifts, matched by a 46 percent grant from Hill-Burton Construction Funds, supported the project.

1975: Dr. Anne Carlsen was inducted into the National Teachers Hall of Fame at Fullerton (Calif.) College.

1976: A second modular dormitory was added.

1980: The name of the school was changed to Anne Carlsen School, in honor of Dr. Anne Carlsen who had served as teacher, principal and administrator for more than four decades.

1981: Dr. Anne Carlsen retired from her administrative position and took a part-time consulting job with the School. She continued to maintain office hours and serve as a consultant and mentor to staff and students until the time of her death.

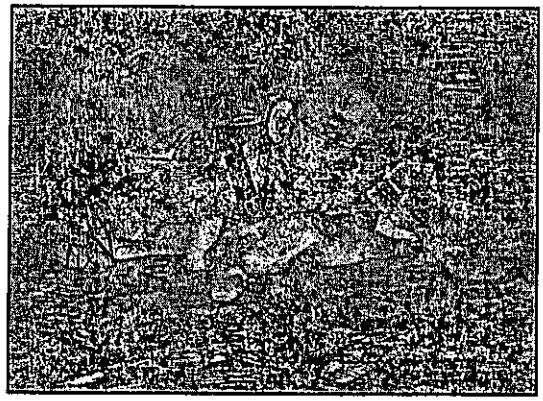
Dr. Anne received the W. Clement Stone Foundation Endow-a-Dream Award, given each year to honor an individual who has used a positive mental attitude to overcome adversity and make contributions to the betterment of humanity. A check for $50,000 was given to the School for its endowment fund.

Henry Edwards was named the school's administrator.

1983: An extensive remodeling project updated the staff and student dining areas, hallways and one dormitory.

President Ronald Reagan appointed Dr. Anne Carlsen vice-chair of the President's Committee on Employing the Handicapped.

1984: The focus of the Center's programs expanded to include young people with severe multiple disabilities.



All the children benefit from the warm-water swimming pool during gym class, in therapy sessions, and for open swim time in the evenings.

1985: The therapeutic swimming pool and whirlpool were completed so students could begin benefiting from physical, recreational and social therapy. The pool floor can be raised and lowered to any water depth between zero and five feet.

A statue of Dr. Anne Carlsen and a child was dedicated at the front entrance of the school.

1986: The School's program was expanded to include services and placement for children with autism.

1987: A Communication and Mobility Assessments program began. As part of the program, a team of therapists evaluates children within and outside the School to recommend more appropriate

communication and mobility programming.

ACC started its program for children with autism and behavior-related disorders.

1988: Anne Carlsen Center was licensed as an Intermediate Care Facility for the Mentally Retarded.

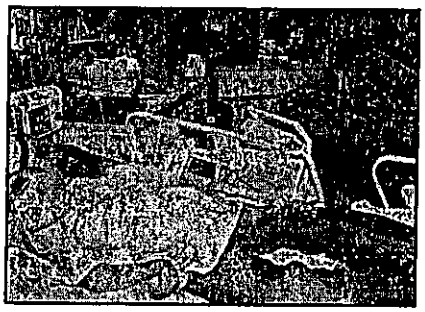
The local Head Start program relocated in the school building, giving young children with and without special needs a chance to interact with each other.

The Community Integration and Vocational Development Program began providing young adults with disabilities valuable work experiences as trainees in local businesses.

1989: The Therapeutic Equestrian Program began offering horseback riding for children with disabilities. The program uses physical, speech and occupational therapies while the children ride.

1990: Michael J. Numrich was named Administrator.

The Advanced Care Unit opened, providing state-of-the-art medical care and skilled personnel for medically fragile youngsters.



The advance care unit provides hospital-level medical care to the most medically-fragile children.

1991: The Center celebrated its golden anniversary with a year-long series of events, including a staff-alumni reunion and celebration banquet.

The program offering daily living skills and vocational experience for young adults with disabilities was named Transitional Services.

1992: The Center's education services received accreditation as an elementary school from the prestigious accrediting agency, North Central Association.

Fundraising began for the Resource Center, a regional focus of information training and equipment for children with disabilities and their families.

The Store Room opened its doors with consigned crafts and goodies. Kids gained work experience there before they moved to jobs in the community.

Dr. Anne Carlsen was chosen as one of 22 North Dakotans to serve on Governor-elect Ed Schafer's transition team and she was named Psychologist of the Year by the North Dakota Psychological Association.

The School received a President's Grant from Lutheran Health Systems to develop and put in place a system of providing rehabilitation services to children from all Lutheran Health Systems facilities throughout the nation.

1993: The name of the school was changed to Anne Carlsen Center for Children to better reflect its broader scope of services.

1995: Dr. Anne Carlsen and the Center celebrated her 80th birthday. Contributions honoring her totaled more than $25,000 and helped purchase a handicapped-accessible van.

1997: Mike Gillen was named administrator.

The Center began a five-year renovation project to enable it to better meet the needs of its children.

1998: The Anne Carlsen Tree of Life was dedicated, revealing 700 names of those who had contributed at least $5,000 to the Center.

1999: The Nature Trail's bridge was completed, thanks to Eagle Scout John Goetz who constructed the bridge as part of his scouting project.

The Guest House, which serves as a home-away-from-home for visiting families, was re-sided.

2000: Dan Howell was named administrator.

The Center's parent company, Lutheran Health Systems, merged with Samaritan Health System of Phoenix, Ariz., to create Banner Health System.

2001: The Center celebrated its 60th anniversary with a number of events including: a ribbon-cutting ceremony which culminated a five-year, $1.6 million remodeling project, an alumni reunion where over 70 graduates of the Center gathered, and a gala event highlighted with a benefit concert by acclaimed pianist Lorie Line and her Pop Chamber Orchestra. Over 1,500 people attended the performance which raised more than $20,000 for Center programs.

The Council on Quality and Leadership in Supports for People with Disabilities gave the Center its highest accreditation rating - three year with distinction. Less than 10 percent of organizations accredited by The Council receive this grade.

2002: The Center's namesake, Dr. Anne Carlsen, passed away on Dec. 22.

2003: On July 1, the Center became an independently-owned organization operated by a governing board of directors.

Construction began on a residential expansion and remodeling, adding three residential cottages to the campus and remodeling the existing dorm area, increasing the Advanced Care Unit from six to 16 beds.

2004: In July, 16 students moved into new homes located just yards from the main campus when two of three houses were completed in the first phase of a major remodeling and expansion project designed to enhance the living environment to better meet the needs of today's residents.

The gardening program is created at the Center, allowing students to grow their own vegetables and fruits. Students also produce market and sell homemade salsa.

2006: The Chaplaincy Program is created, as Pastor JoAnne Moeller is available to students, their families and Center staff for all spiritual needs.

2008: The name of the Center is changed to the Anne Carlsen Center, to better reflect the wide variety of ages the Center serves.

The Center expands its community-based services, offering more supports in more

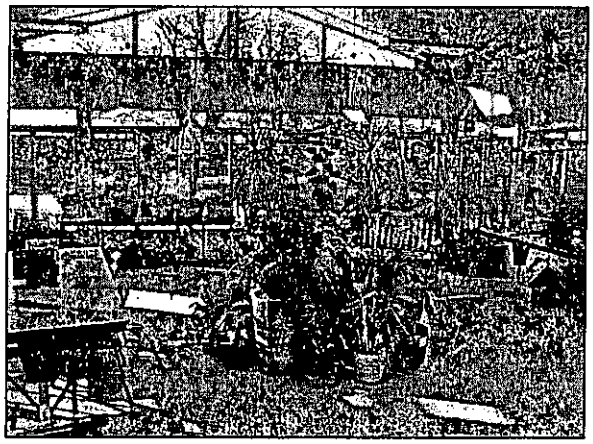
(2008 continued)

parts of the state. As part of the expansion, the Center begins to serve individuals over the age of 21.

Medically-fragile students are allowed to continue residing at the Center following graduation.

In April, the Center holds the first of four major autism-related conferences in 2008. ACC invites nationally-recognized speakers to educate families and professionals from across the state.

The remodeling project in the home living areas of the Jamestown campus is completed, increasing the Center's ability to serve medically-fragile children and behaviorally-challenged children in less-restrictive environments. State-of-the-art, highly-accessible features allow students to be engaged and comfortable in their home environments.



The Solarium project is completed, thanks to the generosity of ACC donors. The new structure, complete with features like non-slip floors, full-spectrum growth lights, and radiant floor heating, expands the gardening program to year-round. Students grow vegetables and flowers from seed for their gardens.

The Sunroom, built in 1943, undergoes a major renovation. New ceramic tile, cabinets, furniture and appliances have made this space more comfortable and convenient for home economics class, Girl Scouts and family visits.

Dr. Anne Carlsen's legacy is celebrated in ACC's new logo. The logo incorporates the authentic signature of the Center's namesake, as well as a redesigned butterfly.

ACC opens a Community Services office in Grand Forks and begins providing In-Home Supports and Day Supports to individuals and families in Northeast North Dakota.

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ISSUES OVERVIEW

COMMUNITY SERVICES

Background

Throughout our nearly 70-year history, Anne Carlsen Center (ACC) has been a leader in providing residential, therapeutic, and educational services to children with a wide array of disabilities. Over time, the Center has further developed its expertise to meet critical and diverse needs, nurturing abilities while changing thousands of lives.

In 2008, the Center began a major expansion of our community-based services. We now provide client-centered, multi-disciplinary care to children with developmental disabilities living with their families, and adults with developmental disabilities living in communities throughout North Dakota.

Through our Community Services, ACC helps individuals with disabilities and their families build a home life of dignity, freedom and well-being. Our expert staff provides **In-Home Supports** for children (birth to 21) and their families. We nurture abilities, enhance independence, and measure progress through a series of goals and objectives. As part of a team, we help children communicate more effectively, learn safety skills, understand how to make choices, develop social skills, and advocate for themselves. ACC also teaches critical skills and routines to parents and caregivers.

We also offer **Personal and Community Supports** (Day Support Services) for adults (age 21 and over). ACC empowers individuals by helping each person create a unique plan for independence and community involvement. Our highly-trained staff provides community access, individualized skill training, community-based programming, guidance in daily living activities, and special assessment of areas of need.

As part of our Community Services, we provide Program Coordination/Family Support Services for all clients. We also offer training and education on developmental disabilities, including autism, for families, providers and advocates, among others. Four major autism conferences, which brought national experts together with parents and professionals, were hosted by ACC in 2008.

The ACC Campus in Jamestown, N.D., will always be a critical component of our service delivery. For some individuals, the specific care they need to live a full life will mean the best option is receiving services at the Center. In other cases, where children and young adults may be able to stay in their homes and/or communities, we are equipped to provide vital services and supports. The Anne Carlsen Center brings our resources and expertise to people ... *where they are.* As a result, the outcomes are often better, families stay together, and—in the end— our efforts save the state money.

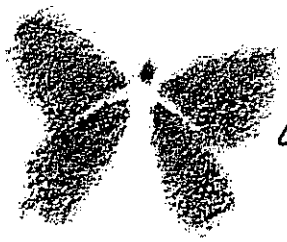
Value of ACC's Community Services:

- Greater access to communities.
- Increasing social roles.
- Keep families together/closer.
- Provide meaningful activities, vocational experiences.
- Better functioning in the home.
- Improved access to familiar schools.
- Reducing challenging behaviors.
- Improving program plan outcomes for clients and families in community-based services.
- Increasing participation in community-based services.
- Less risk of negative/costly outcomes.
- Reducing children's institutional placements and costs.
- Less overall cost to the state.

Bottom line ...

Children and young adults stay in their communities.

Less cost. Better outcomes.



Community Services Data

June 2008 to Present

Site/Client	Behavior Support Level	Behavioral Conditions Criteria Score
GF/1	2	72
GF/2	2	87
GF/3	3+	209
GF/4	2	63
GF/5	2	106
GF/6	3	125
GF/7	3+	220
GF/8	0	0
JT/9	0	0
JT/10	3+	268
Cooperstown/11	2	52
JT/12	2	109
JT/13	See Medical Support Level	
JT/14	See Medical Support Level	

Key Graph

- GF = Grand Forks
- JT = Jamestown

OREGON SCALE CRITERIA SCORES AND BEHAVIOR SUPPORT LEVELS

Level 1
1-50
(*noncompliance, mild symptoms associated with ADHD and self-stimulatory behavior*)

Level 2
51-119
(*mild forms of self-injury, aggressive behavior and property damage*)

Level 3
120-200
(*Elopement/AWOL; significant forms of self-injury, aggressive behavior and property damage; sexually acting out behavior*)

Level 3+
above 200

ACC Community Services

Supports Intensity Scale™

Graph Key

GF Grand Forks

JT Jamestown

Site/Client	Medical Needs Score	Behavior Needs Score	Total SIS Level
GF/1	5	15	3
GF/2			
GF/3	3	10	4
GF/4	2	10	3
GF/5	8	10	4
GF/6	5	10	4
GF/7	4	13	4
GF/8			
JT/9	4	5	3
JT/10			
Cooperstown/11	1	3	
JT/12			
JT/13			
JT/14	17	0	4

Supports Intensity Scale (SIS)

(for ages 16 and above)

Measures the level of practical support requirements. Support needs for each life activity are based on three areas: **Frequency, Daily Support Time, and Type of Support.**

Levels

LEVEL 1
84 or less (mild)

LEVEL 2
85-99

LEVEL 3
100-115

LEVEL 4
116 or more (intense)

Positive Behavior Support Plan

Name: TT
Date of Birth:
Age: 16
Diagnosis: Mental Retardation,
Severe Articulation Disorder, Intermittent Explosive Disorder,
Pervasive Developmental Disorder—Not Otherwise Specified (PDD-NOS)
Program Date:
Approval Date:

I. Purpose:

The purpose of this Positive Behavior Support (PBS) plan is to recommend techniques that may be beneficial in any setting where TT may be interacting such as school, volunteer sites or home. PBS is a collaborative, assessment based process to develop effective individualized interventions for individuals with challenging behavior. Support plans focus on proactive and educative approaches. PBS plans include multiple interwoven strategies and generally prescribe 1) proactive strategies for changing the environment so triggering events are removed, 2) teaching new skills that replace problem behaviors, 3) eliminating or minimizing natural rewards for problem behavior, 4) maximizing clear rewards for appropriate behavior. PBS planning emphasizes improving the overall lifestyle quality as an integrated part of behavior support.

II. Background:

III. Behaviors to Increase (Alternative Behaviors):

What socially appropriate behaviors/skills does the person have or can learn, which may achieve the same outcome or function as the problem behavior: List for each target behavior:

- **Communicating when he is frustrated and asking for a break** (& receiving one).
- **Learning when he is agitated** then…
- **Using calming techniques or walking away to an area to calm himself** when upset.

IV. Behaviors to Decrease (Target Behaviors):

- **Distracting others from their tasks** – poking at other students, laughing or engaging in other inappropriate behavior and looking to see if others are watching or attempting to make sure others are watching his behavior.
- **Refusal to do required tasks** – Refusal to participate in tasks such as going to school, going to bed, going to the next class, putting away an activity.
- **Self-injurious behavior** - banging his head on the table or floor, picking at his skin
- **Physical aggression toward others** – Slapping with an open hand, pulling hair, pinching to the point of hurting but no marks are left, kicking at another person.
- **Object aggression** – Using an object to hit at a person or intentionally or not intentionally throwing or kicking an object in anger (even if not toward a person).

V. Previous Interventions

- A token economy has been used in the high school previously but it was reported that it was likely not used consistently and not used with proper reinforcement timing. TThas a tendency to satiate on reinforcers so they must be changed frequently.

VI. Functional Assessment Summary:

The functional assessment for this positive behavior support plan (10-23-08) is based on information obtained from TT's foster parents, special education teacher, IEP review, and observations at home and the partial hospitalization school. In addition, a Functional Analysis Screening Tool (FAST) was completed. The target behaviors are primarily maintained by the provision of attention, access to preferred items/activities (to get something he wants), escape from demands, and frustration due to the inability to get what he wants to say across to other people (lack communication skills).

Environmental Variables:

TT has been sleeping very little in the evenings. At times it has been 3-4 hours a night. To help him adjust to his environment, TT will have a daily schedule for school and the afternoon with Anne Carlsen integrated programming. TT is allowed or able to make choices on a daily basis (food, clothing, social

companions, leisure activities, daily schedule, chores) where applicable. He will require a 1:1 paraprofessional assisting him in the school setting and a 1:1 direct support staff after school.

It is best to not tell TT "no" when working with him. Say "Stop" instead. If he cannot do something at a particular time, let him know what he can do at that time and when he can do the activity he wants to do. Use a normal matter of fact tone of voice when working with TT. A threatening, aggressive rather than assertive tone of voice will trigger a behavior for TT.

It would be best to cover pictures or not watch videos that may depict violence or aggression. Pictures, even historical pictures, displays of aggression or violence, or seeing a parent discipline a child in an area where TT is going to be doing an activity could be a trigger to aggression. Be mindful of this when working with him and cover or remove these items from the area. Also, be mindful of your own body language and verbal tone when working with TT or asking him to complete a task or to calm, so that he does not infer anger or agitation. Be sure to provide positive attention to TT. Usually 12 to 1 is a good positive ratio of attention to redirection.

TT has obsessive tendencies. He gets ideas about things and will obsess and perseverate over them. Over the Christmas holiday, he has had some difficulty in past years and obsesses and may have some aggression.

It appears when TT is ill he is more likely to become agitated and aggressive.

Communication Variables:

TT has a motor speech disorder and a receptive/expressive language delay. He uses primarily one-syllable words, which are usually intelligible to the familiar listener. He primarily uses gestures, sign language, and speech, when communicating his thoughts, but he continues to grow in the use of a communication binder/folder, a twenty-location voice output device, and a four-location task specific voice output device. He will spontaneously point to pictures and he will sometimes say the words while pointing to the symbols. He is good at finding a picture if he cannot find the exact item.

TT follows simple one step verbal commands. He can follow a very limited amount of two-step commands. TT can imitate a task if it's demonstrated. He is able to understand, respond to, and indicates "yes" or "no".

Compliance Variables:

If TT has a 1:1 paraprofessional available to provide attention, humor is used or a teaching session is made competitive in some way, TT would likely be more compliant and less disruptive. In comparison, if TT is left alone and a teacher was giving attention to other students in the classroom and only talking to TT a few minutes out of the hour, he would likely be less compliant to finish his class work

Antecedent Variables:

At this time, the hyper-agitation is more likely to occur in the evenings. In addition, agitation and aggression occurs when TT is challenged with tasks he doesn't understand how to do or doesn't like to do. It does not appear that a particular setting would matter. At home, if other people are in his home he is more likely to become agitated or hyperactive. TT is more likely to become aggressive when he doesn't get to engage in the activity or get the item that he wants. In addition, TT can become frustrated at times when he is feeling that someone is not understanding what he is trying to tell them and can become agitated or aggressive. TT will more likely become aggressive if there is violence in a TV show he is watching or if he sees violence in person or sees another person in his vicinity or on the computer being scolded or reprimanded.

Aggression is least likely to occur in TT when his communication is understood, he is watching shows with no violence, and he feels that he is doing the activities he has chosen or has some control. In addition, if he enjoys competition and humor. If tasks are presented in ways that he feels he is competing or are presented with humor he is more likely to be less aggressive and to comply.

a. **Summary:**

In summary, the target behaviors are primarily maintained by the provision of attention, access to preferred items/activities (to get something he wants), escape from demands, and frustration due to the inability to get what he wants to say across to other people (lack communication skills). Due to the

function of TT's behavior, it is best to provide one to one paraprofessional or staffing when working with TT at this time. If TT is left alone and a teacher was giving attention to other students in the classroom and only talking to TT a few minutes out of the hour, he would likely be less compliant to finish his class work of engage in disruptive behavior. It is also important to remember to use the communication devices that TT understands to prevent agitation or aggression. TT has a motor speech disorder and a receptive/expressive language delay. TT follows simple one step verbal commands. Furthermore, TT can imitate a task if it's demonstrated. TT is more likely to comply if tasks are presented in ways that he feels he is competing or are presented with humor.

It would be best to cover pictures or not watch videos that may depict violence or aggression. Pictures, even historical pictures, displays of aggression or violence, or seeing a parent discipline a child in an area where TT is going to be doing an activity could be a trigger to aggression. TT is more likely become aggressive if there is violence in a TV show he is watching or if he sees violence in person or sees another person in his vicinity or on the computer being scolded or reprimanded.

To help TT adjust to his environment at school, community and home, TT will have a daily schedule for school and the afternoon with Anne Carlsen integrated programming. It is best to not tell TT "no" when working with him. Use a normal matter of fact tone of voice when working with TT. A threatening, aggressive rather than a calm assertive tone of voice will trigger a behavior for TT.

b. Medications the person is taking (meds are changing frequently – check with physician or parents for updated listing):

- **Neurontin 100 mg, 3 times per day (6 am, 7 pm):**
- **Seroquel 50 mg every morning & 100 mg (4 pm):**
- **Clonidine .1 or .2 mg at night:**
- **Propranolol 160 mg 2 times per day (6 am & 6 pm):**

- **Side-effects which may affect the person's target behavior:**
  - **Neurontin 100 mg, 3 times per day (6 am, 2 pm, 7 pm):** Drowsiness, dizziness, unsteadiness, fatigue, vision changes, weight gain, nausea, **dry mouth**, or constipation may occur.
  - **Seroquel 50 mg every morning & 100 mg (4 pm):** Constipation, drowsiness, dizziness, headache, stomach pain/upset, tiredness, weight gain, nasal congestion, or **dry mouth** may occur.
  - **Propranolol 160 mg 2 times per day (6 am & 6 pm):** Dizziness, lightheadedness, or tiredness may occur as your body adjusts to the medication. Nausea/vomiting, stomach pain, vision changes, trouble sleeping, and unusual dreams may also occur.
  - **Clonidine .1 or .2 mg at night:** Dizziness, lightheadedness, drowsiness, **dry mouth**, or constipation may occur as your body adjusts to the medication.

- **Medical conditions or complications:** Obsessions

- **Psychiatric diagnosis (if applicable):** Mental Retardation, Severe Articulation disorder, Intermittent Explosive Disorder R/O, PDD NOS R/O

VII. Steps of Intervention/Recommendations:

a. Environmental Restructuring:

- **It is better to not tell TT about activities too far in advance, as he will obsess about them.**
- Keep TT's desk as free from distraction as possible. Have his work items set aside in tubs or something where he cannot see them to be distracted by them. Give him the one item at a time with only the necessary tools to use at that time.
- Have him face away from other students or be seated in the front of the class so that the other students do not distract him. Another solution would be to have a cubicle type of seating area for him so that others do not distract him.
- A way to keep TT focused on a task is to put a small amount of work into a folder and then when he finishes the folder he can move onto the next. A timer can be used if necessary to help him know when he will be done and the reinforcer will be earned.
- A timer can be used in a couple of different ways. One is to give him time before he has to engage in a task or activity. He can set the timer for 15 minutes and then he must go to bed or go do the desired activity. The second is to set the timer for the amount of time he has to complete an activity.

Use small amounts of time (maybe start with 5 minutes) since he has very little attention span and have him see if he can get the work done appropriately, but "beat the clock."

b. **Antecedent/Proactive Measures:**
- Utilize the **Premack Principle** when you can. This is simple reinforcement at its finest (i.e., "TT, you can have (what he wants), after you (do his task)."
- **Only reprimand TT about an incident at the exact/immediate time of the incident (only if necessary).** Otherwise, reprimands at a later time or day will **trigger aggression**.
- Redirect TT when he is beginning to engage in distractions/laughing or other target behavior.
- To gain compliance, during difficult times, try and build a **behavioral momentum** by asking him to do "high probability" activities/tasks prior to asking him to do the "low probability" ones.

c. **Educational Components (Visual Supports, etc.):**
- Promote independence and communication skills by having him use his communication book and signs to get his needs/wants across to others throughout his day.
- Have a separate daily schedule for TT to use each day. It can either be picture or a few words. Include a time every day to practice relaxation skills and have it be a check off list for him.
- When disciplining another child, warn TT ahead of time and help him to understand this is a learning time for the other person.

d. **Reinforcement Procedures:**
- **Reinforcement needs to be immediate** and broken into small segments of time in his day every day.
- The current token system may continue to be used at this time. He is currently earning a sticker for appropriate work every 15 minutes. After two hours of work he could earn 8 stickers if he earns 1 per 15 minutes. At the end of the two hours, TT can choose one of the reinforcers from a picture list or out of a special reinforcer box. If it is an item, he can take 5-10 minutes (a timer should be set) to interact with the item and then return to his scheduled activity. If he returns to his activity on time, he can earn another sticker.

Reinforcers:
  - Pop tends to be the most reinforcing for him at the moment (use small amounts at a time)
  - Juices
  - Looking at pictures/Pictures of himself
  - Taking pictures
  - Magazines & Catalogs (medical, sears, toys)
  - Medical Items (e.g. Scrubs, stethoscopes, blood pressure monitor, movies)
  - Visiting amusement parks
  - Vegetables (green/broccoli)
  - Catching a fish
  - Visiting his grandmother
  - Being hugged/kissed
  - Dressing in costume (e.g., medical costume, pirate)
  - Getting mail out of the mailbox
  - Talking on the phone
  - Going swimming
  - Going out to eat (McDonalds, Subway, Applebees)
  - Running errands (grocery's, shopping)
  - Getting new clothes
  - Visiting his biological parents

VIII. Calming Activities, when an adult notices that TT is getting agitated or more active...

- Have TT engage in weight lifting or some push-pull type [Thera-band] of activity first thing in the morning (or a time the gym is available at school). For TT, it can calm his senses enough to help him work but not agitate him.
- Give him two handed hand "hugs" or hand massage.
- Practice relaxation techniques at times when he is not agitated at least once or twice a day. This should be built into his schedule. For example, counting, muscle relaxation, blowing bubbles, blowing a tissue, etc.
- Go for walks.
- Ask him to do push-ups on the floor or pushing against the wall.
- Ask him to carry heavy objects, climbing on monkey bars, or swimming, which are resistance type of activities.

- Have TT sit in a beanbag chair.

IX. De-escalation Procedures: (or Reactive Strategies)

- Using humor or competition to get him to comply.
- Break his tasks into smaller parts.
- Use the **Premack** principle (First/Then): First we will do _____ and then we can do _____ (which the second thing is a fun thing to do).
- If TT is obsessing on a subject, have him talk to you for a few minutes (can set a timer if necessary) and then let him know he can talk about the subject again at a specified time.

Once a target behavior has occurred, what is the plan of action – outline in steps from least to most intrusive as clearly as humanly possible. Address each target behavior.

- If TT gets too close and seems agitated, ask him too move back.
- If he is attempting to hit his head on the table or wall, ask him to move his chair away from the area until he is calm and ready to work.
- If necessary, TT's hands can be held by staff against his body or theirs to keep him from hitting.
- If TT is agitated and does pull hair, first ask him to remove his hand from your hair then back away from him and ask him to move back. If he does not let go use the Therapeutic Techniques to remove his hands as trained at Anne Carlsen Center.
    - He can then be asked to use the calming techniques such as taking deep breaths, etc. to calm in a quiet room/area and he can let you know when he is ready to resume the previous activity.
- If TT hits or kicks at staff, staff will step back, and ask TT to step back. In addition, staff can let TT know that he is upset and it is time to calm down before any type of activity can be done.
    - He can then be asked to use the calming techniques such as taking deep breaths, etc. to calm in a quiet room/area and he can let you know when he is ready to resume the previous activity.
- If the above techniques do not work to assist TT to calm then, when TT engages in striking staff or others, kicking, hitting, or clearing objects or throwing objects in the area, a Therapeutic Techniques approved basket hold may be used to assist TT to calm and be safe in the environment.
- Staff can also call Julie Lombardi at school in the mornings on extension 106 and at noon on extension 869 in the school for backup assistance.
- TT's foster father should only be called in extreme emergency situation.

X. <u>Risk vs. risk analysis</u>

What are the risks of the plan vs. the risks of not having the plan – risks of medications versus not taking them – risks of rights restrictions vs. not having them etc?

- Current rights restrictions as identified within TT's program and his rights restrictions require approval by his guardians or parents, team, and the Human Rights Committee and reviewed at least annually.
- TT is on medication that is prescribed and monitored by his physician, Dr. ----- and Altru medical center. The risks of not being able to attend school, out of home placement, and injury to him and others outweigh the risk of being on the medication and having this plan in place.

XI. <u>Team consensus and staff training</u>

Prior to this plan being implemented, parent or guardian approval is required. Parents, teachers, and staff were consulted during the writing of the plan and their input proved to be invaluable. As for staff training, each staff person that works with TT will be required to read this program and it will be discussed at subsequent meetings and with classroom staff. The Behavior Analyst and the Family Resource Coordinator will do further training and monitoring of the program being implemented.

XII. Data Collection System:

Data will be collected with regards to the frequency of TT's targeted behavior (if not over the entire day, at least during specified intervals where the behavior has a history of occurring). Data will be collected daily in both the classroom and in-home support settings. Data will be reviewed at the end of each month by the Behavior Analyst and reviewed quarterly at TT's team staffing.

_____ _____

Kim Strandberg, MS, Behavior Analyst Date

ISSUES OVERVIEW

MEDICALLY FRAGILE FUNDING REIMBURSEMENT

Background

The Anne Carlsen Center (ACC), based in Jamestown, N.D., is an ICF-MR facility licensed by North Dakota. We provide hospital-level care to a majority of the state's most medically-fragile children. Of our 55 licensed beds, 20 are occupied by children and young adults who are medically-fragile.

To care for these children, ACC is staffed 24/7 by caregivers specializing in pediatric care including a pediatrician, RNs, LPNs, respiratory therapist, and LSAs (direct care providers), a social worker, and behavioral specialist. Supporting our staff are a consulting clinical psychologist, psychiatrist, as well as medical specialists including pediatric neurologists, physiatrist, pulmonologist, and cardiologist.

Medically-fragile students at the Anne Carlsen Center have a variety of complex diagnoses including congenital myelomalacia of the spinal cord, hypoplastic lungs and thorax, seizure disorder, brain atrophy, tracheostomy, gastrostomy and ventilator dependency, and congenital facial abnormalities.

The Anne Carlsen Center uses the **Oregon Scale** to determine the level of medical support needed for each child and young adult.

- Developed by the Oregon Department of Human Services, the Oregon Scale is an assessment tool recognized by the state of North Dakota.
- The baseline score to be considered medically fragile is 15. The higher the score, the more medically fragile an individual is.
- Scores are based on a system-wide evaluation (respiratory, cardiovascular, neurological, gastro-intestinal, urinary, metabolic and overall) in which 73 care elements are assessed and assigned a number of points depending on the level of intervention needed.

The Need

- Since the 2007 session, the number of medically-fragile residents has increased from 19 to 20, requiring even more expenses to meet their specialized care needs.

- DHS currently reimburses ACC at an interim rate of $482.47 per child/day. The four-person average (representing a range of mild to severe medical needs) for the cost of care for our medically-fragile students is $683.

- For reimbursement purposes, the N.D. Department of Human Services (DHS) treats funding of medically-fragile residents the same as all other children and adults in ICF-MR facilities across the state, *including those with no physical disabilities.*

- Other states (e.g., South Dakota, Illinois, Alabama, Florida) distinguish their medically-fragile children from adults and children who are not medically-fragile, and that is reflected in funding enhancements for their care.

- Because of the complexity of the medical needs of many of our students, we currently need 28.4 FTEs in our nursing area. We are reimbursed 21.31 FTEs. That's a shortfall of 7.1 FTEs.

- Reimbursement for a medically-fragile child at a neonatal or pediatric ICU hospital (e.g., Mayo) is approximately $2,000 per day.

- To cover the annual gap in funding reimbursements, ACC must access its donated Foundation funds, which it relies on for capital improvements and modernization as well as support of student activities that help residents have normal childhood experiences like prom, summer camp at Elk's Camp Grassick, and trips to baseball games.

- The ND Legislature granted ACC interim funding in the 2007 session to help the Anne Carlsen Center in its investment in the lives of North Dakota children with medical fragility. In the biennium, it granted ACC $832,870 in severely medically fragile funds. Yet, greater compensation for our high-level of care is still needed.

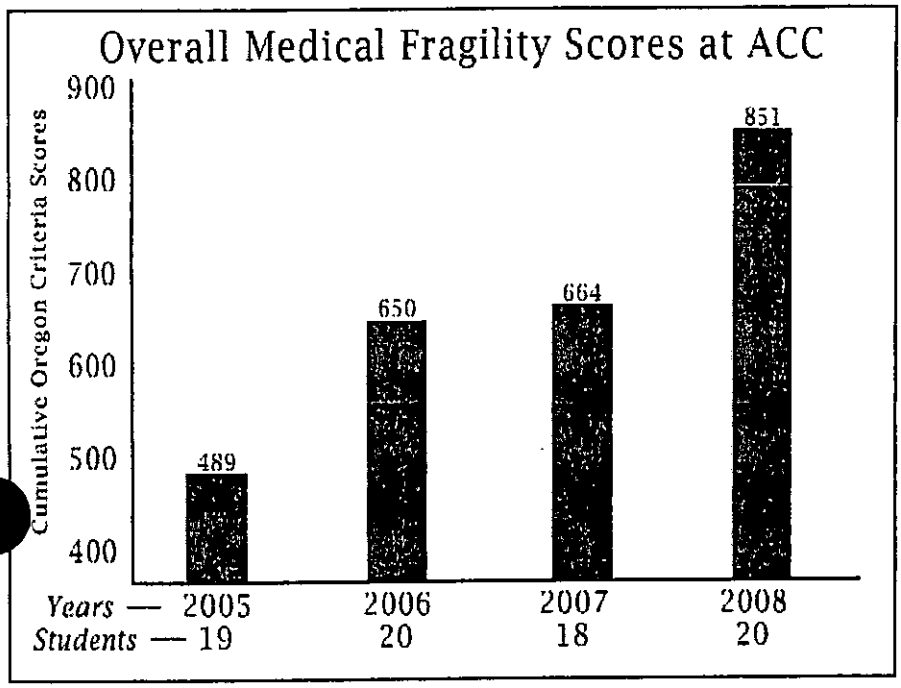
- Without adequate funding reimbursement, ACC may be faced with the need to refuse admission of medically-fragile children or risk financial harm to the whole organization. Anne Carlsen Center will not reduce the level of care medically and legally required to serve children currently under our care be cause of our nearly 70-year tradition to serve and empower these individuals.

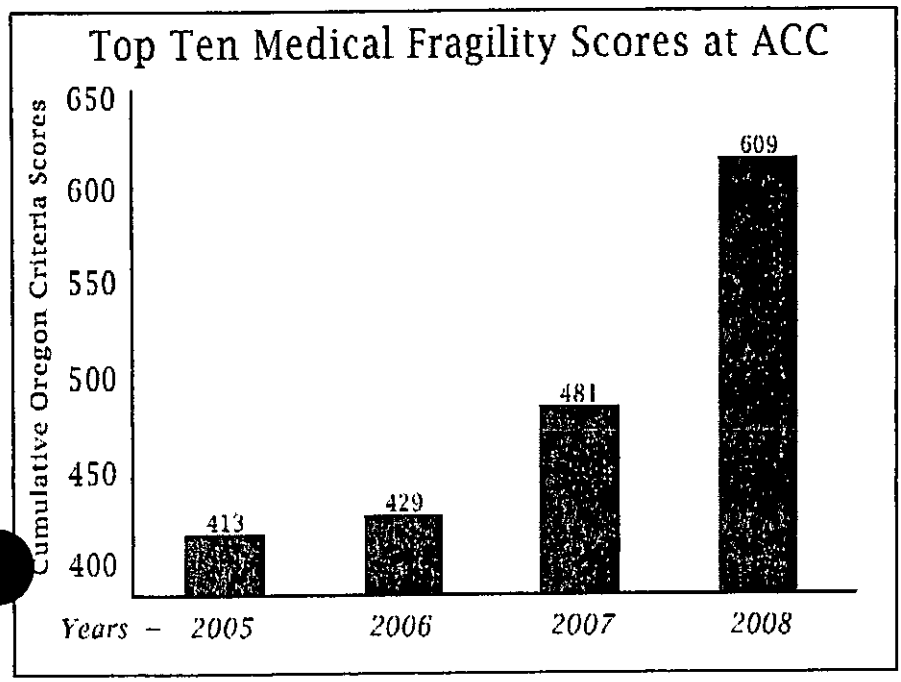
- If North Dakota's most medically-fragile children are not at ACC, they would likely be in nursing homes or at specialty hospitals like Mayo, which are the only other places equipped to provide the level of skilled nursing these children require. ***This would be at significantly higher costs to the state.***

Anne Carlsen CENTER

COMPARISON

Medically Fragile Summary





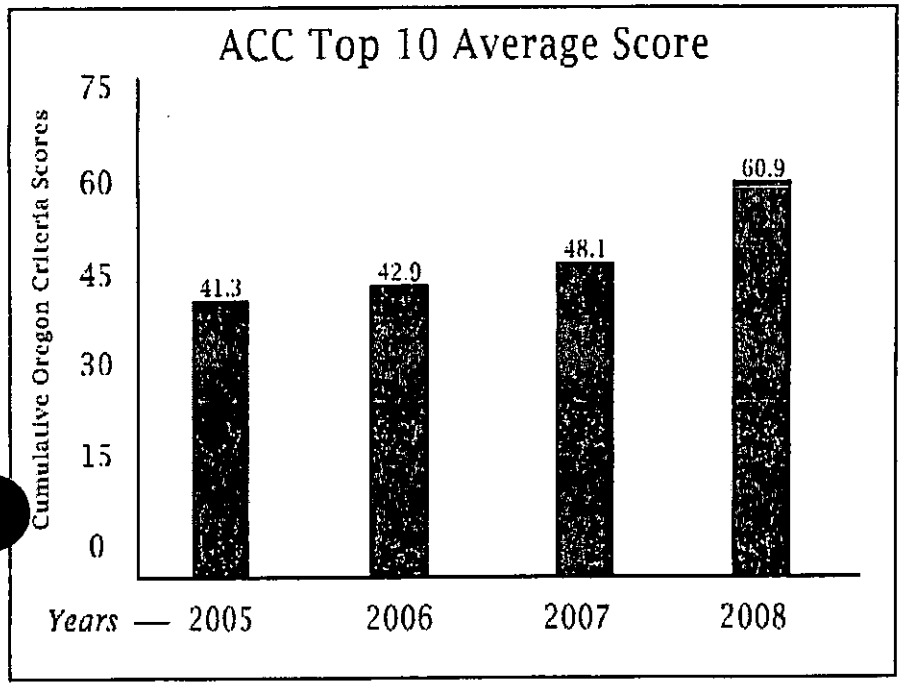
OREGON SCALE CRITERIA SCORES FOR MEDICAL FRAGILITY

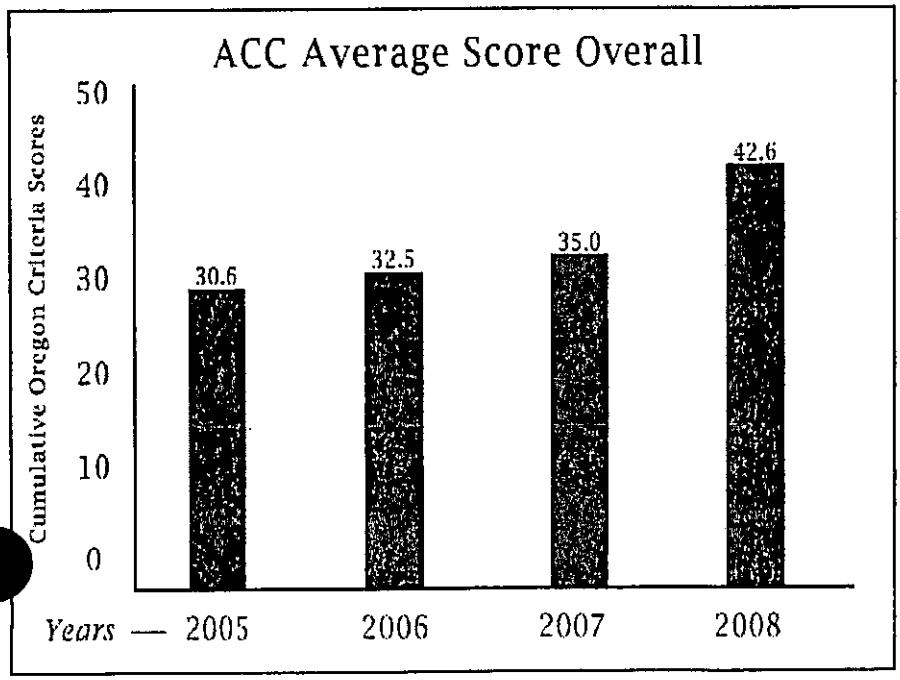
(The baseline score to be considered medically fragile is 15.) Scores are based on a systemwide evaluation (respiratory, cardiovascular, neurological, gastro-intestinal, urinary, metabolic and overall) in which 73 care elements are assessed and assigned a number of points depending on the level of intervention needed.

Anne Carlsen CENTER

COMPARISON

Medically Fragile Summary *(cont'd)*





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Comparative Cost vs. Reimbursement for ACC Medically-Fragile Children

December 9, 2008

Medically-fragile students at the Anne Carlsen Center have a variety of complex diagnoses including congenital myelomalacia of the spinal cord, hypoplastic lungs and thorax, seizure disorder, brain atrophy, tracheostomy, gastrostomy and ventilator dependency, and congenital facial abnormalities. To care for these children, ACC is staffed 24/7 by caregivers specializing in pediatric care including a pediatrician, RNs, LPNs, respiratory therapist, and LSAs (direct care providers), a social worker, and behavioral specialist. Supporting our staff are a consulting clinical psychologist, psychiatrist, as well as medical specialists including pediatric neurologists, physiatrist, pulmonologist, and cardiologist.

Anne Carlsen CENTER

TRINITY

Age 6

Diagnosis

Trinity is a 7-year-old girl who sustained a massive brain injury after a near drowning in June 2008. She has emerged from a coma, and is now recognizing faces, responding to simple directions, and learning again to move her body. She has a tracheostomy, and is fed through a gastrostomy. She has a baclofen pump delivering medication to her spine to decrease the severe muscle spasms caused by the brain injury.

Cost of daily care
$925.19

DHS daily reimbursement
$482.47

(continued)

Comparative Cost vs. Reimbursement for ACC Medically-Fragile Children

ACC STUDENT WITH INTENSE MEDICAL NEEDS Age 4	**Diagnosis** Complicated spina bifida, ventilator dependent, abnomalities of brain stem, paralyzed from the shoulders down.	**Cost of daily care** $712.86 **DHS daily reimbursement** $482.47
ACC STUDENT WITH MODERATE MEDICAL NEEDS Age 11	**Diagnosis** Cerebral palsy, baclofen pump delivering medicine to body, respiratory concerns requiring antibiotics and treatments, fed through gastrostomy.	**Cost of daily care** $558.34 **DHS daily reimbursement** $482.47
ACC STUDENT WITH MILD MEDICAL NEEDS Age 11	**Diagnosis** Spina bifida, uses wheelchair, staff carefully monitors medical needs.	**Cost of daily care** $535.89 **DHS daily reimbursement** $482.47

FOUR-PERSON AVERAGE
Cost of daily care $683.07 **DHS daily reimbursement** $482.47

ISSUES OVERVIEW
BEHAVIORALLY CHALLENGED FUNDING REIMBURSEMENT

Background

The Anne Carlsen Center (ACC), based in Jamestown, N.D., is an ICF-MR licensed by North Dakota. Since 1987, the Center has provided comprehensive care for children and young adults with Autism Spectrum Disorder (ASD) and other advanced behavior-related disorders.

Of its 55 licensed beds, 44 are occupied by children and young adults with behavior-related disorders. To care for these children, ACC is staffed 24/7 by caregivers specializing in pediatric care including a pediatrician, RNs, LPNs, and LSAs (direct care providers), a social worker and behavioral specialist. Supporting our staff are a consulting clinical psychologist, psychiatrist, pediatric neurologists, and a physiatrist.

The Need

- The number of children at ACC on positive behavior support plans has significantly increased from 17 to 44 in the past 12 years while the number of DHS-approved direct-care FTEs has recently gone down one FTE.

- Ten of ACC's medically-fragile residents also have behavioral challenges, critically compounding care requirements.

- Based on Oregon scoring criteria, which is recognized by the ND Department of Human Services, the levels of behaviors of our residents has increased dramatically in the past 12 years. Of the 44 children and young adults currently on behavior support plans, 28 are classified at a Level 3—the highest, most severe level in the scoring matrix.

Behavioral Classifications

The Anne Carlsen Center currently uses two tools to determine the severity of the behavioral issues for the individuals we serve: the Oregon Scale and the Supports Intensity Scale (SIS).

* **The Oregon Scale**

Developed by the Oregon Department of Human Services, the Oregon Scale is an assessment tool recognized by the state of North Dakota. Based on the Oregon Scale Criteria, the Anne Carlsen Center (ACC) not only determines a score based on that Criteria, but also classifies each individual into different levels based on the amount of support that person needs because of his or her behavioral symptoms/issues. The Oregon Scale is typically used to determine the behavioral needs of children but can be modified for adults with disabilities.

The Levels/Behavioral Classifications are as follows:

Level 1 (mild level of staff support):

- Problematic behavior includes: learned helplessness, noncompliance, mild symptoms associated with ADHD, various forms of self-stimulatory behavior.

- Individuals require **"stand by" or indirect supervision** with minimal level of direct supervision (.5 staff for each child).

Level 2 (moderate level of staff support):

- Problematic behavior includes: significant symptoms associated with ADHD, mild forms of self-injury (e.g., hand-biting), mild forms of aggressive behavior where risk of injury is minor on non-existent, and mild property damage (e.g., ripping, clearing a table, etc.).

- Individual requires **line-of-sight supervision** with moderate level of direct supervision (.75 staff for each child).

Level 3 (significant level of staff support):

- Problematic behavior includes: Elopement/AWOL, significant forms of self-injury (e.g., head-banging), significant forms of aggressive behavior where risk of injury is major, significant property damage (e.g., throwing appliances, putting holes in walls, breaking doors/windows, etc.), and sexually acting out behavior.

- Individuals require a **high or constant level of direct supervision** (1 staff member for each child) for guidance, training, and safety.

* **Supports Intensity Scale (SIS)**

The second screening tool used to determine level of support needed is the Supports Intensity Scale (SIS). It is a scientific assessment tool designed to measure the level of practical support requirements of a person with an intellectual or developmental disability. It is used to determine support needed for individuals ages 16 and over, and is composed of three sections:

Section 1 – relates to Home Living, Community Living, Life-long Learning, Employment, Health and Safety, and Social activities.
Section 2 – relates to Protection and Advocacy Activities.
Section 3 – relates to Exceptional Medical and Behavioral Support Needs, and includes medical conditions and problem behaviors that typically require increased level of support, regardless of the person's relative support needs in other daily life activities.

The support needs for each life activity are examined based on three measures of support needed: Frequency, Daily Support Time, and Type of Support.

The Levels/Support Classifications are as follows (*The higher the **Level**, the higher the level of support needs)*:

Level 4 = 116 or more
Level 3 = 100 – 115
Level 2 = 85 – 99
Level 1 = 84 or less

- For reimbursement purposes, the N.D. Department of Human Services (DHS) funding allocations for staffing do not support the children's actual staffing needs. In order to appropriately meet the needs of our students with complex behavioral and medical needs—and meet the Oregon conditions criteria—the Anne Carlsen Center currently has 114 FTE (full-time equivalents) for direct care staffing. DHS-approved direct care staffing is only 88.64 FTE. That is a shortfall of 25.36 FTEs.

- With an average salary of $13.53 per hour (not including benefits) for our direct-care staff, ACC has an annual reimbursement gap of $713,691 for the care and support of children and young adults with behavior disorders.

- To cover the annual gap in funding reimbursements, ACC must access its donated Foundation funds, which it relies on for capital improvements and modernization as well as for support of student activities that help students have normal childhood experiences like prom, summer camp at Elk's Camp Grassick, and trips to baseball games.

- Without adequate funding reimbursement, ACC may be faced with the need to refuse admission of children with high-level behavioral needs or risk financial harm to the whole organization. Anne Carlsen Center will not reduce the care medically and legally required to serve children currently under our care because of our nearly 70-year tradition to serve and empower these children.

- Other group homes in the state have denied admission to some of our current students and clients because they could not adequately afford to support the staffing needs of the individuals.

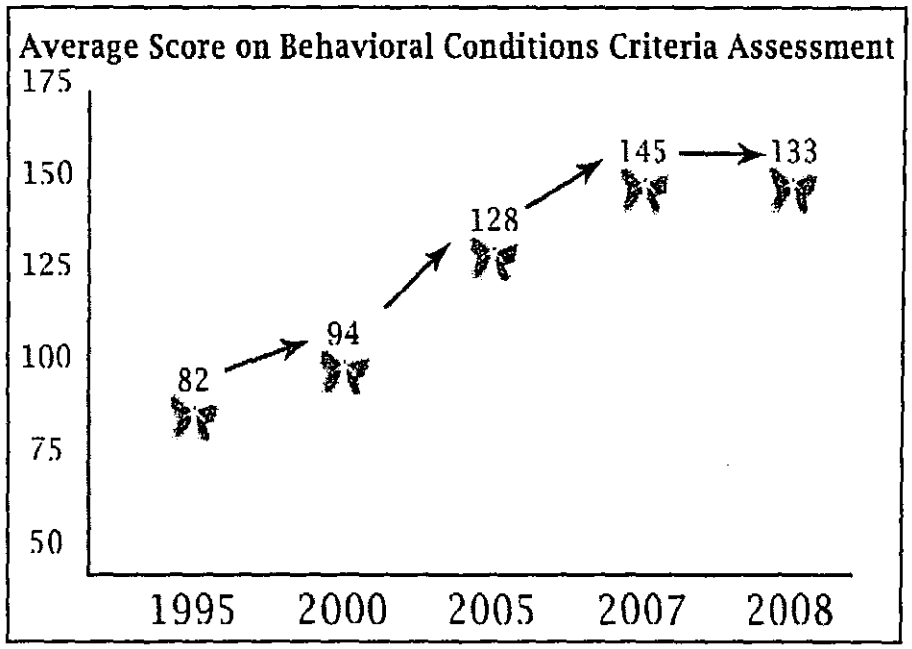
- In 2007, the ND Legislature provided a 4-percent increase in funding *(due to inflation)* in the first year of the biennium, and a 5-percent increase in the second year of the biennium. Lawmakers also approved a 60 cent/hour wage increase for employees. Progress has been made, but more is still needed for ACC to continue to provide quality care to those who need it most.

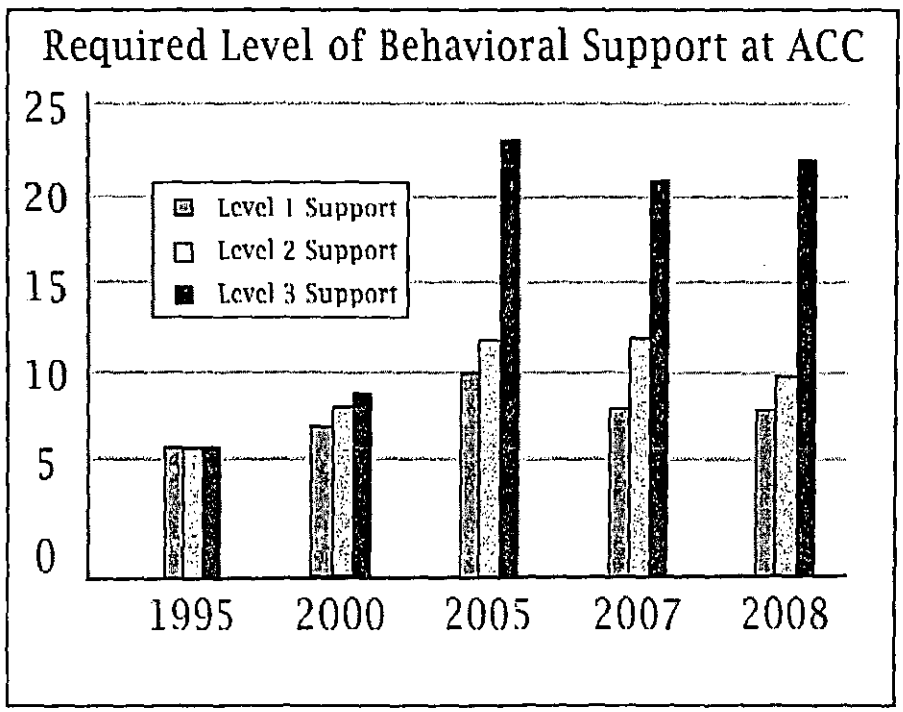
- If North Dakota's most severely behaviorally-challenged children were not at ACC, they would likely be in facilities out-of-state, at a far greater cost to North Dakota.

Anne Carlsen CENTER

COMPARISON

Behavioral Supports Summary





OREGON SCALE CRITERIA SCORES AND BEHAVIOR SUPPORT LEVELS

Level 1
1-50
(*noncompliance, mild symptoms associated with ADHD and self-stimulatory behavior*)

Level 2
51-119
(*mild forms of self-injury, aggressive behavior and property damage*)

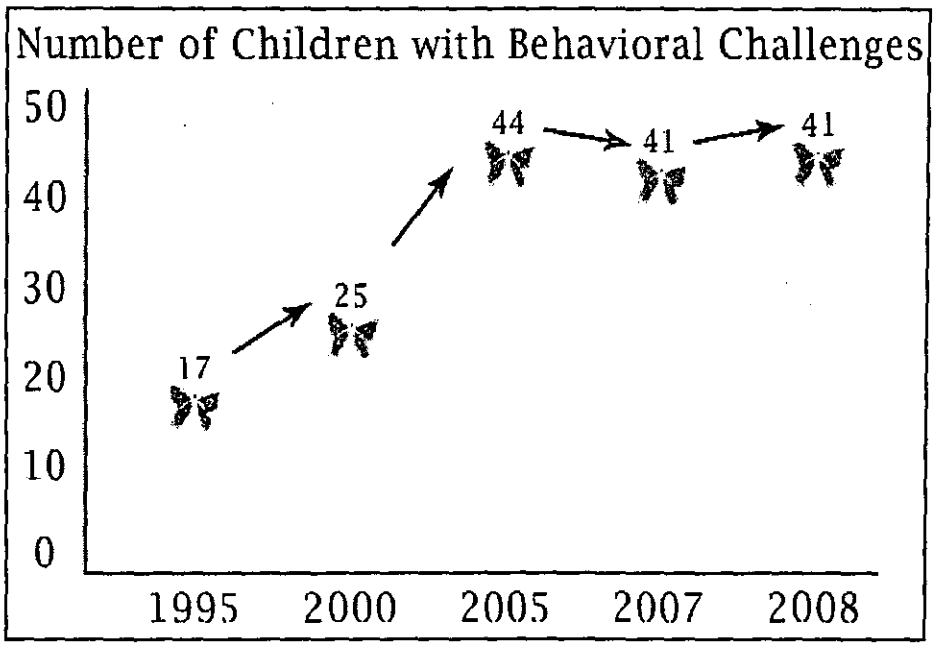
Level 3
120-200
(*Elopement/AWOL; significant forms of self-injury, aggressive behavior and property damage; sexually acting out behavior*)

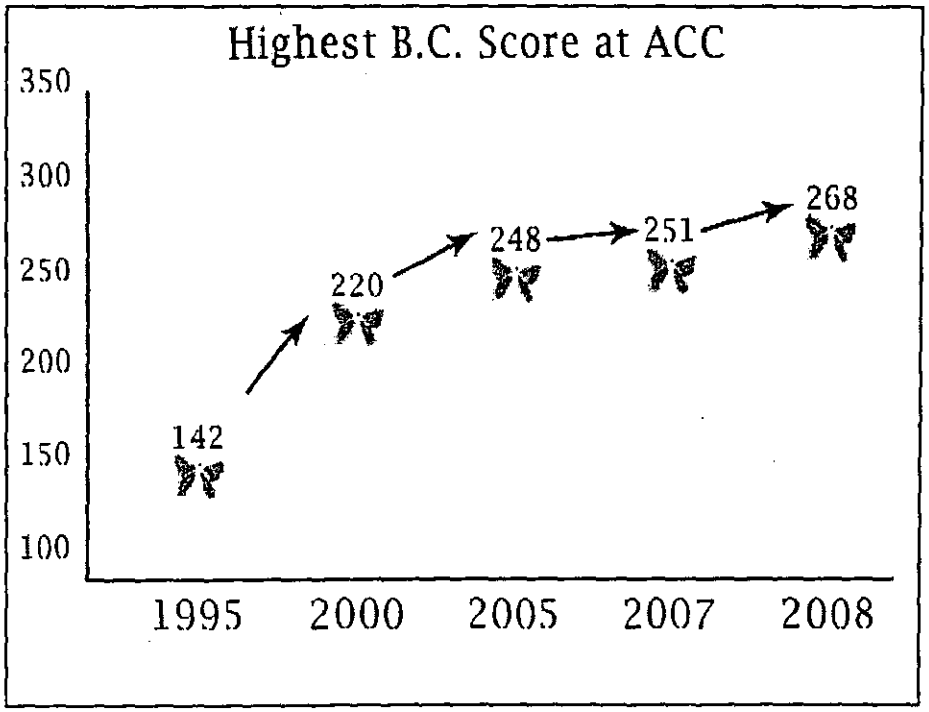
Level 3+
above 200

Anne Carlsen CENTER

COMPARISON

Behaviorally-Challenged Level Changes





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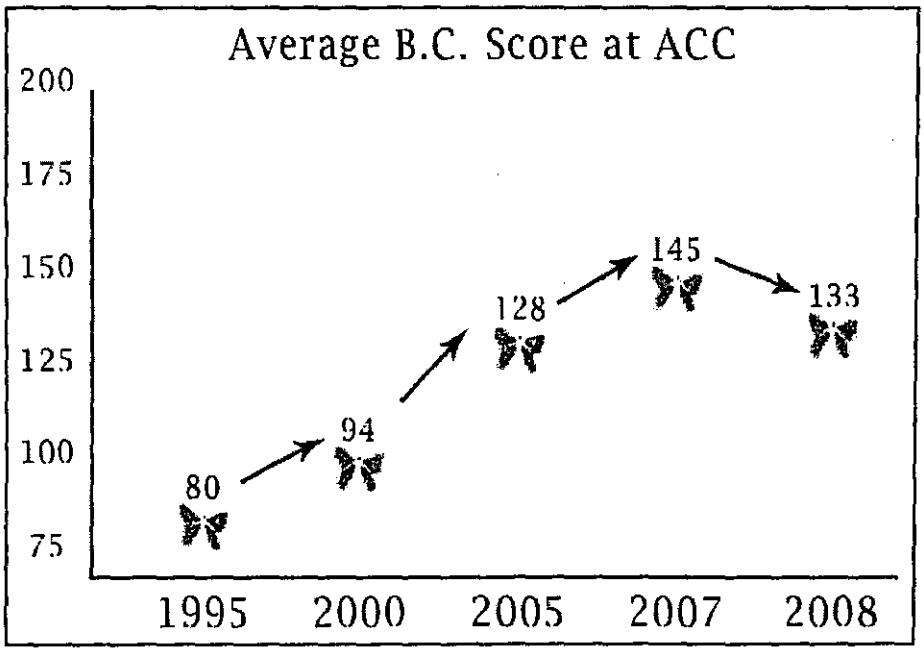
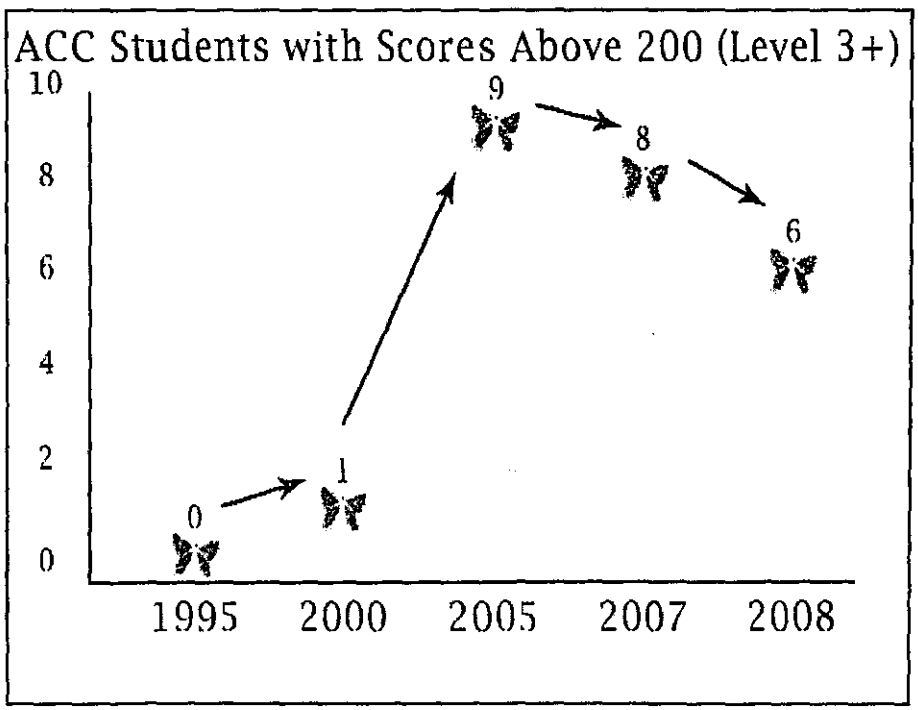
Anne Carlsen CENTER

COMPARISON

Behaviorally-Challenged Level Changes *(cont'd)*





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Level 3+
above 200

ANNE CARLSEN CENTER
Positive Behavior Support Plan

Name: M.L.
Date of Birth: November 3rd, 1995 **Age:** 12 years, 10 months
Date of Review: October 8th, 2008 **Approved Through:** October 31st, 2009

Diagnosis: Autism and Moderate Mental Retardation

Background: M.L. is a 12 year old boy who resides in the Horseshoe Park Neighborhood and attends school at ACC.

Positive Behaviors: M.L. is an affectionate young boy who has a wonderful smile/laugh. Over the past couple of years, his verbal speech has increased significantly. M.L. enjoys helping others and takes pride in his work. He is tidy and likes to have things in "their place" and organized. M.L. loves being outdoors.

Targeted Behaviors:
1. Aggression towards others – defined as attempting to bite, grab, slap, or kick others.
2. Aggression towards self (SIB) – defined as biting hands, hitting his head, and banging his head against hard-surfaces.
3. Elopement – defined as wandering away from others (safety issue).

Previous Interventions:
Medication
Time-out
Structure and Routine
Specialized Diet
Physical Restraint
Communication Training

Functional Analysis:
1. **Environmental Variables:**
   - **a. Medications the person is taking and potential side effects:**
     - i. Medications:
       1. Risperdal (0.625mg in the am, 0.375mg at 12pm, 1mg in the evening) and 0.25mg every 24 hours if needed for agitation.
       2. Paxil (20mg at hs) for OCD type behavior.
     - ii. Most common side effects for both medications may be:
       1. Insomnia, Agitation, Anxiety, Extrapyramidal Symptoms
       2. Somnolence, Dizziness, Insomnia, Constipation, Headache, Diarrhea, Asthenia, Impotence
   - **b. Medical conditions or complications:**
     - i. (None)
   - **c. Psychiatric diagnosis:**
     - i. (None)
   - **d. Sleep patterns:**
     - i. M.L. generally sleeps okay. Typical his bedtime is 9pm. M.L. is usually awake between 5-6am. He is woken up at 2am to use the bathroom and then goes back to sleep.
   - **e. Unusual diet, eating routine, or food preferences:**
     - i. M.L. is on a Gluten free / dairy free diet.
     - ii. Please consult meal card for technique, strategy, and other considerations..
   - **f. Typical schedule of activities (when she goes to bed, wakes, up general routine):**

i. In the neighborhood, M.L.'s day is not set or formally structured. He does have set times/activities built into his day (e.g., mealtime, bedtime, etc.), but in a 24-hour plan format.
ii. At school, M.L. has a set daily schedule. He utilizes visual supports to assist with letting him know what comes next.

g. Predictability of daily activities (does the person know what will be happening and when):
i. As stated above, when at school, M.L.'s day is very predictable. It should be noted however, that at times, if there is an interruption to his routine/schedule, it can be very difficult on him.
ii. Schedule changes should be avoided whenever possible. When not, utilize priming to help make that change/transition less difficult.

h. To what extent is the person allowed or able to make choices on a daily basis (food, clothing, social companions, leisure activities, daily schedule, chores, etc.)?
i. During free/break times, M.L. is able to choose what item/activity he would like to do. He often makes these choices independently.
ii. When using the First...Then... (grandma's rule) paradigm, M.L. is often allowed to choose the "then" activity.
iii. M.L. can make choices by using his voice and by making choices using pictures/symbols.

i. How Many other persons are in their home and work/day setting:
i. There are seven students (including M.L.) in the classroom along with a special education teacher, a regular education teacher, and 4 paras. M.L. gets along well with all of them.
ii. In the neighborhood, shares a room with his brother and one other peer. There are a total of 14 individuals residing in the neighborhood. As for staffing, there are supposed to be 10 staff on working with the 14 children/young adults. M.L.'s room is supposed to be staffed with 3 staff.

j. Staffing Pattern and quality of staff interactions:
i. Listed directly above.

k. Nature of Demands placed on person (consider the number, how demands are made, tone of voice, body language, when demands are made, timing of the demand, ratio of positive interaction requests-especially important in escape/demand situations):
i. When working with M.L., it is important to gain his visual attention before given the demand or expecting compliance..
ii. When asking him to do something, use as simple statements (as few words as possible).
iii. If M.L. is having a difficult time, it is beneficially to use a firm but fair voice tone.

2. **<u>Functional Alternative Behaviors:</u>**

a. What socially appropriate behaviors/skills does the person have which may achieve the same outcome or function as the problem behavior?
i. <u>Aggression towards others</u> - The following is suggested:
1. M.L. can use his voice and or PECS symbols to communicate with others. This is being worked on in ST, the classroom, and the residential setting.
ii. <u>Aggression towards self (SIB)</u> - Same as above.
iii. <u>Elopement</u> – M.L. can use his voice and or PECS symbols to communicate with others as to where he would like to go or what he wants to go see.

b. Describe the person's communication abilities (complex speech, simple words or phrases, etc.)?
i. M.L.'s expressive communication skills are at a lower level than his receptive skills. He however, continues to improve with his expressive language ability.
ii. M.L. often communicates with others using vocalizations, facial expressions, body language, and verbalizations. He may also use negative behavior to communicate.

iii. ST is working on a picture exchange communication book (also using a sentence strip with the carrier phrase "I want").
iv. M.L. is encouraged by staff to use his words.
v. He often speaks softly, so he needs encouragement to speak louder.
vi. M.L. continues to display echolalia as well.

c. Describe the sorts of communication for the following areas?

i. To ask for help – will take the hand of a staff person and say "help please".
ii. To ask for attention – lying his head on the lap of staff, holding hands, sit down next to someone, eye contact, and smiling.
iii. To ask for a break – by saying "all done", leaving an area, vocalizing loudly, or wringing his hands.
iv. To show you something or someplace – taking you to the item.
v. To indicate pain or discomfort – by using communication symbols, crying, vocalizing, or self-abuse.
vi. To protest or say no – communication cards, verbalizing "yes" or "no" or simple accepting or rejecting.

d. Does the person follow verbal requests?

i. Yes...usually, as long as you have M.L.'s attention when making the request and he understands what you are asking him to do.

e. Can the person imitate a task if it is demonstrated?

i. Yes

f. How does the person respond to gestures or physical prompts?

i. M.L. does respond to gestures, but he is more likely to do so if it is paired with a verbal prompt.
ii. M.L. responds well to physical prompting unless he is in the middle of a meltdown.

g. How does the person indicate "yes" or "no"?

i. Yes – verbalize, acceptance, communication symbol.
ii. No – verbalize, rejection, communication symbol.

h. What things can you do to make the person more cooperative and to improve a teaching session?

i. Keep it simple/familiar.
ii. Follow a routine.
iii. Utilize a work station.
iv. Soft but firm voice tone.
v. Utilize priming.
vi. Utilize visual supports (e.g., schedule, First...Then...,etc.).
vii. First...Then... (alternate between work/fun)
viii. Limit distractions (work station).
ix. Need to establish limits/expectations (e.g., stay seated, definite end to a task, etc.).
x. Utilize sensory techniques/strategies to set the occasion for work.
xi. Consider lowering (not eliminating) expectations when not feeling well or having a difficult day.

i. What things can you do which would lead to noncompliance or disrupt a teaching session:

i. Give directions or expectations that he cannot understand or is not familiar with.
ii. Using the word "NO!" You need to correct responses/behavior by using words/phrases that do not use the word "No".
iii. Introduce change in schedule.
iv. Setting is too warm.
v. Requiring him to wait and not given materials or attention to help with the "wait-time".
vi. Not providing something to look forwards to or nothing to work for.
vii. Not establishing definable limits or expectations.
viii. Not using sensory strategies when struggling.

j. **What things tend to be positive, enjoyable or reinforcing for the person (e.g., events, activities, objects, people)?** *The following is a non-exhaustive list of preferred activities/objects:*

i. PLAYING OUTSIDE!
ii. FAMILY!
iii. Swinging (must be controlled or he can become over-stimulated)
iv. Water play / swimming (especially at the YMCA)
v. Food
vi. Going out to eat
vii. Favorite books
viii. Watching TV/Movies (likes to rewind on VCR)
ix. Computer (emerging)
x. Being around his peers
xi. Various sensory activities
xii. Having his shoes off
xiii. Bouncing on large therapy balls
xiv. Puzzles
xv. Gross-motor room
xvi. Home-economics (cooking)
xvii. Delivery chores/jobs
xviii. Snow-sledding
xix. Gym activities
xx. Matching games
xxi. Going for walks

3. **Antecedent Variables:**

a. What time of day is the target behavior(s) most likely to occur?

i. Aggression (others) – No specific time.
ii. Aggression (self) – No specific time.
iii. Elopement – No specific time..

b. What time of day is the target behavior(s) least likely to occur?

i. Aggression (others) – No specific time.
ii. Aggression (self) – No specific time.
iii. Elopement – No specific time.

c. Where is the target behavior most likely to occur?

i. Aggression (others) – Nowhere specific.
ii. Aggression (self) – Nowhere specific.
iii. Elopement – When outside and he perceives nobody is watching him.

d. Where is the target behavior least likely to occur?

i. Aggression (others) – In the pool or on the playground.
ii. Aggression (self) – In the pool or on the playground.
iii. Elopement – When inside and engaged in an activity.

e. With whom is the target behavior most likely to occur?

i. Aggression (others) – Can occur with anyone.
ii. Aggression (self) – Can occur with anyone.
iii. Elopement – Can occur with anyone.

f. With whom is the target behavior least likely to occur?

i. Aggression (others) – Can occur with anyone.
ii. Aggression (self) – Can occur with anyone.
iii. Dropping – Can occur with anyone.

g. What activities are most likely to lead to a target behavior?

i. Aggression (others) – Nothing specific.
ii. Aggression (self) – Nothing specific.
iii. Dropping – Nothing specific.

h. What activities are <u>least</u> likely to lead to a target behavior?

i. <u>Aggression (others)</u> – While swimming, playing outside, or during break-time.
ii. <u>Aggression (self)</u> – While swimming, playing outside, or during break-time.
iii. <u>Elopement</u> – While engaged in a preferred activity and nothing else "catches his eye".

i. Are there particular situations or events, which "set off" the target behavior?

i. <u>Aggression (others)</u> – Transitioning to an activity that he may not want to do or that is "out of routine.". This is especially true when transitioning from a very preferred activity (e.g., playing outside). This behavior is also more likely if he is not feeling well.
ii. <u>Aggression (self)</u> – Transitioning to an activity that he may not want to do or that is "out of routine.". This is especially true when transitioning from a very preferred activity (e.g., playing outside). This behavior is also more likely if he is not feeling well.
iii. <u>Elopement</u> – Is more likely if staff attention is taken away from him and there is water close by.

j. Are there any particular situations or events, which never (or almost never) lead to the problem behavior?

i. There are no guarantees, however, as stated above, if engaged in a very preferred activity such as playing outside, it is unlikely that he will have a meltdown or engage in the targeted behaviors.

4. <u>Consequence Variables:</u>

a. **Based on the above analysis as well as interview and observation – what do you think is the function of the target behavior? List for each target behavior.**

i. Based on interview information, observation, and the Functional Analysis Screening Tool, M.L.'s aggressive behavior towards himself or others serve the primary function of escape or task avoidance. That being said, there are also components of his diagnosis of Autism that also come in to play in that he has significant sensory issues, difficulty communicating, and is resistant to change. Also, there is almost always an increase in aggressive behavior when he is not feeling well.

<u>Behavior Change Procedures</u>

1. <u>Prevention of identified Behaviors:</u>

a. What are the best bets for preventing the target behavior based on the above information? Be as clear as humanly possible. Address each target behavior.

1. <u>Aggression (others)</u> - Utilize the following:
    1. Utilize Priming.
    2. Utilize Social Reinforcement (i.e., praise and high-fives) and affection.
    3. Utilize Premack (First...Then...)
    4. Be aware/cognizant of his not feeling well. Notify nursing to see if there is something that can be given for pain or illness.
    5. Stick to his schedule/routine.
    6. Provide access to preferred activities when possible.
    7. Stick to dietary guidelines.
    8. Utilize sensory calming strategies (especially before school each day).
2. <u>Aggression (self)</u> - Utilize the following:
    1. Same as above.
3. <u>Elopement</u> -
    1. Be very aware of his likelihood or possibility to engage in this behavior. This is especially true when outside and if there is water around.
    2. Stay within arms reach of M.L. when in this type of situation.
    3. Follow the outdoor strategies listed at end of this document.

2. **Enhancement or alternative (positive) behaviors:**
    a. **What's the best bet for making sure the alternative behaviors, which will be replacing the target behavior, occur? Be as clear as humanly possible. Address each target behavior.**
        1. Aggression (others) –
            1. As stated throughout this document, staff are working with M.L. so that he can communicate choices, desires, acceptance, rejection by either using his voice and or PECS symbols.
            2. When M.L. is starting to get upset, encourage him to use his voice or provide him with picture symbols so he can let you know what he wants.
        2. Aggression (self) –
            1. Same as above.
        3. Elopement –
            1. Same as above.

3. **Reaction to identified behaviors:**
    a. **Once a target behavior has occurred, what is the plan of action – outline in steps from least to most intrusive as clearly as humanly possible. Address each target behavior.**
        1. Aggression (others) – Utilize the following:
            1. Verbal prompt to stop and block attempt to strike out at you with his hands, feet, or mouth. ***(Encourage M.L. to use his voice to tell you what he wants or what is wrong)***.
            2. If necessary, hold-his hands briefly while repeating your verbal prompt to stop.
            3. Utilize sit-n-watch timeout procedure:
                a. He is to sit calmly in a chair for 3-minutes to regroup. Utilize a visual timer to help indicate "the end".
                b. If M.L. is really struggling, it may be beneficial to reducing the time criterion. If so, just make sure he is calm for at least 30-seconds.
            4. As a last resort, utilize a baskethold (safety restraint) as instructred in Therapeutic Intervention (T.I.). Remember to document its use on a restraint log and deliver to nursing and behavior analyst as soon as possible.
        2. Aggression (self) – Utilize the following:
            1. The same process is used for his self-injury as for the aggression towards others. The only difference is:
                *a. Unless he is hitting his head with his hand-very hard, biting to a point where he is breaking the skin, or if he is banging his head...**ignore the behavior** when possible for a couple of minutes as it will often stop on its own.*
        3. Elopement – Utilize the following:
            1. Provide a verbal prompt for M.L. to "STOP" and run after him.
            2. Have him come back to where he took off from. Utilize a come-along to escort him back to where he was supposed to be if necessary.

In addition to the above, there are protocols developed for both swimming and when outdoors. They are as follows:

Swimming:

- Give M.L. a choice of whether or not he wants to swim. You can ask him for a verbal response, but you will get a more reliable response if you use a YES / NO card.

a. If he is upset while walking down to the pool or once he is ready but isn't in the pool yet...don't push it. Give him time to calm or perhaps avoid the pool all together.
b. If he chooses not to swim during P.E., he can do another structured activity (e.g., riding bike) in the gym.
c. If he chooses not to swim during evening swim, give him some other activity options.

- If M.L. chooses to swim, he is expected to follow these rules (please review them with him prior to getting into the pool):
  d. No climbing on people.
  e. No rough play.
  f. No grabbing people.
  g. No running if he gets out of the pool.
- M.L. is expected to remain in the pool area for at least 10-minutes. If he makes it through 10-minutes, he is expected to do another 10-minutes (keep increasing by 10 minute intervals). Although it is our goal, he doesn't need to remain in the pool for 10-minutes, just in the pool area.
- If he gets out of the pool during the 10-minute interval or if he is very agitated while in the pool, he is expected to sit nicely (Cool Down Time).
  h. This can be done on a chair, or preferably the mat that will be made available for him (it will be located right next to the drinking fountain).
  i. Encourage him to have a cold drink as the heat does affect him.
  j. Use the visual timer to indicate the 10-minute intervals.
  k. If he gets out of the pool for a while and is behaving well and then decides he wants to get back in the pool, please let him.
- If M.L. is getting out of the pool and running around or keeps getting in and out of the pool, ask him to go Cool Down and if necessary, escort him there. Do not chase him around the pool. There is usually one person sitting on each side of the pool, so just stop him as he goes by.
- Also keep a large towel next to the pool. If he is ever in a meltdown while in the pool or pool area, do not attempt a physical intervention/hold in the pool. Assist him out of the pool, dry him down with the towel and do a baskethold on dry land. When doing a baskethold, either do it in a chair or while seated on the ground...and make sure that someone is holding his legs. When trying to secure the legs, be careful when trying to get a hold of them as he kicks hard. Always watch a person's head as well (don't have it within striking distance of your head).

Outdoors / Off Campus:

- Structure outside walks and off campus outings so that there are other staff in the immediate area. When going in a group, stay with the group. M.L. can continue to go to the ACCC playground with a staff person that knows him well but that staff person needs to be engaged in what M.L. is doing and not just let him wander.
- M.L. should be highly supervised when walking with a group through potential hazard areas. "Sandwich" M.L. between staff and hold his wrist and/or hand to get past potential hazards. [For example but not limited to, crossing a street or crossing the railroad tracks, when walking around bodies of water]
- When approaching a potential hazard, verbally prepare M.L. in the following way: "M.L., I need to hold your hand to keep you safe because we are walking by _____ and this can be dangerous." After: "Thanks you for letting me hold your hand and help keep you safe from danger."
- When walking on sidewalks have M.L. walk on inside and staff on street side and try to anticipate what might catch his attention or things that he might impulsively run toward.
- Staff who know M.L. and his programming well should be assigned to him when going out on walks or off campus. His direct staff assignment in this situation should not be a new staff that has not been specifically trained on his programming or has not passed employment probation period.
- M.L. needs to have a staff directly assigned to him when outside. He should not be pared with another student outside around potentially dangerous situations due to his impulsiveness and lack of safety skills.
- The use of a tether (try and conceal) can also be used when the staff to student ratio is not ideal.

k vs. risk analysis: What are the risks of the plan vs the risks of not having the plan – risks of dications versus not taking them – risks of rights restrictions vs. not having them etc.?

- It is important that M.L.'s inappropriate, aggressive behavior, and his attempts at hurting himself decrease by providing him the support that he needs to develop alternative/appropriate replacement behaviors and/or increase his expressive communication skills. Therefore, efforts need to focus and teaching him alternative ways to communication frustration, when he needs a break, etc.. Efforts are also being made to meet his sensory needs and getting him to become more tolerant or less resistive to change.
- Current rights restrictions as identified in M.L.'s IHP are seen as necessary for learning and safety. These restrictions are approved by his parents, team, and Human Rights Committee and reviewed at least annually.

Fading: Some of the restrictive procedures utilized in this PBS (i.e., level of supervision, physical redirection, and come-along, physical blocking, holding of hands, and baskethold) will be assessed for the possibility of reducing/eliminating them from his program if/when the frequency of his negative behavior (i.e., aggression and elopement) decreases to zero (or near zero) levels for 3 of 4 months.

Generalization and Maintenance: To promote Generalization of skills, M.L.'s program will be followed by all staff at ACC that work with him. To assure maintenance of skills, the supports will continue in his program as needed.

Team consensus and staff training: Prior to her plan being implemented, parent/guardian approval is required. Staff were consulted during the writing of the plan and their input proved to be invaluable. As for staff training, each staff person that works with M.L. will be required to read this program and it will be ıssed at subsequent classroom meetings as necessary.

Data collection: Data will continue to be collected with regards to the frequency of M.L.'s target behavior as well as more detailed data collection if/when a physical safety restraint is performed.

Thomas Gaffaney, Behavior Analyst

Anne Carlsen Center
Positive Behavior Support Plan

Name: S.S.
Date of Birth: October 29th, 1990 **Age:** 18 years, 1 month
Date of Approval: December 3rd, 2008 **Approved Through:** December 31st, 2009

Diagnosis: Moderate Mental Retardation, Pervasive Developmental Disorder, Anoxic Brain Injury and Encephalopathy due to Hypoxic Ischemic Insult at birth, Seizure Disorder (by history.

Background: S.S. is a 18-year old young man who moved to the Anne Carlsen Center on April 1, 2003.

Positive Behaviors: S.S. is generally a pleasant young man who is fun to be around. He has a great sense of humor and a likeable personality around those that he is comfortable with. S.S. has a dynamic vocabulary and good word usage. He is very expressive through the use of his verbal communication as well as his body language.

I. **Targeted Behaviors**

a. Invasion of Personal Space – involves, touching others (with the obvious exceptions of tapping a person's shoulder to get their attention, shaking hands, and hugging family members), and/or sitting/standing to close to someone.

b. Aggression – hitting self or others with his hand, pinching and scratching directed towards others, and disrupting property.

c. Sensory Overload (Extreme Negativism) – Making negative comments about people, places, and activities.

II. **Previous Interventions**

- Medication.
- Picture Symbol and Word Schedule (both group home and school)
- Timeout

III. **Functional Analysis**

a. **Environmental Variables**

- **Medications the person is taking and potential side effects:**
  - Zyprexa (2.5mg @ 7am, 3.75mg @2pm, and 10mg @ 8pm). Medication is used for behavioral control. Side-effects can include: lethargy, agitation, insomnia, headache, nervousness, hostility, tremors, dizziness, motor restlessness, weight gain, and Tardive Dyskinesia.

  - Depakote (375mg @ 7am, 2pm, and 8pm). Medication is used for seizure control and mood. Side-effects can include: sedation, nausea, vomiting, anorexia, tremors, drooling, and elevated liver enzymes.

- **Medical conditions or complications:**
  - S.S. had complications at birth due to the lack of oxygen and a brain hemorrhage resulting in brain injury. As a result, has a seizure disorder and has learning and emotional difficulties. These include:
    - Executive brain functions (direction and organization of all behavior...both emotional and cognitive).

    - Auditory processing delays (takes extra time to process what is being said to or asked of him.

- Right visual field impairment.
- Leg length discrepancy which can lead to poor balance.

- **Psychiatric diagnosis if the person has one:**
  - None.

- **Sleep patterns:**
  - S.S. is generally a good sleeper. He usually goes to bed between 8:00-8:30pm and wakes up between 7:30-8:00 am.

- **Unusual diet, eating routine, or food preferences:**
  - S.S. is usually a good eater. If he doesn't like what is being prepared, he can assist staff in making something else. He is currently on a regular diet and can have seconds if he desires. S.S.'s sweets are limited, he is to have only 100% juice, small portions of desserts, and please limit products with artificial sweeteners.

  - S.S. has Breakfast and Snack menus in the cottage from which he can make choices.

- **Typical schedule of activities (when go to bed, wake up, general outline of week):**
  - S.S. has a daily schedule in the classroom where his day is broken down into 30-minute intervals. He also has a Daily Planner, where his activities are written down in the order in which they occur. This list is done on a ½ day interval. S.S. is also starting to use a Daily Activity Planner.

  - In the home setting, S.S. uses the same TO DO LIST, where he and staff review what activities he has to do and wants to do (choices) and again, they are written down in the order in which they will occur. He has some "free time in the cottage (more so on the weekends), but much of is day is scheduled to help provide structure and routine. Some set daily activities in the home setting include:
    - Laundry.
    - Chores.
    - Exercise (1-3 times per day).
    - Bath/Shower in the morning.
    - Calming time before bed.
    - Church (each Sunday with mom).

- **Predictability of daily activities (does the person know what will be happening and when):**
  - As stated above, most of S.S.'s "classroom day" and much of his "home day/evening" is scheduled and very predictable. If any changes occur, S.S. needs to know about them as soon as possible (preferably 1-2 days in advance if possible).

- **To what extent is the person allowed or able to make choices on a daily basis (food, clothing, social companions, leisure activities, daily schedule, chores):**
  - Some of S.S.'s activities associated with his schedules are set. However, others aren't necessarily, and he can have some flexibility with regards to the order.

  - S.S. is allowed to choose snacks, what he eats at meals, etc. with some restrictions based on calories, sweets, etc..

- S.S. is allowed to choose what to do during free time and for most of his leisure activities. Staff encourages his participation with others.
- He is allowed to choose the clothes that he wears.

- **How many other persons are in their home and work/day setting:**
  - Residential – S.S. has his own bedroom in the Summer Cottage but resides with a group of seven other children/young adults. At any given time (during non-sleeping hours) there are five staff working in the home.
  - Classroom – S.S. is one of seven students in his classroom. There are five staff who work in the room.

- **Staffing pattern and quality of staff interactions:**
  - S.S. has direct supervision to line-of-site during waking hours.

- **Nature of demands placed on the person (consider the number, how demands are made, tone of voice, body language, when demands are made, timing of the demand, ratio of positive interaction requests – especially important in escape demand situations):**
  - When working with S.S., please use a calm voice.
  - It will be helpful to utilize the Premack Principle (IF…THEN), especially if you are working on a "less-preferred" activity.
  - Utilize a timer, so S.S. knows how long he needs to work on something.
  - Priming

b. <u>Functional Alternative Behaviors</u>

- **What socially appropriate behaviors/skills does the person have which may achieve the same outcome or function as the problem behavior:**
  - S.S. <u>is learning</u> the social rules and personal space boundaries but doesn't always follow them. Therefore, he will require reminders, especially when over-stimulated and/or distressed.
  - At times S.S. is able to communicate frustration verbally as opposed to being aggressive towards himself, others, and property.
- **Describe the person's communication abilities (complex speech, simple words or phrases):**
  - S.S. is able to communicate verbally with others at times. However, it may take him longer to process what you say to him and longer for him to put together the idea or sentence that he wants to say to you. Please be patient. He also tends to talk softly, so you may need to respectfully ask him to repeat what he said and to use a louder voice.
  - S.S. is beginning to develop the ability to communicate a range of feelings/emotions. At the present, he often requires curing or modeling to recognize/label the appropriate feeling.
- **Describe the sorts of communication for the following areas:**
  - <u>To ask for help</u> – verbal ("I need help").

- To ask for attention – verbal/physical (will tap you on the shoulder or just start talking).
- To ask for a break – verbal, but may also display a negative behavior.
- To show you something or some place – verbal or gesture (will often point or lead you to something)
- To indicate pain or discomfort – verbal.
- To indicate frustration – verbal or negative behavior.
- To protest or say "no" – verbal or negative behavior.

- **Does the person follow verbal requests or instructions:**
  - Yes, when stated in simple terms and given time to process what is asked of him. It may be beneficial to also use gestures, written word, etc. to communicate with S.S.

- **Can the person imitate a task if it's demonstrated?**
  - Yes, but depends as he does have poor hand-eye coordination. He needs reminders to use his right hand.

- **How does the person respond to gestural or physical prompts?**
  - Does fine with gestures.

- **How does the person indicate "yes" or "no"?**
  - Verbally states "yes" and "no".

- **What things can you do to make the person more cooperative to improve a teaching session?**
  - Respect S.S.'s feelings and recognize that at times he has difficulty controlling his emotions. Do not get frustrated or angry when S.S. gets upset, emotional, cries, etc.. Acknowledge this behavior (i.e., ask him what is wrong) and work through it.
  - Utilize a calm voice.
  - Utilize Premack
  - Utilize Priming (e.g., "We have to stop this and do ____ in a two minutes.").
  - When you are doing more than one work activity, give S.S. a choice of which one he wants to do first if possible…this gives him some control.
  - Alternate between work and play/leisure activities.
  - Utilize a timer to indicate completion of the work time when applicable.
  - Quiet setting.
  - Respect S.S.'s physical workspace.
  - Follow the steps listed in *attachment #3.*
  - Use fewer words, rather than more.
  - Be as positive, pleasant as possible and encouraging.

- **What things can you do which would lead to non-compliance or disrupt a teaching session?**
  - If you are too firm, negative, you will have difficulty with S.S.
  - Work, work, work….with no play.
  - Noisy work environment is not conducive for S.S. to focus.
  - Large groups do not go as well as small group or individual instruction.
  - If the work session is too long (try to keep it to 15-20 minutes maximum).

- Too much verbal prompting with not enough time to process what you said to him.
- Sarcasm…viewed as mocking.

- **What things tend to be positive, enjoyable or reinforcing for the person (events, activities, objects, people)?**
  - Spending time with family
  - Computer
  - Music (hip/hop)
  - Keyboard
  - PBS television shows
  - Eating
  - Reviewing weather information via the internet, newspaper, or TV
  - Visiting/interacting with others
  - Journal entries (positive statements only…not referencing negative behavior)
  - Animated movies

c. <u>Antecedent Variables</u>

- What time of day is the target behavior **most** likely to occur?
  - Nothing specific, can occur at anytime.
- What time of day is the target behavior **least** likely to occur?
  - Nothing specific, can occur at anytime.
- Where is the target behavior **most** likely to occur?
  - School, more demands.
- Where is the target behavior **least** likely to occur?
  - Community and home setting.
- With whom is the target behavior **most** likely to occur?
  - No one specifically.
- With whom is the target behavior **least** likely to occur?
  - No one specifically, although less likely to occur with his mother.
- What activities are **most** likely to lead to a target behavior?
  - Exercise and Gym times.
- What activities are **least** likely to lead to a target behavior?
  - Computer time and watching movies.
- Are there particular situations/events, which "set off" the target behavior?
  - The following can set off some negative behaviors:'
    - Crowded setting (lots of people).
    - Noisy environment.
    - Some transitions (use Premack and priming to help).
    - New activities or schedule changes.
    - Sarcasm – S.S. perceives this as mocking him.
    - Using too many words or directives given together.
    - Using too complex of sentences.

- Are there particular situations or events, which never (or almost never) lead to the problem behavior?
  - Watching movies.
  - Computer time.

d. <u>Consequence Variables</u>

Based on the above analysis as well as interviews and observations – what do you think is the function of the target behavior? List for each target behavior.

- Invasion of personal space – Function appears to influenced by impulse control issues, attention seeking behavior, lack of understanding appropriate behavior, and asserting control.
- Aggression – impulse control, issues, task-avoidance, frustration, and asserting control.
- Sensory overload (extreme negativism) – difficulty with emotional regulation, and a response to anxiety.

IV. Behavior Change Procedures

a. Prevention of identified behaviors

- **Invasion of personal space –**
  - Review S.S.'s social rules with him (attachment #2). Post them so that he can read them to you as opposed to you reading them to him.
  - Role-play appropriate social behavior throughout the day and praise S.S. when is appropriate.
  - Review Social Story (attachment #1). Again, have S.S. read it.
  - Sex Education and social skills training.

- **Aggression –**
  - Utilize S.S.'s schedule (Daily Planner).
  - Alternate between "less preferred" and preferred activities.
  - Utilize priming and Premack strategies.
  - Use calm voice. Do not get upset with S.S..
  - Do not use sarcasm with him; he perceives that you are mocking him.

- **Sensory overload (extreme negativism) –**
  - This behavior is difficult to predict as typically there is no forewarning. He can be in a great mood one second and then go to the other extreme the next.

b. Enhancement of alternative behaviors

What's the best bet for making sure the alternative behaviors, which will be replacing the target behavior occur? Be as clear as humanly possible.
Address each target behavior.

- **Invasion of personal space** – in addition to what is listed directly above, the following may be helpful:
  - Reminders and role play on how to great and interact with others such as shaking a persons hand and interacting at arms length without touch.
  - Sex Education and social skills training.
  - Allow S.S. private time in his room if he desires.

- **Aggression –**
  - Prime S.S. that if he needs a break to ask for one.
  - Encourage S.S. to express his emotions verbally as opposed to physically and praise him when he does. He has made improvements in this area over the past year and we want this to continue.
  - Do Problem Solving Sheets

- **Sensory overload (extreme negativism) –**
  - Allow S.S. some time to calm/regroup and then:
  - Do Problem Solving Sheets

c. Reaction to identified behaviors

Once a target behavior has occurred, what is the plan of action – outline in steps from least to most intrusive as clearly as humanly possible. Address each target behavior.

- **Invasion of personal space –**
  - Verbal prompt to stop the behavior (calm voice). Praise if he stops the behavior.
  - Role-play what he should have done instead.

- **Aggression -**
  - Verbal prompt to redirect the behavior.
  - Praise if she stops the behavior and review what he should have done rather than being aggressive towards self, others or property.
  - If he doesn't stop it can be helpful to send S.S. on a mission or task. Often transition from the current activity/setting helps him calm.
  - It can be helpful to introduce a new staff person (although this person needs to be familiar to S.S.) to work with S.S.
  - If Aggression continues, you may have to hold his hands.
  - Once the behavior is over and S.S. is calm, have a teaching interaction (what he could have done instead...such as verbally stating his frustration).
  - Role-play appropriate behavior.

- **Sensory overload (extreme negativism) –**:
  - Verbally interrupt the behavior and redirect to a positive or neutral discussion.
  - Again, a new setting (mission) or new person may break the behavior chain.
  - Develop an action plan and review it. Utilize Premack in doing so. Problem Solving worksheets as well once calm (or at least not as negative).

Risk vs risk analysis: The potential result of some of S.S.'s behavior is that of social isolation and at times a safety concern for those who live and work with S.S. Therefore, this program is designed to try and prevent these behaviors by continued promotion of S.S. using verbal communication, problem solving skills and structuring his environment in such away that he can be successful. There are some restrictive measures within the plan (holding his hands) as well as his rights restriction document (supervision level). At this point, these strategies are seen as appropriate steps to be taken.

Team consensus and staff training: Prior to this plan being implemented, parent approval is required. Staff were consulted during the writing of the plan and their input proved to be invaluable. As for staff training, each staff person that works with S.S. will be required to read this program and it will be discussed at subsequent Cottage/home meetings and with classroom staff. Further training and monitoring of the program being will be done by S.S.'s Teacher, Home Coordinator, and his Home Team Leader.

Data Collection: Data will continue to be collected with regards to the frequency of S.S.'s target behavior as well as extreme mood swings.

Thomas Gaffaney, Behavior Analyst

[redacted]ttachment #1

[redacted]OCIAL STORIES

Greeting others

- When I greet people, I say "hi and am friendly to others.
- I ask people their names when I don't know who they are (e.g., "Hi, my name is ____, what is your name?").
- I shake a new friend's hand when I am being introduced to them.

TOUCH

- I do not kiss or hug people that I just met, or my roommates, or my classmates or those that work with me. I also keep my hands to myself except for when I shake someone's hand.
- I do not touch people on their heads or faces because they may not like that.
- I do not lean on people or stand too close to them (arms distance). If I am tired, I should sit down in a chair.
- I do not ever touch people in their swimsuit or private part areas.
    - For girls, a swimsuit would cover their chests and on the front and back of their bottoms. I should not touch them there.
    - For boys, a swimsuit would cover the back and front of their bottoms. I should not touch them there.

[redacted]NG FRIENDS

- I will greet my friends with a nice smile, hello, and a handshake. I do not hug my friends.
- We do fun things that we both enjoy, and we take turns deciding what we are going to do.
- I am nice when I am with my friends, and don't get upset with, scream at, or hit out at my friends.
- When our time together has ended, I will say thank-you and good-bye until next time.

GOOD TOUCH AND RESPECTING OTHER'S PERSONAL SPACE (Social Story)

- I know it is important for me to keep my hands to myself and where they belong.
- I know my hands do not belong on other people.
- I should be respectful of other people's personal space.
- To Respect Other's Personal Space: I must keep my hands to myself. I do not touch others unless I am shaking hands or hugging a family member like my mom. I also do not stand too close to or lean on other people.

Attachment #2

HOUSE/COTTAGE RULES

- I do not go into others' bedrooms.
- I do not invite or take other students into my bedroom.
- I do not wander into areas of the home/cottage where I have not been invited.
- I do not talk about private parts to others.
- I do not touch the private parts of others.

[redacted]ttachment #3

WHEN WORKING WITH S.S., IT IS HELPFUL IF:

- Get rid of boredom. Plan the evening on S.S.'s PLANNER and work with him to make choices of activities.
- Go with S.S. to use the restroom every 60-90 minutes.
- Realize if you are frustrated with S.S., he can sense that and chances are he is also frustrated with you. Switch with another staff if you have to.
- Give choices and keep S.S. activity/busy. Reduce your verbal commands/directives and when talking to S.S., give him at least 15 seconds processing time to respond. And please leave him in his room by himself when he is behaving inappropriately as your presence/interaction can escalate the behavior.
- If you know that S.S. is being inappropriate, calmly redirect him to be "appropriate" (using that term) for the current activity. If necessary, tell him ways that are appropriate.
- Don't let him get in staff or peers personal space. He does not need to touch anyone's hair, lean on them, etc.. He can give an appropriate handshake and respect other's personal space.
- Be positive, do not show frustration, and plan creative activities that grab his interest.

Jenny Maertens and her Life Skills Assistant Amber Olson look at movies and books at the Cooperstown Library. Trips to the library and other fun activities are built into each day, balancing the time Jenny is at work and helping to create a fulfilling life.

Close to Home

ACC Opens Doors of Opportunity for Cooperstown Woman

It was an exciting time for a social, outgoing young woman. Jenny Maertens had just graduated from high school. But anticipation was quickly replaced by frustration.

When Jenny graduated this past May, she was no longer a child with a disability—she was an adult with a disability. This meant there were limited age-appropriate programs or services available for the 21-year-old in her hometown of Cooperstown.

The choices presented to her and her family were not that appealing. Jenny could move away from her mom, her dad, a handful of siblings, a grandma, and the only community she had ever known, or remain in Cooperstown and receive no help.

Jenny was born with a cognitive disability. Though she possesses wonderful qualities and many abilities that allow her to perform a wide variety of tasks, she does require some assistance.

A meeting in May, which put Jenny's Special Education director in contact with the Anne Carlsen Center, proved to be life-changing for Jenny.

Putting the Pieces into Place

Jenny has a larger-than-life personality. She seeks out conversation and connections with other people. Her mother says that

(continued)

Jenny puts the finishing touches on a cake she baked in her apartment. With supervision, she is able to learn a wide variety of kitchen skills.

was the most discouraging part about her daughter's situation. Jenny is someone who could create a fulfilling life, if just given the chance.

"It is fun working right now," said Jenny. "Oh yeah, it is really fun. I make coffee and do towels and washcloths. And I walk the dogs and lots of stuff."

ACC staff met with Jenny and her family at the end of August, crafting schedules that would play to the young adult's strengths and get her involved in her community. ACC Community Program Coordinator Laurie Skadsem visited businesses in Cooperstown, and found a variety of employers eager to work with Jenny.

"I tried adding incentives at each business and, of course, social interaction," Skadsem added. "At the nursing home, if she finishes with the towels and washcloths by 11 a.m., Jenny joins the exercise group there. Then from 11:30 a.m. to 1 p.m., she makes her own lunch, cleans up, and gets ready for her afternoon schedule."

The final piece of the puzzle fell into place when Amber Olson was considered to be Jenny's Life Skills Assistant (LSA). LSAs assist someone in performing everyday tasks, and they administer health and personal cares during therapeutic, educational, vocational, recreational and leisure activities.

"I help individuals get to know their community and communities to get to know individuals," said Olson. "With it, you don't have to uproot anyone from their community. And you can tell the community is 100-percent behind Jenny. When they see her, they always smile and say hi and ask her how it is going. They are thrilled."

Looking to the Future

Jenny's parents hope eventually their daughter can live with a roommate, though she will probably always require a certain amount of support. However, having a roommate would allow her a greater measure of independence during evenings and weekends.

And hopefully this success story acts as a springboard for others.

"I'm very, very pleased with the staff support. It has been wonderful," said Sharon of the ACC staff. "They have really made it feel like getting Jennifer in a program is a high priority. I hope Jennifer is cutting a path for others. It is so valuable for her as a person. They have really done something, and with the community being so open, I have to give Cooperstown a lot of credit, too."

A chance at a productive, fulfilling life is something the Center believes is every individual's right.

"Every kid at her age is expected to leave home and branch out on their own," added Sharon. "The Anne Carlsen Center is giving Jennifer the ability to do that, just like anyone else."

Jenny selects towels from a closet while at her apartment. The 21-year-old is learning many skills that will help her lead a more independent life.

After Trinity was severely injured in a swimming pool accident, she spent more than a month in the hospital before coming to ACC. Here, she enjoys a bedtime story read by Kristen Nagel, a nurse at the Center.

From Trauma to TLC

ACC helps Bismarck girl following devastating swimming accident

It wasn't easy keeping up with Trinity. The Bismarck youngster was the picture of good health — full of energy, full of life, and full of love for her family.

The six-year-old loved singing and dancing, Tae Kwon Do lessons, and playing games with her sister, Angel. She was getting ready to enter the first grade and was being recommended for the gifted reading program. Never one to cry or complain, she stifled the tears when she broke her collar bone while playing.

"Always smiling, dancing and singing," is the way her father, Brandon, describes her. "A quick learner ... very quick ... soaked everything up like a sponge."

On June 13, 2008, Trinity went to a Mandan swimming pool with her summer daycare program. It was supposed to be a day of fun in the sun, but it took a tragic turn. Trinity was seen standing at the edge of the pool before getting knocked in. She was under water for a dangerously long time — it's estimated between four to seven minutes — before being rescued.

Severely injured in the accident, she was hospitalized at St. Alexius Hospital in Bismarck for over a month. Her accident resulted in an anoxic brain injury (lack of oxygen to the brain). On July 23,

(continued)

she came to the Anne Carlsen Center (ACC) in Jamestown for rehabilitation services as an emergency admit.

The Center applied to be licensed for an additional bed in order to accommodate Trinity. ACC staff knew the injured girl would have had no other place to go. With her extensive medical needs, she couldn't return home. Staying at St. Alexius wasn't an option either, with hospital care costing thousands of dollars each day.

Trinity was comatose for about two months after arriving at ACC. She occasionally suffered from thalamic storming — she'd start perspiring, her heart rate would dramatically increase, and she would clench her hands. Because of her injuries, she was extremely sensitive to sensory input. Staff kept lights low to help calm her. She became anxious when surrounded by people, so they carefully monitored the number of people in her room at one time.

After those first weeks — much to the delight of her family and ACC staff — Trinity started responding to touch. She also started to smile, turn and stretch.

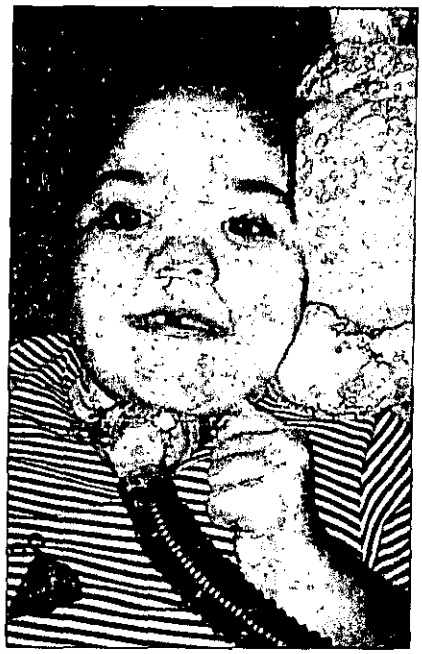
"I was excited — it brought tears to my eyes," says Stacy Jaegar, one of Trinity's nurses at ACC. "I cried the first time I saw her smile. Her personality is really shining through."

ACC staff provide Trinity with 14 hours of nursing care a day (monitoring of vital signs, rocking, feeding, administering medication, assessment) and twelve hours of care each day by a Life Skills Assistant (dressing, rocking, freshening, oral care, repositioning). She also receives 16 hours of therapy each week, which includes physical therapy, occupational therapy, speech therapy and respiratory therapy.

Trinity isn't able to eat solid foods right now — she is fed formula through a tube. Staff also administers a dozen different vitamins and medications to her.

"If it wasn't for the Anne Carlsen Center, I literally would have had to stay at home with Trinity and hire a nurse," says Brandon. "It would have been extremely difficult to care for her and take care of her sister at the same time."

In November, Trinity was feeling well enough to dress up like a princess and participate in a special event for a fellow classmate. She has started



This fall, Trinity began to come out of her coma. She started to smile, turn, stretch, and respond to touch.

leaving her room more often to spend time with fellow students, usually on a one-on-one basis. When presented with choices, such as which color crayon she likes or what shirt she wants to wear, she is able to firmly grasp the preferred item.

"It was extremely difficult in the beginning, but the more I see her, the more I am encouraged," says Brandon. "When I look in her eyes, I see the daughter I know. There is hope. She is making so much progress."

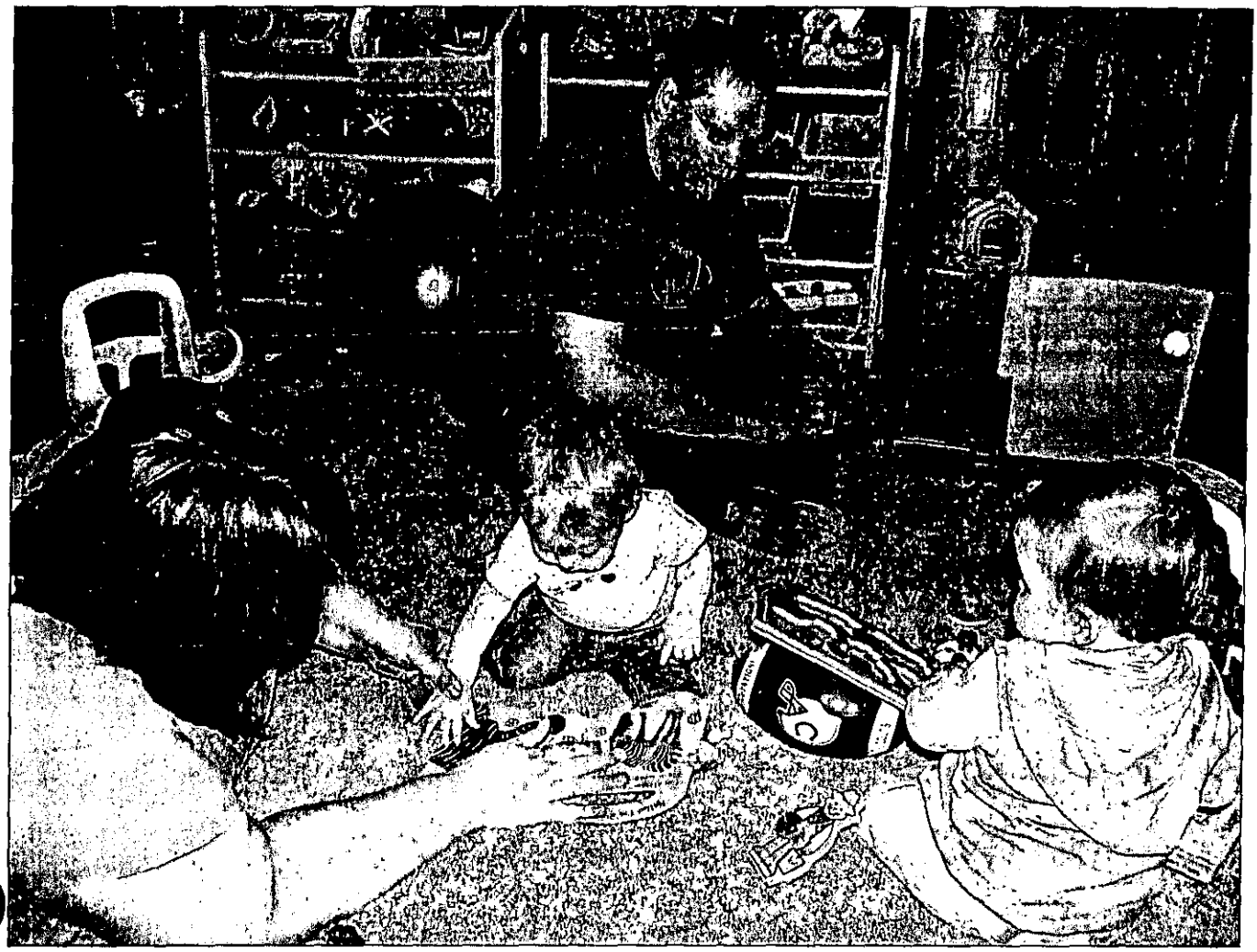
"She is very sweet and fun-loving," says Leann Gumke, a nurse at ACC. "We enjoy telling her jokes because she'll look at us and smile. She loves it when we talk about kittens or Strawberry Shortcake."

Sharon Olson, a Special Education teacher in the Early Childhood classroom at ACC, spends time each morning with Trinity. Olson visits Trinity's room with a basket full of learning tools and craft projects. Trinity will be joining her friends in the classroom in January.

The extent of the brain injury from the near-drowning isn't known. But staff members are working diligently to help restore the little girl's health and strength.

"She loves challenges," says Brandon. "The more she is challenged, the more she excels. I know she is determined to get better."

This brave little girl continues to amaze those around her with her strength and will power, spreading hope each day with every smile.



It's playtime at the Schneider house as Jennifer and Dusty spend some quality time with their twins, Jaleigh and Jaxon. The children were born nine and a half weeks early and each survived major health scares.

Hope at Last

ACC helps toddlers, parents through troubled times

The smiling faces of twins, a boy and a girl, were hiding a variety of health problems.

Jaxon and Jaleigh were born nearly 10 weeks premature. Throughout the months of health scares, their mother, Jennifer, was not able to be at her job. After a year of medical challenges for both children, she was in danger of losing her job.

Meanwhile, the twins' dad, Dusty, was trying to supplement his family's income with his construction job. Going to work with broken bones in both feet, he was struggling to make it through the work day, much less care for his children who required some extra attention. The Jamestown family was hanging on — barely — but without some kind of assistance, things were looking bleak.

In October 2007, an ear, nose and throat doctor examined Jaxon, and the little boy was rushed into surgery. Jaxon's airway was

(continued)

Jaxon investigates bubbles with Ann Albrecht, a speech language pathologist with the Anne Calrsen Center. Albrecht visits the Schneiders each week, providing care in their home.

being restricted by scar tissue that had formed around his trachea.

"The doctor told us on the outside, Jaxon looks healthy," said Jennifer. "Until you listen to his lungs. He is a fragile little boy."

The Anne Carlsen Center was called and began providing services for the family. Jaxon started attending class at the Center during the day because health problems prevented him from joining his sister at a Head Start program. This allowed Jennifer to return to work and finish out the school year. More importantly, she was now able to retain her job.

Jaxon attended ACC for just over a month, earning a measure of celebrity status there with staff through his overpowering smile and easy-going nature.

"Everyone was so nice," said Jennifer. "They'd take pictures of what they were doing in the classroom and send them home. You could just see he was so happy. I learned a lot."

Once the school year ended and Jennifer was at home full-time for the summer, the Center continued to help the family. Therapists provided in-home supports, giving the children specific attention for speech, eating and respiratory issues.

Today, the Center and the Schneiders still enjoy a relationship that sees Jaxon and Jaleigh making strides. Experts from the Center meet with the toddlers a few times a week to work on speech therapy. Both children are still experiencing some health problems, but those issues are more manageable now and no longer life-threatening. The family is optimistic about the future.

"I think back to 12 or 13 months ago," said Dusty. "I never thought we'd be at this point."

"We didn't get the perfect dream, the perfect situation," Jennifer said. "But we wouldn't trade it for anything."

Jaxon and his mom, Jennifer, read a book together. After many struggles, the future is brighter now for this Jamestown family.

Every Tuesday, Chris LaCroix folds more than 200 pizza boxes at Domino's Pizza in Jamestown. At the Anne Carlsen Center, vocational training begins at age 14.

Training for Tomorrow

Teen rises above adversity in preparation for adulthood

It's 11:30 a.m. and the mouth-watering aroma of cheese and pepperoni fills the air. At Domino's Pizza in Jamestown, N.D., half a dozen employees keep busy taking orders, spreading toppings, and sliding discs of delectably-covered dough into an enormous oven. When each pizza is finished baking, it's tucked into an appropriately-sized box—and chances are, on this day, into a box assembled by Chris LaCroix, a 17-year-old student at the Anne Carlsen Center (ACC).

"He is very energetic and very focused," says Frank Jensen, owner/franchisee of Jamestown's Domino's. "He never quits."

Others are benefitting from Chris' hard work and determination. As part of ACC's vocational training program, Chris spends time each week at two other Jamestown businesses, as well as an area church.

The contributions Chris is making in the Jamestown community are significant. Even more impressive is how far he has come in order to perform successfully in each of these settings.

Chris has autism, a complex developmental disability that typically appears during the first few years of life. It is the result of a neurological disorder that impairs an individual's ability to communicate and relate to others. Today, one in 150 individuals is diagnosed with autism.

Over the years, Chris has had difficulties with communication—verbal and non-verbal—and with social interactions. He has exhibited physical over-activity, self-abusive behaviors, tantrums, ob-

(continued)

It was a dream fulfilled when Chris LaCroix was confirmed in November at The Basilica of St. James in Jamestown. His parents, Arlene and Jerry, were beaming with pride throughout the entire ceremony.

sessive attachment to objects, and low tolerance for abrupt changes. As a child, Chris was constantly in motion ... climbing cupboards and shelves, banging his head on floors and walls, and throwing his body repeatedly to the ground.

Since becoming a student at the Anne Carlsen Center in December 2006, Chris has made significant improvements in many areas. Teachers, therapists, and other staff members have used a highly-individualized program to help Chris become more comfortable and compatible with his surroundings.

A Community Life for Chris

"His behaviors have gone way down," says Rachel Coppin, a speech/language pathologist at ACC. "He has a greater tolerance of the things that happen to him. His ability to cope has improved."

Chris is developing social and communication skills that are helping him function well during the school day—and out in the community.

That is encouraging for Chris' parents, Arlene and Jerry LaCroix of Bottineau, N.D.

"Chris needs to have a job that can get him satisfaction each day of his life," says Jerry. "We don't want him just sitting in a room watching television. He has so much to offer the world."

For most of Chris' childhood, encounters with the outside world had brought pain and disappointment. "Sometimes, when we'd go places, Chris would have a meltdown," Arlene remembers. "People didn't understand that something in Chris' environment had caused him to act that way. They would never see him for who he really was."

With the guidance of ACC staff, Chris has learned to handle most any situation in public, which has become readily apparent—and appreciated—during visits home.

Reaping the Rewards

One of the most memorable experiences happened over the summer, when the LaCroixs were able to attend a sporting event together—for the first time in many years. Chris' younger brother, Mark, was playing in a baseball tournament. Before, either Jerry or Arlene would have had to stay at home with Chris. A baseball game would have been too overwhelming for him; the sensory overload likely causing outbursts of negative behavior. But on this occasion, Mark's parents and his big brother were there to support him and cheer him on.

And while they have enjoyed watching Chris become more accepted in the community, one of their biggest dreams for their son has been to see him acknowledged in the community of the church.

"It's something we have always worked for," says Arlene. "But when we went to church, Chris would scream or stand up in the middle of the service. We'd go home and feel defeated."

On Nov. 16, that all changed. Chris, along with three other ACC students, was confirmed at The Basilica of St. James in Jamestown. He looked calm and confident as he took a major step in his journey of faith.

"It was a long wait, but a special part of his life has finally come together," said Arlene with tears in her eyes. "We didn't think this would ever happen. Chris is a member of a church now. He belongs."

The LaCroixs say they hope Chris, now 17, can live semi-independently following graduation. They picture their son having a roommate and working at a job he finds interesting and fulfilling.

"Nothing is impossible when you are working with someone who believes in you," says Arlene.

"The groundwork has been laid," adds Jerry. "Someone else knows our dreams and is working towards those dreams. We are all seeing a response. We are all growing."

Statement of Need

Senate Appropriations Committee

2009 North Dakota
Legislative Assembly

With the exception of following page same testimony given to House/Senate

Anne Carlsen

CENTER

Nurturing abilities. Changing lives.

Anne Carlsen CENTER

Funding Reimbursement Needs Summary

Staffing to Meet Medical Needs at ACC

ACC nursing FTE staffing of 28.4	$1,892,666
DHS reimbursement of 21.3 FTEs	$1,419,500
Annual Loss	-$473,166

Staffing to Meet Behavioral Needs at ACC

ACC direct-care FTE staffing of 114	$3,208,233
DHS reimbursement of 88.64 FTEs	$2,494,542
Annual Loss	-$713,691

Total Annual Loss	**-$1,186,857**

TESTIMONY
HOUSE BILL 1012
SENATE APPROPRIATIONS
SENATOR RAY HOLMBERG, CHAIRMAN
March 4, 2009

Chairman Holmberg, members of the Committee, my name is Dan Howell and for the past 9 years, I have had the privilege and honor to be the Chief Executive Officer of the Anne Carlsen Center (ACC) located in Jamestown, North Dakota.

I am here today to testify in support of HB 1012, as well as Optional Adjustment Request (OAR) #5. Specifically, in OAR #5, the line item addressing DD staffing to meet critical needs. The issues overview summary, which we have handed to you, outlines this OAR request in greater detail for the ACC, as well as other providers around the State of North Dakota. Chairman Holmberg and members of the Committee, in my testimony today I wish to cover three (3) items.

<u>Community-Based Services</u>

During the 2007 legislative session, the ACC made a promise to the North Dakota Legislature. The promise was that if indeed providers around the State of North Dakota, including the ACC would be fully recognized financially for serving children, as well as adults with complex special needs, that the ACC would explore alternatives for providing care to the State's most vulnerable.

The ACC began its community-based services for medically complex and behaviorally challenged children and adults in April of 2008. The Board of Trustees of the ACC allocated over $900,000 from our foundation for this new venture. We choose the community of Grand Forks to launch these home and community based services. During 2009, we will also begin offering these services in the Fargo and Bismarck areas. These services consist of two (2) programs: in-home supports and adult day supports. The in-home support program is currently serving 13 clients, and our adult day support program is currently serving 9 clients. Our expectation is that these two programs will be a less costly alternative than providing residential care, as well as providing services close to or in many cases within the communities in which the child or adult resides. These new programs today have kept families intact and our in-home support programs in some cases have eliminated or at least delayed the entry into a more costly residential program.

If you turn to Tab 8 in the packet of materials that was set forth in front of you, you will read the story about Jenny. Jenny is a recent high school graduate, who with the support of the ACC has been allowed to stay within her home community of Cooperstown. As Jenny approached her 21st birthday, there were many individuals who believed that Jenny could not stay in Cooperstown, but would need residential placement in a community outside of Cooperstown. Although Jenny would be well

taken care and would have a very fulfilling life in another community, neither Jenny nor her parents wanted her to leave the community of Cooperstown.

With Jenny continuing to live at home, the ACC is now providing a 1:1 day support program where Jenny volunteers in a number of businesses within the community. Jenny is now enjoying a great social network, loves her work opportunities, and on a daily basis is becoming a more independent person with disabilities.

If Jenny were to have gone to a residential setting outside the community of Cooperstown, the cost would be approximately $100,000 for her residential care. We are pleased to report that the cost to the State of North Dakota for keeping Jenny in her home community and being an active part of the community of Cooperstown is a far less costly alternative-perhaps about one-third of the cost of residential care.

Even though the community support program that we began in April is in its infancy, the early results have shown great satisfaction from parents, as well as clients, and as importantly, the costs of keeping individuals out of other more restrictive environments has been greatly reduced.

Behaviorally Challenged Clients

Mr. Chairman, and Committee members, as indicated earlier, the ACC supports HB 1012 but specifically is looking for support for OAR #5, which is titled DD staffing to meet critical needs.

In 2003, the Department of Human Services sent correspondence to all providers taking the position that due to budget issues there would be no additional staffing enhancements granted. There were some exceptions to this, but for the most part, most providers have not received staffing enhancements to meet the needs of complex individuals under their supervision since 2003. Three (3) years ago, the Department asked each provider to look at where the gaps were for critical needs staffing. From that request came the $6,317,916 within that OAR. If granted, the ACC would be entitled to approximately 37.5% of that dollar amount or $2,495,288 in the new biennium.

Your colleagues in the House passed this portion of the OAR with a greatly reduced fiscal amount. The House of Representatives reduced the funding from over $6.3 million in OAR #5 to $1,168,000. Today, I stand before this Committee asking for reinstatement of the full request from OAR #5 for $6,317,916.

44 of the 52 children on our campus have a behavioral related disorder. 28 of the 44 or 63.7% of the children and young adults are classified at the highest level in our scoring matrix. Children with

behavioral support plans have increased 159% over the past 12 years. The ACC uses the Oregon Scoring Criteria, which the Department of Human Services has recognized as an appropriate tool to gauge severity in children with behavioral complexities. In 2003, the average score for a child at the Center was 94, and in 2008 the average score was 133. This represents a 42% increase in severity. Approved fulltime equivalents (FTEs) at the Center rose only 4 FTEs or 4.5% during that same time. The ACC staffs today at 114 FTEs for children with behavioral challenges. We are reimbursed for only 88.64 FTEs. This 25.36 FTE variance equates to $713,691 per year.

Medically Fragile Clients

The other population when considering critical staffing needs is children with great medical fragility. The State of North Dakota has also adopted the Oregon Scoring Criteria as valid criteria to measure the complexity and acuity of children with great medical fragility. The ACC has 20 students that meet the definition of medical fragility. The average score for a child with medical fragility in 2005 at the ACC was 30.56. In 2008, the average score was 42.6. However, the top 10 children today had an average score of 60.9, a 20% increase over this past year. The ACC staffs for 28.4 nursing professionals to meet the complex needs of clients being served. The Department of Human Services reimburses at 21.3 FTEs. It is interesting to note that other states, such as South Dakota,

Illinois, Florida and Alabama, to utilize acuity and severity models for their reimbursement methodologies for medically fragile clients. The difference in how ACC staffs for medical fragility and what is allocated for reimbursement by the Department of Human Services is 7.1 FTEs or $473,166 per year.

Mr. Chairman, and members of the Committee, once again the investment that our Board has made for these two programs; the behaviorally challenged program and the medical fragility program, is $1,186,857annually or $2,373,714 biannually.

A colleague of mine once said, "When there is an elephant in the room it is best to introduce it." The elephant in the room for the ACC is our Foundation. The Center has been blessed and privileged over the past many years to receive generous one time gifts, as well as many end of life gifts towards the care of children at the Center. This has put the Center in a unique position, as well as responsibility towards accepting children with great medical and behavioral complexity regardless of adequate reimbursement. Other providers around the State of North Dakota will accept children and adults with complex needs, but need to be assured that there is adequate reimbursement for these individuals. Without adequate reimbursement, it would sadly become a financial hardship on many of these organizations. For providers around the State of North Dakota to adequately serve the growing complexity with

respect to the clients that we serve, it is imperative that funding for critical staffing needs is placed in HB 1012.

Mr. Chairman, and members of the Committee, this is the third session that I have come before you to ask for additional funding for medically fragile and behaviorally challenged clients. While I enjoy and respect each and every one of you, I am most certain that our request for enhanced funding at times gets old. That is why we have submitted HB 1556 which is a Bill for an interim study to collect the methodology and calculations for the rating setting structure used by the Department for clients who are medically fragile and behaviorally challenged. This would include children and adults in both the ICR/MR and home and community based setting.

My hope is that systemic change occurs so the ACC and other providers find it no longer necessary to continue to come to the Committee asking for additional funding for the medically fragile and behaviorally challenged populations.

Mr. Chairman and members of the Committee, I thank you for the job that each of you does, and at this time, I will answer any questions that you may have.

Thank you.

Dan Howell, Chief Executive Officer
Anne Carlsen Center

Issues Overview

Critical Needs Staffing

- **$6,317,916 – staffing needs in the biennium for providers around North Dakota to meet complexity of clients being served – in OAR, but not in budget**

- **ACC has 37.5 % of total dollar amount = $2,373,714 in the biennium**

A. Behaviorally Challenged Staffing

- **44 of 55 children on campus have behavioral related disorder (80%)**
- **28 of 44 or 63.7% of children and young adults are classified at level 3 -the most severe level in scoring matrix**
- **Children with behavioral support plans have increased from 17 to 44 in past 12 years or a 159% increase**
- **ACC currently staffs at 110 direct care FTEs to deal with complexity of children and young adults**
- **Number of approved FTEs for direct care staff from Department willing to reimburse has only increased from**

    - **2003 – 84.63 FTEs**
    - **2004 – 84.79**
    - **2005 – 86.70**
    - **2006 – 87.48**
    - **2007 – 87.48**
    - **2008 – 88.64**

- **4.5% increase in approved FTEs, but a 42% increase in severity/acuity of clients**
- **4.01 FTE increase in 5 years**

Staffed - 114.00 FTEs
Reimbursed - 88.64 FTEs
Variance 25.36 FTEs

25.36 FTE x $13.53 (salary and benefits) = $713,691 per year loss

B. Medically Fragile Staff

- **20 children at the ACC meet the definition of medically fragile as defined by the Oregon Scoring Criteria adopted by the Department of Human Services**

Medically Fragile Clients Served by ACC:

- **2005 - 19 students, a cumulative total of 489 (Oregon Scoring)**
- **2006 - 20 students, cumulative total of 650**
- **2007 - 18 students, cumulative total of 664**
- **2008 - 20 students, cumulative total of 852**

Top Ten Medically Fragile Clients Supported by ACC:

- **2005 - a cumulative total of 413 (Oregon Scoring)**
- **2006 - a cumulative total of 429**
- **2007 - a cumulative total of 481**
- **2008 - a cumulative total of 609**

Average Scores Overall:

- **2005 - 30.56**
- **2006 - 32.50**
- **2007 - 34.97**
- **2008 – 42.60**

Average Score Top Ten:

- **2005 - 41.3**
- **2006 - 42.9**
- **2007 - 48.1**
- **2008 – 60.9**

- **Other states (South Dakota, Illinois, Florida, Alabama) distinguish acuity and severity in reimbursement methodology for medically fragile clients**
- **ACC staffs 25 nursing professional FTEs to meet the complex needs of clients being served.**
- **The Department of Human Services reimburses for 18.9 FTEs**

Staffed - 28.4 FTEs
Allocated - 21.3 FTEs
Variance - 7.1 FTEs

7.1 FTEs x 32.04 (salary and benefits) = $473,166 per year

Summary

1. Critical staffing needs for behavioral challenged program (loss)	**$ 713,691**
2. Critical staffing needs of medically fragile program (loss)	**$ 473,166**
TOTAL LOSS PER YEAR – FTE Staffing only	**$ 1,186,857**

Developmental Disabilities Case Management Service Providers

Human Service Center Contact Information

Bismarck – 701-328-8888
888-328-2662

Devils Lake – 701-665-2200
888-607-8610

Dickinson – 701-227-7500
888-227-7525

Fargo – 701-298-4500
888-342-4900

Grand Forks – 701-795-3000
888-256-6742

Jamestown – 701-253-6300
800-260-1310

Minot – 701-857-8500
888-470-6968

Williston – 701-774-4600
800-231-7724

North Dakota Department of Human Services, Medical Services Division

Jake Reuter, MFP Grant Program Administrator,
Email: jwreuter@nd.gov Phone: 701-328-4090,
Fax: 701-328-1544

MFP Website http://www.nd.gov/dhs/info/pubs/mfp.html

north dakota department of human services

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Award # 1LICMS030171/01

DN 1364 (8-08)

MFP

MONEY FOLLOWS THE PERSON

Developmental Disabilities

Program Information and Transition Services

What is the Money Follows the Person Demonstration Grant?

The Money Follows the Person Demonstration Grant (the MFP Program) is a special program developed by the federal government that provides participating states (like North Dakota) with funding that the State uses to assist people to leave the North Dakota Developmental Center or other intermediate care facility for persons with mental retardation (ICF/MR, institution) and move to their own home in the community.

Who is Eligible to Participate in the MFP Program in North Dakota?

The MFP Program is limited to persons residing in ICFs/MR (institutions) who are Medicaid eligible, who have resided in an institutional setting for at least six months, and who meet the requirements for at least one of the following programs:

- MR/DD waiver (Meets ICF/MR Level of Care, Requires supports for Health & Safety, and needs can be met through specific services for individuals with mental retardation),
- Self Directed Supports for Families or Adults waivers (Meets ICF/MR Level of Care, Requires support for Health & Safety, Needs can be met through specific services for individuals with mental retardation, Person lives with a primary caregiver who is capable of self directing services or Person lives with a primary caregiver or independently and is Capable of self directing services)
- Medically Fragile Children waiver (Determined to meet nursing facility level of care, 3 to 18 years of age, Greatest need as determined through a Level of Need ranking process, Requires support for Health & Safety, Needs at least one waiver service quarterly to remain in family home setting, Child lives with a primary caregiver capable of self directing services).

Persons who are not Medicaid eligible or who have resided in an institutional setting for less than six months may be assisted with transition from an institution by Developmental Disabilities case management staff through other programs, as appropriate.

How Does MFP Work?

The MFP Program can assist individuals interested in leaving an ICF/MR by providing:

- Information to help them make an informed choice regarding transition and participation in the MFP Program;
- Access to transition services and assistance from a transition coordinator through North Dakota's Centers for Independent Living;
- Payment for some one-time moving costs or activities; (rental deposits, home furnishing, household supplies) and
- Post-discharge follow-up to ensure the move is satisfactory and the individual's needs are being met.

What Housing Choices Will Money Follows the Person Offer?

The MFP grant will operate throughout the state of North Dakota and will transition individuals into a qualified residence, such as:

- The individual's home or a family home;
- A shared home, where no more than three other (four total) unrelated individuals reside;
- An adult foster care home (AFCH) where no more than three other (four total) unrelated individuals reside;
- An apartment, including those in HUD subsidized housing complexes or congregate housing complexes.

When is the Money Follows the Person Program in Effect?

The MFP program will operate in North Dakota beginning June 20, 2008 and will end September 30, 2011.

MFP will provide services to individuals participating in the program for 365 days after transition to the community. After that, individuals will continue to receive needed services from the State without interruption.

If you, or someone you care about, lives in an ICF/MR and would like to learn about options available to return to the community please contact: Your local Human Service Center or Jake Reuter, MFP Program Administrator at 701-328-4090.

DHS
HB 1012
ISLA - Individuals served by PAR level

Par 5 - highest functioning	160	
Yr 1 growth	6	
Yr 2 growth	5	
Subtotal		171
Par 4	139	
Yr 1 growth	6	
Yr 2 growth	5	
Subtotal		150
Par 3	151	
Yr 1 growth	6	
Yr 2 growth	5	
Subtotal		162
Par 2	130	
Yr 1 growth	6	
Yr 2 growth	5	
Subtotal		141
Par 1	137	
Yr 1 growth	9	
Yr 2 growth	8	
Subtotal		154
Total endind caseload		778

The computations are based on ISLA authorizations as of March 2008 plus anticipated caseload growth for the 09/11 biennium, which are 44 high school graduations (22 each year) and 17 from the Developmental Center (year 1 -9; year 2 - 8). The growth for the remainder of the 2007 - 09 biennium was not factored in.

The ending number for this estimate is short from the anticipated ending caseload of 805.

"Spenddown Sheet" - average caseload - 790.
Calculated as follows:

Beginning Caseload	775
Ending Caseload	805
Total caseload	1580
Divide by 2 = average caseload	790

H

Department of Human Services
HB 1012
2009 - 2011 Budget
ISLA and FCO III Rate change

	Rate	Year 2 inflation of 5%	Rounded
2007 - 2009 Monthly Rates			
Regular	275	288.75	**290**
Enhanced	420		

2009 - 2011 Monthly Rates	
Par 5 - highest functioning **(290 + 50)**	340
Par 4	390
Par 3	415
Par 2	440
Par 1	540

PAR - Progress Assessment Review level
ISLA - Individualized Supported Living Arrangements
FCO III - Family Care Option III - for those under age 18

NOTE: These monthly amounts are then converted to daily rates.

North Dakota Centers for Independent Living

January, 2009

Senate letter to Senate

Members of the North Dakota House Human Resources Division:

This letter represents continuation of the efforts initiated during the last legislative session that would increase the four Centers for Independent Living (CIL's) ability to provide services across the State. While the increase received during the last session is appreciated, there remain many areas of the state that are underserved or unserved. If the funding request were realized it would mean that all areas of the state would have a CIL presence.

The Independent Living program in North Dakota has been in existence for nearly 30 years offering the citizens of the State a local resource point from which to identify the many services available to them so that they can become productive members of society and learn the skills needed to move forward from a life of dependency. During the last 30 years gradual progress has been made in creating a system whereby every person with a disability has access to CIL services however, statewide presence is still far from a reality.

The Center Directors have determined that in order to have sufficient staff presence, each CIL would need about $600,000 per year, or $1.2 million per biennium. For that to be realized, we would need an additional $1.89 million per biennium. With this amount of funding, staff and offices would be added in various communities, creating a physical presence across the State. Once staff are hired, trained and proficient it would be anticipated that service levels would increase 40%.

Your assistance would be greatly appreciated. We feel strongly that this is a good investment for our state, as over 98,000 people identify themselves as having a disability, and this number is projected to grow as our population ages.

Thank you for your time and attention. If you'd like more information, please give any of us a call.

Sincerely,

Royce Schultze	Steve Repnow	Nate Aalgaard	Randy Sorensen
Dakota CIL	Independence, Inc.	Freedom RCIL	Options RCIL

SUMMARY OF FUNDING REQUEST
NORTH DAKOTA CENTERS FOR INDEPENDENT LIVING

The Center for Independent Living (CIL) directors estimate that in order to have a presence and availability of core services in every county of the state, they would need $1.2 million per biennium each. Each of four Centers for Independent Living are designated to serve a quadrant of the state (see Future expansion areas, page 5).

Current biennial budget, including state and federal funds: $2,905,814
Estimated total amount needed for statewide availability: $4.8 million
Additional funds needed to provide services statewide: $1,894,000 per biennium
Governor Hoeven's budget recommendation: $800,000

Services:
All Centers for Independent Living are required to provide four core services, which are: **Independent Living Skills Training, Individual and Systems Advocacy, Peer Counseling**, and **Information and Referral**. They also provide many others, such as nursing home relocation and prevention, community education, technology, and recreation.

How is independent living unique among disability organizations?

- A commitment to systems changes, whereby the long-term goal is a society where everyone with a disability has the opportunity to be a vital and productive member of the community in which they choose to live.

- Availability for any person with any type of disability of any age, geographic location, or economic status to access services.

- North Dakota Centers for Independent living are consumer-driven community organizations. A majority of our staff, board and management staff are people with disabilities from the areas we serve, who use their personal experience as a basis for the services that are provided based on the needs of the area as reported by the people.

- CIL's make use of volunteers with disabilities to provide peer support to other people with disabilities, but also to use their personal experiences as a base for our organizational and advocacy direction. This personal experience with disability sets CIL's apart from other traditional service providers.

- Centers for independent living promote self-determination and empowerment for people with disabilities through direct one-to-one and group services including skills training, individual advocacy, information and referral, and peer support. Independent Living has the concept of consumer control, whereby people with disabilities coming to them for services have the final say in what it is they want to accomplish. Consumers are responsible for their own actions.

Rationale for funding request

- The Independent Living program is part of the state/federal rehabilitation system. It is authorized by both state and federal law. The full array of services is not, however, available to every citizen of the state who would be eligible due to lack of resources. As a service-based industry, more staff are needed in order to reach unserved and least served areas of the state.

- It is cost effective. Independent Living is part of the solution to the ever-increasing costs of long-term care. Centers provide information to people about community resources, and are actively involved in helping people either avoid institutional placement, or relocate from nursing facilities or other institutions to the communities of their choice.

Fiscal Year 2008 funding levels for North Dakota Centers for Independent Living

	Dept. of Education	ND Dept of Human Services	Total
Dakota Center for Independent Living, Bismarck	373,246	64,859	438,105
Independence Inc., Minot	116,284	221,778	338,062
Freedom Resource Center, Fargo	173,910	164,715	338,625
Options Resource Center, Grand Forks	121,439	216,676	338,115
Total IL funds			$1,452,907 per year ($2,905,814 Per biennium)

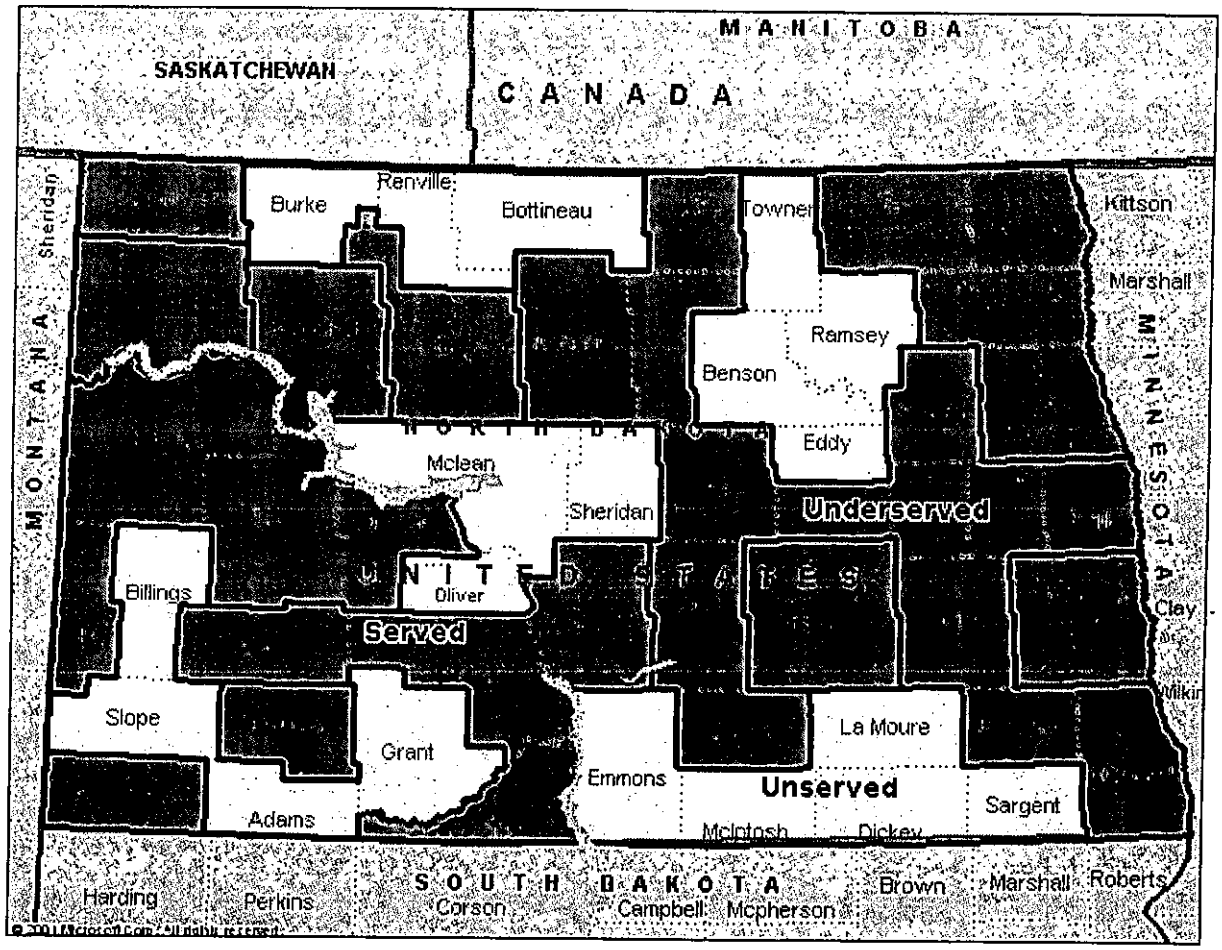
The Centers for Independent Living are committed to providing a statewide system whereby IL services are available throughout the state. To do this, more funding is needed.

Funding request

With a base level of $600,000 per year in funding, the Centers for Independent Living estimate they would have a presence in every county of the state. This would total $2.4 million per year, or $4.8 million per biennium. Funding per year needed to get to that level:

$1,894,000 per biennium.

Current availability of Independent Living services

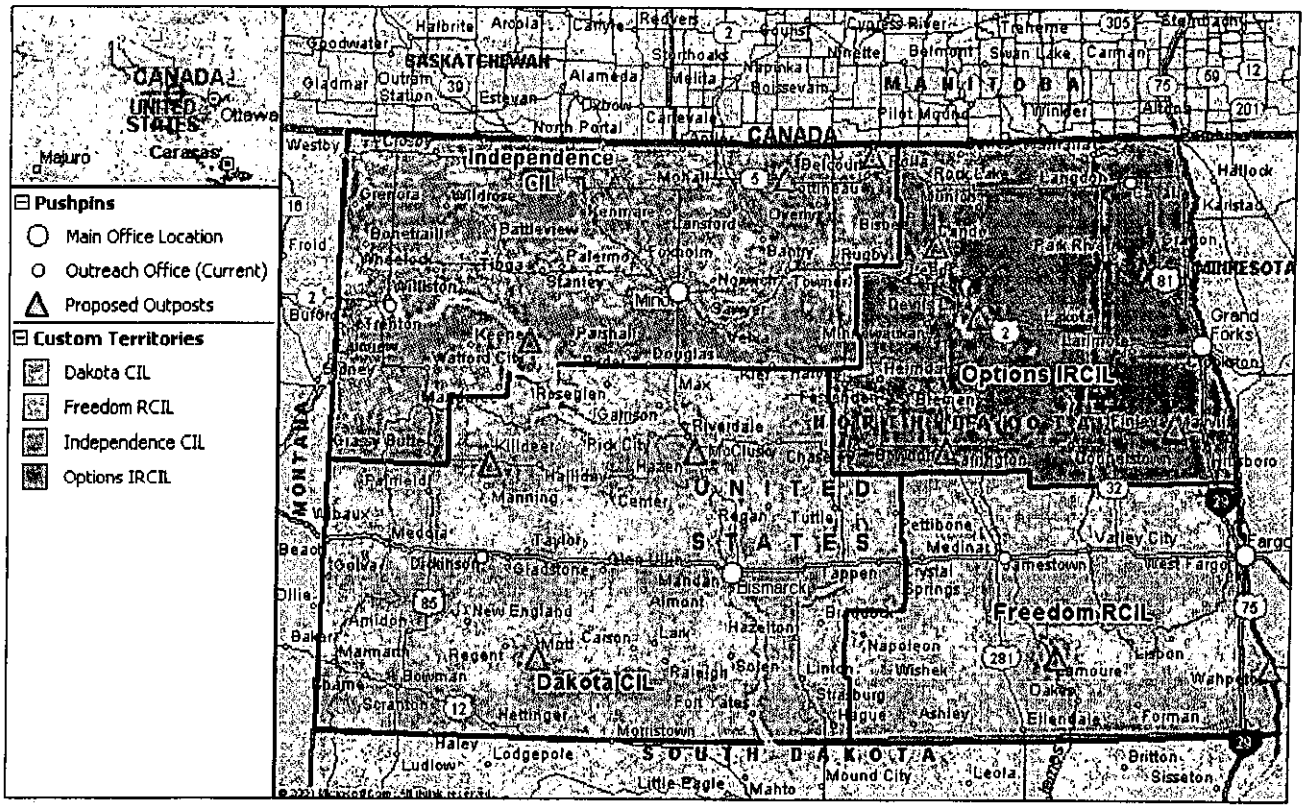


13 counties served (purple)

21 counties underserved (orange)

19 counties unserved (yellow)

Future expansion areas



The blue triangles indicate communities where the Centers for Independent living would add staff and/or branch offices. All of those counties and surrounding areas are currently unserved or underserved by the Center, meaning that a full array of core Independent Living services are not available. These include skills training, advocacy, peer mentoring, and information and referral.

Dakota CIL, Bismarck
Top priority for expansion: Mott
Secondary priority: Killdeer

Independence Inc., Minot
Top priority for expansion: Belcourt/Turtle Mountain
Secondary priority: Watford City

Freedom Resource Center, Fargo
Top priority for expansion: Wahpeton
Secondary priority: LaMoure

Options IRCIL, Grand Forks
Top priority for expansion: Devil's Lake
Secondary priority: Mayville

Progress made with 2007 – 09 additional appropriation of $250,000

The additional $250,000, 2007-09 biennium increase for Center for Independent Living services, was allocated in order to initiate balance between the disparity of funding realized by each CIL and to increase services for the unserved/underserved. Independence CIL (northwest quadrant) received 73% ($182,692) of the funding the remaining 27% ($67,308) of the funding was dispersed between Options Resource CIL (northeast quadrant) and Freedom Resource CIL (southeast quadrant) This brought the three lowest funded Centers to levels that are similar.

During the last two years strides were made to expand services for people with disabilities in unserved and underserved areas of North Dakota. Options Resource CIL and Freedom Resource CIL utilized the funding for program enhancements to increase services for rural residents while Independence CIL expanded to the Williston area.

In October of 2007, Independence CIL found a location for the opening of an outreach office. The lease was secured in January of 2008. During the months of January and February an outreach specialist was hired, training initiated, and services delivered as competencies were acquired. An outreach plan was implemented that included informing area service providers, the general community, and people with disabilities of the availability of services as well as collaborative activities with area providers and stakeholders. Service information unique to the area is being identified along with input from area residents of the areas needs as it pertains to people with disabilities in order to design service enhancements that will meet the need of the area. All data collection, need identification and service capacity enhancements are designed in order for the local staff person to raise their level of competency so that they can provide service in the most effective manner possible both in cost and efficiency. Historically, it takes three years to raise the level of competency of a staff person in order for them to be proficient due to all the service system information they must learn and unique elements inherent to the area they serve. Forty-six consumers have been served thus far with one hundred and twenty-eight individuals benefiting from community education services.

In addition to the person hired in Williston, a .75 FTE was added to the main office located in Minot. This staff person is responsible for assisting the residents of the quadrant with information, referral and assistance services and completing consumer intakes. As with the aforementioned position training has been taking place, building competencies in order to increase consumer contact. Fifty-nine consumers have been served as competencies have been acquired. In addition to the training activities time is being spent ramping up systems for the collection and the easy retrieval of resources that callers will need and the position will be required to manage.

Both Options Resource CIL and Freedom Resource CIL have used the money made available to them to enhance service capacity. Prior to the increase by the North Dakota Legislature both Centers had experienced years of flat funding or reductions in funding due to Federal budget constraints. As a result, line items were cut or not increased during that time which had a direct affect on the provision of services to people with disabilities. One of the main line items that had been restricted was travel. Considering the ruralness of North Dakota and the lack of transportation it is vital that staff be able to go to the communities in which people reside. The additional funding during the 2007-09 biennium has allowed both Freedom Resource CIL and Options Resource CIL to continue outreach and community education, increasing the overall numbers served from 2007 to 2008. Another line item that suffered was in the area of salaries. Pay freezes caused the Centers to lose their ability to be competitive. If the Center is not competitive it becomes a training ground for entry level human service workers who once they have gained experience move on to locations where they can receive greater pay and benefit packages. This results in inefficiencies because the resources are never utilized for maximum benefit to the people it is allocated to serve instead it is used to further professional carriers.

- Assisted Iraq war veteran with post-traumatic stress disorder and Parkinson Disease to obtain new rep-payee; an accessible apartment; obtain transit tickets; coordinated services with county; budgeting skills; obtained legal representative; applied on-line for classes and located a Parkinson support group. Consumer is living independently with her children and graduated from college with an Associate Degree.
- Assisted 21-year old woman with learning disabilities and mental illness to attended CIL Youth Leadership Training. Through this experience she had the opportunity to meet new people with disabilities who had similar life experiences. Since completing the training, she has participated as a speaker on a Youth Panel at "Discovering the Magic Conference" in Minot, sharing her story and addressed the Jamestown Mayor's Partnership Committee on accessibility concerns within her community. She continues to be employed and looks forward to more opportunities to help empower others with disabilities.
- CIL's assisted one hundred and ninety-eight Medicare recipients with researching and enrolling in Medicare D Programs that best met their medication needs.
- Assisted two consumers to obtain SSDI benefits, write Plans to Achieve Self-Support (PASS) with Social Security to purchase vehicles in order for them to maintain their employment and to understand social security work incentives for them to seamlessly move from public services to becoming independent.
- Helped a 67-year old homeless man who is deaf and has traumatic brain injury that was evicted from apartment. Assistance involved finding apartment, setting up a household, and obtaining assistive technology to live independently.
- CIL collaborated with a fraternity at a University to sponsor a fundraiser, purchase building materials and built a ramp for an individual with a disability in a two-week time span.
- A man in his mid 20's, with a degenerative vision impairment, was assisted in order for him to keep his job. Skills were taught that enabled him to use public transportation to get to work and assistive technology (Sense-View lighted magnifier) in order for him to complete his job duties.
- CIL assisted an individual who had been involved in a car accident to coordinate services in his hometown and funds for a ramp, which enabled him to remain in his hometown.
- Program information was provided in addition to assistance in applying in order for a child to access services through the Medicaid "buy in" program for children.
- CIL provided assistance to area families/students in learning how to utilize the Capitol Area Transit system.
- Twelve consumers who needed rep-payees as determined by Social Security met with CIL staff to learn how to budget, pay bills and balance their accounts. Two consumers have been able to take over their own accounts.
- CIL assisted homeless couple living in their car to locate an apartment, secure money for a deposit, obtain a gas voucher, food commodities, essentials for their apartment, and learn to budget. The couple is currently looking for employment to remain independent in their home.

COMMUNITY EDUCATION AND OUTREACH (CEO)

Durable Equipment Loan Program: Two CIL's have established loaner programs, while persons wait for program eligibility or delivery of their own equipment.

Dental Access: In NE North Dakota, the CIL collaborated with other entities to start a dental clinic that provides services to those on Medicaid or without dental insurance.

Long Term Care: Provided training to members of the long term care association on the rights of individuals regarding service animals, and also collaborated with them on the newly enacted Money Follows the Person (MFP) program. Collaborated and participated with DHS in the assisted living policy and procedure work group.

Education: Provided advocacy skills trainings and disability awareness trainings to high school aged (transition) and university students. Participated with parents in IEP meetings with school officials.

Transportation: Collaborated with local and state transportation and transit providers to provide enhanced local access, availability and affordability to the elderly and those with disabilities.

Domestic Violence: NW North Dakota CIL collaborated with local domestic violence services to advocate for the rights and safety of those with disabilities in domestic violence situations.

Recreation: Provided recreational outings such as fishing, hunting, dances and other leisure time activity for youth and adults with disabilities.

Accessibility: Provided technical assistance to architects, builders, business and individuals with regard to accessability regulations.

POTENTIAL INSTITUTIONAL CARE COSTS SAVED BY NORTH DAKOTA CENTERS FOR INDEPENDENT LIVING

Part of the mission of independent living centers is to assist persons with disabilities in either leaving or preventing their placement in institutions. This effort by the four centers for independent living in North Dakota has the potential to save the state $ 536,181.62. This potential savings is the difference between what it costs for individuals to live independently using Home and Community Based Services verse the increased cost that North Dakota would spend on institutionalized care.

The figure was computed using the average nursing home cost (FY 2007), adjusted for room and board, and the average cost of Home and Community Based Services for the 26 individuals who the Centers assisted in moving from institutional care during FYs 10/01/06-9/30/08.

$ 159.96	**AVERAGE NURSING HOME COST PER DAY**
x 80%	**ADJUSTMENT FOR ROOM AND BOARD @ 20%**
$ 127.968	**ADJUSTED COST PER DAY FOR NURSING HOME CARE**

$ 127.97	**ADJUSTED NURSING HOME RATE**
x 365	**DAYS OF THE YEAR**
$ 46,709.05	**COST PER YEAR FOR NURSING HOME CARE**

$ 46,709.05	**COST PER YEAR FOR NURSING HOME CARE**
26,086.68	**AVERAGE COST PER YEAR FOR HCBS's**
$ 20,622.37	**COST SAVINGS**
x 26	**PEOPLE WITH DISABILITIES**

$ 536,181.62 TOTAL POTENTIAL SAVINGS

Note: Centers for Independent Living reported that Independent Living Services prevented 33 persons from entering nursing homes or other institutions during the last budget period. Using the average nursing home rate as a benchmark these persons may have cost the State of North Dakota an additional $ 680,538.21 for institutional care. These are people that the medical staff or families were actively looking at placement.

E

Testimony on HB 1012, relating to Centers for Independent Living
January 27, 2009

Chairman Pollert and members of the Human Resources Division:

My name is Nate Aalgaard, and I am here today representing the North Dakota Centers for Independent Living (CIL's). We are four private nonprofit organizations that provide an array of independent living services by contract with the State. We are part of the state/federal rehabilitation system. Our goal is a society where every person with a disability has the opportunity to be as independent and productive as possible.

In the few minutes we have here today we want to make the case that this program, Independent Living, is worthy of additional state funding. The $250,000 increase for Center for Independent Living services during the 2007-09 biennium was allocated to balance the disparity of funding realized by each CIL and to increase services for the unserved and underserved. Independence CIL (northwest quadrant) received 73% ($182,692) of the new funding. The remaining 27% ($67,308) was dispersed between Options Resource CIL (northeast quadrant) and Freedom Resource CIL (southeast quadrant) This brought the three lowest funded Centers to a similar level.

Options Resource CIL and Freedom Resource CIL utilized the funding for program enhancements to increase services for rural residents. Independence CIL expanded to the Williston area, opening a branch office. They also added an information and referral position in their Minot office. There is expanded information on our progress in your packets.

We are here again because although progress has been made in bringing our services to people in more areas of the state, there are still many counties and communities where we cannot reach due to insufficient resources.

The other Center Directors and I have determined that in order to have sufficient staff presence, each CIL would need about $600,000 per year, or $1.2 million per biennium. For that to be realized, we would need an additional $1.89 million per biennium. With this amount of funding, staff and offices would be added in various communities, creating a physical presence across the State. Once staff are hired, trained and proficient it would be anticipated that service levels would increase 40%.

We have an expansion plan in place for each quadrant of the state. For our Center, Freedom Resource Center, I would like to first start an office in Wahpeton. This is a community with one of the larger populations in our service area. We have done some limited service there, such as community education on accessibility and job accommodations, individual advocacy in special education, and a youth leadership training. Every time we go there we get a great response. Unfortunately, we cannot sustain services due to lack of resources. We have found in other areas that when you have staff in an area, people come, and requests for individual and community services increase.

We have included some service highlights in your information packets. There, you will see that we are doing a number of different types of things to help people with disabilities be more independent. We have helped people find funding for ramps; assisted people navigate the complexities of Medicare Part D; matched them with volunteer mentors who can teach them things like riding public transit or managing their health condition; and given advice on work incentive programs. Many people who come to our Centers simply don't know where to turn. The onset of their disability and all the changes it brings to their lives is just too much. We can help them figure out where to start, who to call, and how to move forward.

And finally, we are actively working to assist people avoid unnecessary institutional placement. We have been doing this for several years, and now we are also contracting with DHS on the Money Follows the Person project. This systems change opportunity promises to create more community options for long term care, and help the State keep rising costs under control.

Centers also provide many community services, and I'd like to turn that part of our presentation over to John Johnson.

E

January 21, 2009

Mr. Chairman Pollert and Members of the Committee:

My name is Troy Brusven; Dakota Center for Independent Living is my Rep-payee. We meet once a month were they are teaching me how to write out my own checks to pay my bills. There teaching me how to balance my checkbook, so one day I'll be able to be independent and take over my own checking account.

Being with them I've learned many things. To name a few Nutrition Classes explains what types of foods to eat and what to stay away from, share recipes with each other and teach us cooking hands on. Winter and Summer severe weather classes, how to be safe in tornadoes and blizzards. We have picnics where we can socialize with others. It is a good program where people like myself can go for help. I'd like to Thank you for your time and supporting House bill 1012 for increased funding for cil's.

Troy Brusven
809 N 26TH St. #3
Bismarck, ND 58501
(701) 222-0368

Troy Brusven

January 22, 2009

Mr. Chairman Pollert and Members of the Committee:

My name is Bonnie Brusven; I've been with Dakota Center for Independent Living almost 4 years. I heard about there Drivers Ed Program through Vocational Rehab. After failing my permit test 4 times I thought I'd try one more time. I went through there 7 week program. I PASSED my test taking it just once. With out the help of DCIL it wouldn't have been possible for me to pass my test.

I continue going to Dakota Center for Independent Living for there Social and Recreational programs. Because of my disability it gets me out of my home and meet with people out in the community.

I would like to Thank you in support of House Bill #1012 for increased funding for centers for independent living.

Bonnie Brusven
809 N 26th St. #3
Bismarck, ND 58501
(701)222-0368

Bonnie Brusven

William R. Carnes
2008 E. Capitol Ave
Bismarck, N.D. 58501-2257

Attention: Representative Pollert
Bill # 1012

Additional Financing for North Dakota C.I.L.'s

I've used the Bismarck C.I.L. for several years and have found them very effective providing guidance for health, behavior and financial issues, along with a great social outlet.

I've made numerous friends at the local C.I.L. and we all seem to wholeheartedly enjoy the great camaraderie between us. We also were introduced to Legislative Sessions and Lobbying Actions which leads us to live our Mission Statement.

I feel the assistance provided by Dakota C.I.L. is a wise investment to the community and state for people with disabilities.

Please include us in your 2009 budget.

Sincerely,

William R. Carnes

William R. Carnes

January 20, 2009

Mr. Chairmen and Members of the Committee:

My name is Martin Cochrane. Dakota Center for Independent Living has helped me out in many ways. They helped in teaching me how to fill out job applications, how to cook and how to do grocery shopping.

Dakota Center for Independent Living has helped me to live out on my own, has helped me in to manage my money and to learn hoe to get out and participate in social and recreation activities.

Dakota Center for Independent Living has let me use them for emergency contact number in case I have an accident. I think you should consider and give more funding to the Center for Independent Living so they can continue to help other like myself.

Thank you for your time;

Marty Cochrane
305 N 23rd St, #124
Bismarck, ND 58501
(701) 222-4739

Martin Cochrane

January 21, 2009

RE: House Bill 1012

Dear Chairman Pollert and members of the committee,

As a disabled resident of North Dakota, I'm writing to share with you about my feelings about House Bill 1012 and why the Independent Living Centers have continued funding.

For the last twenty years, I have been a consumer of the Dakota Center for Independent Living. I received the following services:

Independent living skills training, Advocacy Services, Information and Referral Services, and Social Activities to developed new friendships. Today, I live in my own apartment and live independently. Currently, I volunteer at the Dakota Center for Independent Living.

I urge you to support House Bill 1012 so the disabled North Dakotan may have the opportunity to live independently.

THANK-YOU, for your support on House Bill 1012.

Sincerely,

CARLOS

Carlos Joseph Garza
3001 Ohio St. Apt. 16
Bismarck, ND 58501

Randee Sailer
311 E Thayer Ave
Bismarck, ND 58501

Chairman Pollert and Members of the Committee, My name is Randee Sailer. I've been a consumer of Dakota Center for Independent Living for a year and a half. They have helped me a lot. I have a learning disability and never been on my own. They have and are helping me to live on my own and be independent. I never knew how to cook on a stove. I got sent here from another agency for them to help. I also didn't know nothing about Bismarck and have difficulty learning and the directions. They've helped me learn the bus transport. I'm going to be taking self-defense class. If it wasn't for this, I wouldn't of gotten this far. This helps for people to not be in group homes, and to live on your own. I've also learned how to be social and in recreational activities. I have a job I can enjoy, and also get their by bike. That way I save money on transport. Please support increased funding for C.I.L.'s in HB# 1012.

Sincerely,

Randee Sailer

To Rep. Pollert

Dear Sir, I would like to express my thoughts on additional funding for NDCIL. My daughter made several attempts to pass her Drivers Permit test. She was unable to pass until she received asstance from DCIL. After working with DCIL she was successful. I'm very greatful for all the help she received. I trust that you will support additional funds for this wonderful program.

Thank You,

Susan R. Westberg
St Anthony, ND

e-mailed to Dakota Center For Independent Living

To Rep. Pollert

Hi, I would like to ask you to support more funding for the NDCIL. I was unable to pass my Drivers Permit test several times. Once I received help from the DCIL I was able to pass. I hope you will help with more funding for the DCIL. It helped me and I hope it will help others.

Thank You

Anna K. Westberg
St Anthony ND

e-mailed to Dakota Center for Independent Living

Testimony on Increase funding of DCIL.

Finance and Taxation

January 27, 2009

Good Mr. /Mrs. And Committee Members. My name is Sarah Rush. I am from Bowman and District 39.

I am in favor of increase funding on behalf of Dakota Center for Independent Living. They help people with disabilities to be more independent in their lives. They helped me to get TTY phone. A TTY phone is a special phone I can use because of my disability. They helped me to create support group for people with disabilities and their families' members. They help me to study for my Driver license. If they get more funding, they can do more to help people with disabilities.

Thank you for your attention to me. Do you have any questions?

SARAH RUSH

Sarah Rush

805 – 3rd St NW Apt 2 South

Bowman, ND 58623

701-523-3989

January 22, 2009

Dear Legislators,

Dakota Center for Independent Living has helped with getting me Assistive equipment and I also volunteer here. It's nice to have a volunteer program use I can get out into the community.

Thank you,

Tanya W.

344 5th Ave West

Dickinson, ND 58601

701-225-1758

January 21, 2009

As an independent disabled person, I have found myself in need of some help. The Dakota Center for Indpendent Living has been there for me in many ways. I have gotten the training for the computer that I need. They have helped me get my medicines straightened out, because of my disability. I have had problems finding an apartment. I have found an apartment with the centers help. By getting my medical bills straight to get me started in the right direction. My disabilities are heart, back, diabetes, and high blood pressure.

Cary Marsh

Cary Marsh

3111 – Hwy 22 North
Dickinson, ND 58601
701-290-2183

January 22, 2009

To Legislators,

Dakota Independent Living should receive more money to help people like me. Dakota Independent Living helps me with Driver's Ed. The things that I did was speaking about Oreo's Animal Rescue at a coffee club. The things that I'm involved with is coffee club, the socials, and I'm the birthday coordinator. My disability is my coordination, mental retardation, lack of understanding, left eye. They help me with my computer skills and get to know people. I've been volunteering at DCIL for a long time. My bosses are Gloria, Chantel, and Mel-Lisa.

Raileen M Clark

Raileen M. Clark

580-8th Street SE #9

Dickinson, ND 58601

701-483-6109

January 21, 2008

Dear Legislators,

Dakota Center for Independent Living helps me to be able to learn things. I continue to live on my own in my own house and use public transportation to get around town, because I don't drive myself. When I have problems with Dickinson's public transportation, DCIL has helped me to stand up for myself at the Transportation Board meetings. DCIL should continue to get money so that elderly people like me who have difficulty seeing can continue to live on my own. My family lives in other states. DCIL does good things for people.

Thank you,

Georgianna Campbell

Georgianna Campbell

946 Meadows Drive

Dickinson, ND 58601

701-227-2576

F

Chairman Pollert, and members of the Appropriations-Human Resources Division Committee:

My name is John Johnson, and I am testifying in support of funding for the Centers for Independent Living, which would allow them to have a 'statewide' presence for the first time.

I would like to stress two points; the uniqueness of services that Center's provide and the Community Education and Outreach impact of the CIL's.

1) Provides 'skills training' to all disability groups-both cognitive and physical disabilities; advocacy, cooking, housekeeping skills, management of their home care workers, budgeting, drivers education, social security, etc.
2) Serves all age groups, birth to end of life
3) Home and business accessibility
4) Consumer driven and controlled
5) Resource center for disability and age related issues

By approving the complete request of $1.89 million there would not be a duplication of services.

The second aspect of service I would like to address is that of our 'outreach' efforts into the communities we serve. We see the impact of that outreach in the cities and counties we presently serve and would like to have that same impact throughout North Dakota.

- Durable Equipment Loan Program: Loan out, free of charge medical equipment while individuals wait on program eligibility or delivery of their own equipment.
- Provide education to transition aged youth and college students about disability issues, advocacy, and awareness of disability. These efforts have empowered students to become active in their school, university or community (self advocacy).
- Worked with city, county and state transportation entities to improve access to and expansion of transportation options.
- Educated and provided technical assistance to business entities, as well as individuals, with regards to accessibility. This would include public and private entities, contractors, architects, housing authorities and recreational areas. This is done to increase the availability of affordable, accessible housing and access.
- Provided recreational outings such as fishing, hunting, dances, bowling and other leisure time activities for youth and adults with disabilities.
- Collaborated with local domestic violence and law enforcement officials on providing the most effective services for persons with disabilities.
- Provided information and assistance to returning veterans with disability issues.
- Educated assisted living and other residential living facilities on the rights those with disability issues to ensure optimum quality of living experience.
- Educated social security staff on the services of Independent Living Centers.
- Collaborated to increase the availability of dental care to those uninsured or on medical assistance.

We, the four Centers for Independent Living are a resource center for information on aging and disability issues, we do

provide skills, training, we provide information and technical assistance on various disability issues, we teach and provide advocacy to the elderly and those with disabilities, we offer peer mentoring to those with disabilities, and our services are free of charge to those we serve.

Thank you for your time, any questions.

John W. Johnson, Advocate/Trainer

Options Resource Center for Independent Living, serving the NE North Dakota area..

Tonia Johnston
1101 Westwood St. #118
Bismarck, ND 58504

Same to Senate

Mr. Chairmen Pollert and Members of the Committee:

My name is Tonia Johnston and I am writing to support HB1012 for funding for Centers for Independent Living.

Dakota Center for Independent Living has helped me in many ways to maintain my independence while dealing with my physical and mental disabilities. I have had problems managing my money which has caused many financial hardships. Dakota Center for Independent Living has helped me to figure out a budget that works for my family and they make sure my bills are paid and on time. They allow me to be as involved in paying the bills as I feel I am able to be.

Dakota Center for Independent Living has helped me learn about the different transportation options that I have so that I am able to get around town by myself. I do not drive anymore and that has made getting around difficult. With their help I have learned how to use the Transit system and I have also learned how to use the city bus system and I am now able to do a lot of things on my own.

Dakota Center for Independent Living has helped me with obtaining special equipment or services that make my life a little easier. They helped me to get a scooter when I was unable to walk that worked with my specific disabilities so that I could be independent. They gave me a

medication machine in order to try to help me manage my medications. They have had the city nursing system talk to me about what they could offer me such as coming into my home to help me set up the medication machine and fill it for me, along with making sure I refilled my medications on time. If they think of any other services or equipment that may be useful to me they make sure I know about it. If I find something that I feel may be beneficial to me they help me to find a way to try it.

Dakota Center for Independent Living has helped me with finding housing that was accessible for me. They took the time to go with me to look at the apartment and make sure that it was accessible whether I needed to be in my wheelchair or I could walk. They helped me make sure it was near a bus route so I had easy access to transportation.

Dakota Center for Independent Living has helped me in dealing with all the different agencies that I have to deal with. When my symptoms are more severe it makes dealing with too many people difficult for me. Having the people at Dakota Center for Independent Living handle that for me makes my life better. They have helped me in dealing with the Veterans Administration and they have helped me to find a Medicare prescription plan that covers most of the medications I need. Trying to deal with some of these agencies can feel very overwhelming to me but with their help it has made it a much better experience.

These are just a few of the things that Dakota Center for Independent Living has helped me with. There are many more that I could list but overall without their help I would still be struggling to live day to day. They keep me independent which is very important to my children and I. I look forward to continuing to work with Dakota Center for Independent Living because I

know they have my best interests in mind and will do all they can to make sure I can stay as independent as possible for as long as possible.

Tonia Johnston

Tonia Johnston

H

January 27, 2009

Good Morning, Chairman Pollert and Members of the Committee. Thank you for the opportunity to speak with you today.

My name is David Shove, I live in Fargo, ND, and I'm asking you to support the expanded funding for ND Centers for Independent Living in HB 1012.

Centers for Independent Living have played an important role in my life; first, when I was seeking help in planning for college and later when I was looking for accessible housing and employment in my community.

Now, I'm an active volunteer with my local Center for Independent Living as well as in the community at large. I'm a peer mentor, helping others by sharing my life experiences. I participate in community activities, such as the annual ADA Celebration and the recent Martin Luther King (MLK) National Day of Service.

None of this would have been possible if not for the help I've received at my local Center for Independent Living. Therefore, I ask you to support the expanded funding for ND Centers for Independent Living to provide services across the entire state.

Thank you for your time and attention.

David Shove
3219 18th St S Apt #105
Fargo, ND 58104
(701)297-8027
wheelerdave@msn.com

January 18, 2009

I

Hello Chairman Pollert and Members of the Committee:

My name is Charmaine Yvette Boehler; I am a lady with many disabilities. Some of which I will address. I am a partial amputee on Right Foot from smoking cigarettes, known as Burgers disease, Heart disease, Hepatitis C, Osteoporosis, TMJ, Chronic Sinusitis, and Glaucoma. I am happy to be alive and able to do the things I am doing. I could not have accomplished anything without the help of DCIL. The counselors there encouraged me and gave me hope for the future. I did not know how to get around without being depressed and feeling hopeless. These counselors are in wheel chairs and happy and helping people like me and others with mental and physical disabilities. They referred me to Vocational Rehabilitation and taught me how to get back out in the world and be a citizen of the community. Because of their programs to help people, I was able to attend college at BSC and finished my degree for Associate in Applied Science as an Administrative Assistant Medical. Please give DCIL increase in financial support, which is desperately needed to continue the education and hope to put people back in the communities and live happy again.

- They teach many things to all of us:
- How to grocery shop.
- How to balance a check book, and budget.
- How to ride a bus.
- How to get out be social and meet other people.
- How to apply and fill out an application for a job.
- How to protect ourselves in case of an emergency in the town or state we live in.
- How to cook, exercise, learn nutrition and many things that need to be taught and shared by people.
- Because of this we are able to live independently and happy with jobs, volunteer, and social activities. DCIL makes this possible and I ask all of you to support the many laws we need to do this and continue the education needed. Thank you for all your support and listening. It is greatly appreciated.

Charmaine Y Boehler

Charmaine Boehler
PO Box 254
Bismarck, ND
701 751-0776

J

North Dakota Statewide Independent Living Council

CELEBRATING 20 YEARS

1988 - 2008

North Dakota Statewide Independent Living Council
Representative Chet A. Pollert
Chairman, Human Resources Division
House Appropriations Committee
State Capitol
Bismarck, ND 58505

Reference: Testimony HB 1012-Disability Services-Independent Living/VR

Dear Chairman Pollert,

My name is Michelle Barth; I currently have the privilege of serving as North Dakota's Statewide Independent Living Council President (ND SILC). The mission of the Statewide Independent Living Council (SILC) is: To guide the development of the Independent Living (IL) system in North Dakota through the active involvement of the people with disabilities. It is with this mission in mind that the ND SILC would like to express its' full support of HB 1012.

N.D is known for its' rich history, and the people that live here. North Dakotan's are hard working, generous, and kind of spirit. We are also a state that has approx 1 in 6 people identified as having a disability, and an aging population that will reach close to 2/3 of the state's counties will have folks living in them that are 65 years or older in the year 2020. (ND Data Source)In case anyone is adding, that is only eleven years away! North Dakotans are prideful and want to age with dignity and independence. Someone with a disability is no different, they also want to be independent, and with this in mind we need to look at the needs of the all North Dakotans with disabilities.

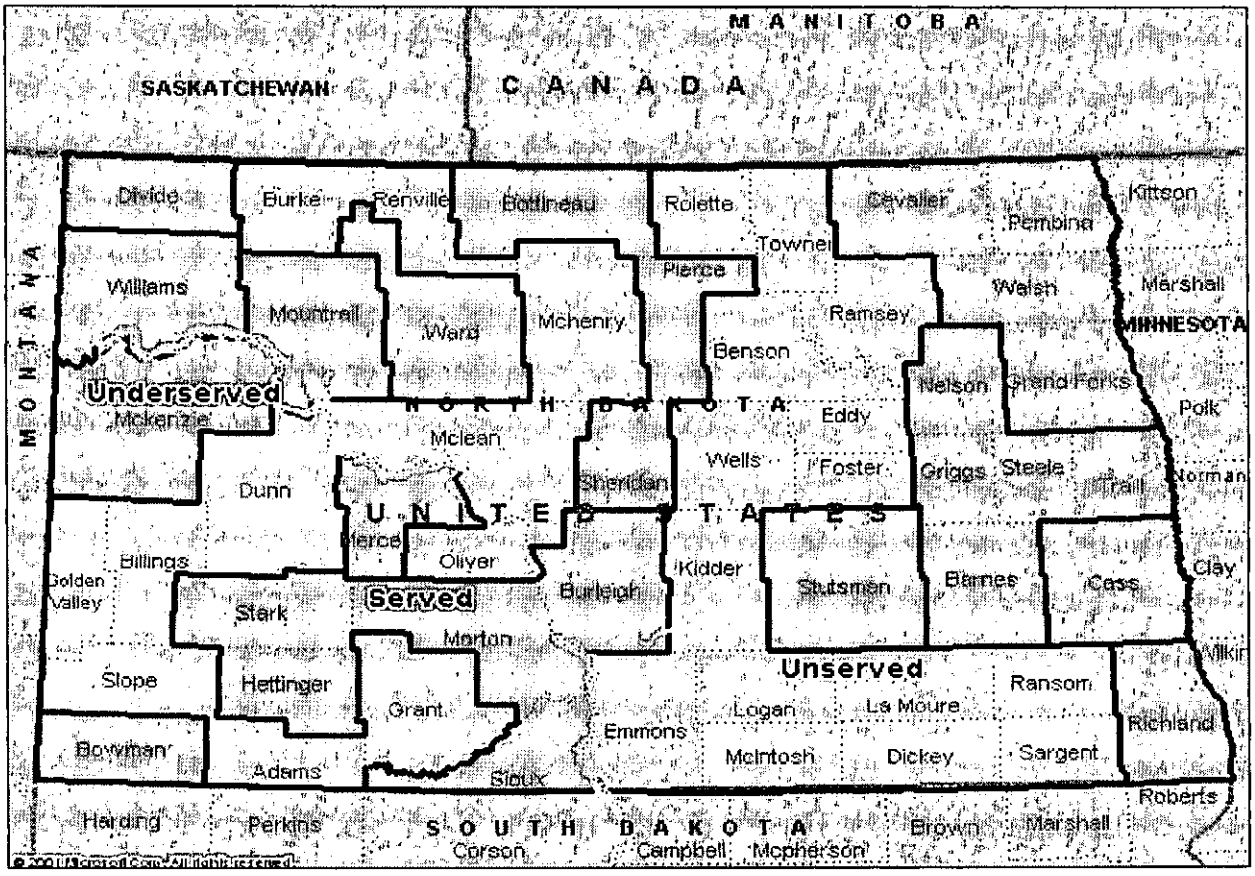
Chairman Pollert we are appreciative for the additional appropriation of $250,000, for the 2007-09 biennium for Center for Independent Living services. Some of the funds helped Independence CIL of Minot open a much needed branch in Williston. In 2008, 8,198 people had contact with VR and 2,743 received at least one of the four core services provided by CIL. The SILC supports and encourages an additional increase of $ added to Gov Hoven's budget during this legislative session for independent living centers. Increasing funding to independent living centers would mean services could be provided to the 13 counties in North Dakota that are currently underserved or the 26 counties that are not served at all.

and opportunities available in their county or area of the state. Their outcomes could be very different from my families.
I hope that you too can see how vital the CIL's ***full*** presence in ND is. The services they provide are unique, successful, and cost effective, and empowering to the people that receive their services. Investing in the CIL is a win--win for ND!

If you have any questions please feel free to call me at 701-223-1280.
Thank You,

Michelle Barth,
ND SILC President
Enclosure

Cc: Representative Larry Bellew
Representative Alon C. Wieland
Representative James A. Kerzman
Representative Ralph E. Metcalf



14 counties served (purple)

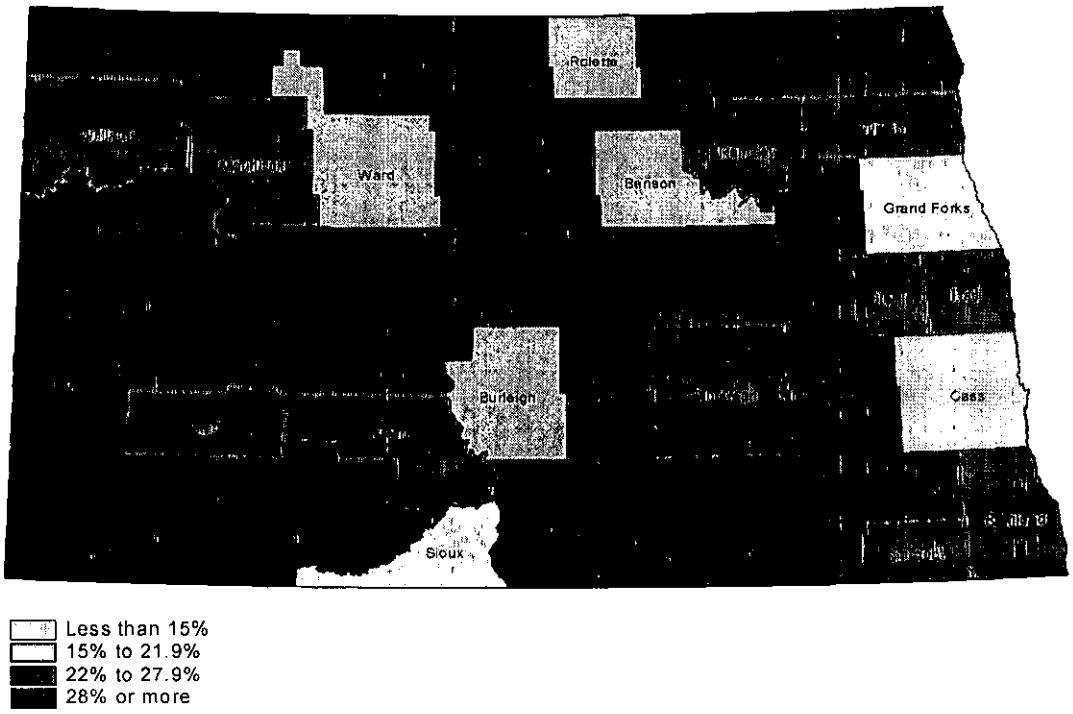
13 counties underserved (orange)

26 counties unserved (yellow)

Providing independent living services to North Dakotans is cost effective. Consider the following example: 26 people were moved from institutional care settings (nursing homes or LTC) to independent living community settings with a savings of $536,181.62 The CIL's are unique in that they provide services to anyone with a disability of any type, geographic location, economic status or age.

On a personal note, I feel blessed to live in Bismarck ND, an area that the CIL's have a strong presence in. My husband and I have two children with disabilities. They have grown into wonderful young adults. My daughter will have a college experience just like any other graduated high school senior, thanks in large part to VR's help. My son is getting ready to graduate this Spring and will probably need a little more help getting ready for the "real world" I am not panicked but rather enjoying the process in part because I know what services the CILS have available such as: Independent Living Skills Training, Individual and Systems Advocacy, Peer Counseling, and Information and Referral. should he need help and the help VR offers people with disabilities. What a difference these two organizations can make in someone's life that has a disability, they have touched our families' lives forever. When I think about what our family has been through, I know there are other families that are going through similar situations with their children or teens; the only difference being that if they don't have the same services

(Map from Data source showing aging population in 2020)



DHS HB 1012
Grants to Independent Living
Legislative Action

	2007 - 09 Current budget	Increase	Governor's Budget 2009 - 2011	House changes	Senate Changes	To Conference Committee
Total	1,344,539	800,000	2,144,539	(400,000)	150,000	1,894,539
General	530,958	800,000	1,330,958	(400,000)	150,000	1,080,958
Federal	813,581	-	813,581	-	-	813,581

D

Department of Human Services
HB 1012
Centers for Independent Living

	2005 - 2007 Budget	Increase / Decrease	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget
Grants	1,094,539	250,000	1,344,539	800,000	2,144,539
General	280,958	250,000	530,958	800,000	1,330,958
Federal	813,581	-	813,581	-	813,581

Transition Coordination Providers

Dakota Center For Independent Living
3111 East Broadway Avenue, Bismarck, ND 58501
Phone (Voice/TTY): (701) 222-3636
Toll Free: (800) 489-5013
E-mail: dcil@dakotacil.org

Options Resource Center For Independent Living
318 3rd Street NW, East Grand Forks, MN 56721
Phone (Voice/TTY): 218-773-6100
Toll Free: (800) 726-3692
E-mail: options@myoptions.info

Freedom Resource Center For Independent Living
2701 9th Avenue SW, Fargo, ND 58103
Phone (Voice/TTY): (701) 478-0459
Toll Free: (800) 450-0459
E-mail: freedom@freedomrc.org

Independence, Inc. Center For Independent Living
300 3rd Avenue SW, Suite F, Minot, ND 58701
Phone: (701) 839-4724, TTY: (701) 839-6561
Toll Free: (800) 377-5114
E-mail: agency@independencecil.org

North Dakota Department of Human Services, Medical Services Division
Jake Reuter, MFP Grant Program Administrator,
Phone: 701-328-4090, Fax: 701-328-1544
E-mail: jwreuter@nd.gov

MFP Website http://www.nd.gov/dhs/info/pubs/mfp.html

This document was developed under grant CFDA 93.779 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.
Award # 1LICMS030171/01

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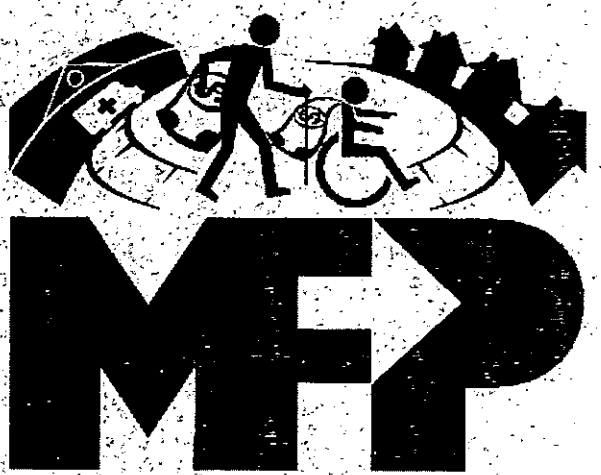

MONEY FOLLOWS THE PERSON

Program Information and Transition Services

north dakota department of human services

What is the Money Follows the Person Demonstration Grant?

The Money Follows the Person Demonstration Grant (the MFP Program) is a special program developed by the federal government that provides participating states (like North Dakota) with funding that the State uses to assist people to leave a nursing facility and move to their own home in the community.

Who is Eligible to Participate in the MFP Program in North Dakota?

The MFP Program is limited to persons residing in nursing facilities who are Medicaid eligible, who have resided in an institutional setting for at least six months, are not severely impaired in cognitive skills for decision making, do not have an Alzheimer's diagnosis, and who meet the requirements for at least one of the following State programs:

- Home and Community Based Services waiver, (Determined to be in need of nursing facility level of care, and Age 16 and over and physically disabled or at least 65 years of age);
- Technology Dependent Waiver, (Determined to be in need of nursing facility level of care, Age 18 and over and physically disabled or at least 65 years of age, Medically Stable, Competent, and Vent dependent at least 20 hrs per day);
- Medically Fragile Children waiver (Determined to be in need of nursing facility level of care, 3 to 18 years of age, Greatest need as determined through a Level of Need ranking process, Requires support for Health & Safety, Needs at least one waiver service quarterly to remain in family home setting, Lives with a primary caregiver capable of self directing services).

Persons who are not Medicaid eligible or who have resided in an institutional setting for less than six months may be assisted with transition from a nursing facility by Centers for Independent Living staff through other programs, as appropriate (contact information on back).

How Does MFP Work?

The MFP Program can assist individuals interested in leaving a nursing facility (NF) by providing:

- Information to help them make an informed choice regarding transition and participation in the MFP Program;
- Access to transition services and assistance from a transition coordinator through North Dakota Centers for Independent Living;
- Payment for some one-time moving costs or activities; (rental deposits, furniture, household supplies) and
- Post-discharge follow-up to ensure the move is satisfactory and the individual's needs are being met.

What Housing Choices Will Money Follows the Person Offer?

The MFP grant will operate throughout the state of North Dakota and will transition individuals into a qualified residence, such as:

- The individual's home or a family home;
- A shared home, where no more than three other (four total) unrelated individuals reside;
- An adult foster care home (AFCH) where no more than three other (four total) unrelated individuals reside;
- An apartment, including those in HUD subsidized housing complexes or congregate housing complexes.

When is the Money Follows the Person Program in Effect?

The MFP program will operate in North Dakota beginning June 20, 2008 and will end September 30, 2011.

MFP will fund services provided to individuals participating in the program for 365 days after transition to the community. After that, individuals will continue to receive needed services from the State without interruption.

If you, or someone you care about, lives in a nursing facility and would like to learn about options available to return to the community please contact your local Center for Independent Living (contact information on back) or Jake Reuter, MFP Program Administrator at 701-328-4090.

MFP
MONEY FOLLOWS THE PERSON

north dakota
department of
human services

SUMMARY OF FUNDING REQUEST
NORTH DAKOTA CENTERS FOR INDEPENDENT LIVING

The Center for Independent Living (CIL) directors estimate that in order to have a presence and availability of core services in every county of the state, they would need $1.2 million per biennium each. Each of four Centers for Independent Living is designated to serve a quadrant of the state (see Future expansion areas, page 5).

Current biennial budget, including state and federal funds: $2,905,814
Estimated total amount needed for statewide availability: $4.8 million
Additional funds needed to provide a statewide presence: $1,894,000 per biennium
Governor Hoeven's budget recommendation: $800,000 per biennium
North Dakota House of Representatives recommendation: $400,000 per biennium

3 9 09

Services:
All Centers for Independent Living are required to provide four core services, which are: **Independent Living Skills Training, Individual and Systems Advocacy, Peer Counseling**, and **Information and Referral**. They also provide many others, such as nursing home relocation and prevention, community education, technology assistance, and recreation programming.

How is independent living unique among disability organizations?

- A commitment to systems changes, whereby the long-term goal is a society where everyone with a disability has the opportunity to be a vital and productive member of the community in which they choose to live.
- Availability for any person with any type of disability of any age, geographic location, or economic status to access services.
- North Dakota Centers for Independent living are consumer-driven community based organizations. A majority of our staff, board and management staff are people with disabilities from the areas we serve, who use their personal experience as a basis for the services that are provided based on the needs of the area as reported by the people.
- CIL's make use of volunteers with disabilities to provide peer support to other people with disabilities, but also to use their personal experiences as a base for our organizational and advocacy direction. This personal experience with disability sets CIL's apart from other traditional service providers.
- Centers for independent living promote self-determination and empowerment for people with disabilities through direct one-to-one and group services including skills training, individual advocacy, information and referral, and peer support. Independent Living has the concept of consumer control, whereby people with disabilities coming to them for services have the final say in what it is they want to accomplish. Consumers are responsible for their own actions.

Rationale for funding request

- The Independent Living program is part of the state/federal rehabilitation system. Both state and federal law authorize it. The full array of services is not, however, available to every citizen of the state who would be eligible due to lack of resources. As a service-based industry, more staff is needed in order to reach unserved and least served areas of the state.
- It is cost effective. Independent Living is part of the solution to the ever-increasing costs of long-term care. Centers provide information to people about community resources, and are actively involved in helping people either avoid institutional placement, or

March 9, 2009

65

DAKOTA CENTER FOR INDEPENDENT LIVING

Hello Chairman Holmberg and Members of the Senate Appropriations Committee:

My name is Charmaine Yvette Boehler; I am a lady with many disabilities. Some of which I will address. I am a partial amputee on Right Foot from smoking cigarettes, known as Burgers disease, Heart disease, Hepatitis C, Osteoporosis, TMJ, Chronic Sinusitis, and Glaucoma. I am happy to be alive and able to do the things I am doing. I could not have accomplished anything without the help of DCIL. The counselors there encouraged me and gave me hope for the future. I did not know how to get around without being depressed and feeling hopeless. These counselors are in wheel chairs and happy and helping people like me and others with mental and physical disabilities. They referred me to Vocational Rehabilitation and taught me how to get back out in the world and be a citizen of the community. Because of their programs to help people, I was able to attend college at BSC and finished my degree for Associate in Applied Science as an Administrative Assistant Medical. Please give DCIL increase in financial support, which is desperately needed to continue the education and hope to put people back in the communities and live happy again.

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Charmaine Y. Boehler
Charmaine Y. Boehler
P.O. Box 254
Bismarck ND 58502-0254
701.751.0776
char_zap@yahoo.com

I AM THANKFUL

I am Thankful because; I can go to a restaurant and have a meal with no smoke.

I am Thankful because; I can breathe fresh air and not smoke.

I am Thankful to GOD for allowing me to wake up with a breath.

I am Thankful I have friends, who are loving and supporting to me.

I am Thankful that there are lawmakers working on my behalf and others.

I am Thankful that I am able to walk today with half a foot, and not all my limbs.

I am Thankful to the doctors that saved my life.

I am Thankful to the teachers and counselors that have helped me on my journey.

I am Thankful to certain members of my family.

I am Thankful that I am able to go to college.

I am Thankful to GOD AND THE MEN AND WOMEN FIGHTING FOR OUR COUNTRY, SO WE CAN BE FREE.

I AM THANKFUL I AM ALIVE. THIS IS DEDICATED TO THE SISTERS, BROTHERS,

MOTHERS, FATHERS, GRANDMA'S AND GRANDPA'S AND FRIENDS WHO HAVE GONE BEFORE ME, BECAUSE OF TOBACCO RELATED COMPLICATIONS.

THEY DID NOT HAVE A CHANCE; I DO WANT TO MAKE A DIFFERENCE IN SOMEONE'S LIFE.

THANK YOU AND GOD BLESS EVERYONE ON THANKSGIVING AND ALWAYS,

Charmaine Yvette Boehler

-----Original Message-----
From: Charmaine Boehler [mailto:char_zap@yahoo.com]

A

Testimony
House Bill 1012 – Department of Human Services
House Appropriations Committee – Human Resources Division
Representative Pollert, Chairman
January 13, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, I am Maggie Anderson, Director of Medical Services, for the Department of Human Services. I am here today to provide you with an overview of the Long-Term Care Continuum budget.

Programs

The long-term care services included in this area of the budget are Nursing Facilities, Basic Care Facilities, Developmentally Disabled Community-Based Care, and the Home and Community-Based Services Programs which have the following funding sources: Service Payments for the Elderly and Disabled (SPED); Expanded SPED; Personal Care; the Program for All-Inclusive Care of the Elderly (PACE); Targeted Case Management; and the Medicaid Home and Community-Based Services Waiver.

The Long-Term Care Continuum encompasses a wide range of medical and support services for individuals who lack some capacity for self-care, and are expected to need care for an extended period of time.

Program Trends

Nursing Facilities

As of September 30, 2008, the percentage of Medicaid-eligible individuals in nursing facilities was 54 percent, which has been fairly consistent for many years. Attachment A shows the Licensed and Occupied Nursing Facility Beds for the current biennium, and Attachment B shows the

Medicaid occupied beds. Based on the September 30, 2008, occupancy reports, 23 facilities were below 90 percent occupancy. The average occupancy for these 23 facilities is 83 percent. The Department continues to believe that a moratorium on the number of nursing facility beds should remain. Throughout the interim, the Department has been in contact with the North Dakota Long Term Care Association for the purpose of tracking the nursing facility beds that are being shifted through the state. The Department's 2009-2011 Budget takes the "bed shifting" into account and is predicated on the moratorium continuing.

During the 2007 Legislative Session, approval was provided for the expansion of Geropsychiatric Services. As of December 2008, the additional 16 Geropsych beds are filled. We expect these beds to be filled throughout the 2009-2011 biennium.

The number of individuals receiving hospice service in Nursing Facilities is reported on Attachment C (Nursing Facility Hospice). As you can see, this number, which includes individuals receiving hospice from all funding sources, has significant fluctuation; however, it has trended higher since July 2005.

Basic Care

Overall, the Basic Care program has seen very little change over the interim. The Department continues to believe that a moratorium on the number of basic care beds should also remain. The process in place for requested exceptions to come before the Department of Health and the Department of Human Services appears to be working well to manage the number of Basic Care beds. Similar to Nursing Facility beds, the Department has been in contact with the North Dakota Long Term Care

Association for the purpose of tracking the basic care beds that are being shifted and added through the state.

Home and Community-Based Services (HCBS)

Home and Community-Based Services continue to provide options for clients who find a need for long-term care services. Staff members work closely with county case managers and providers to ensure clients have the services needed. Often times, it takes a considerable amount of collaboration between formal and informal supports, as well as programs and funding streams, to wrap the necessary services around those who need care. The HCBS staff members are committed to continuous program review to ensure clients and their families have the information needed to make the best choice for their care needs. You will hear throughout this testimony about program changes that have occurred during the interim and those that are funded in the Executive Budget.

Developmental Disabilities

As you will hear from JoAnne Hoesel when she provides the overview testimony for the Developmental Disabilities (DD) programs, there continues to be various areas for program focus. These range from the renewal of the DD waivers, consumer choice, transitions of individuals from the Developmental Center and increased oversight from the Centers for Medicare and Medicaid Services. I will cover the DD Community Grant expenditures later in this testimony.

Major Program Changes

HCBS Waiver

The 2007-2009 Appropriation for the Home and Community-Based Services Waiver included funding to add Family Personal Care, Extended

Personal Care and Home Delivered Meals. **Family Personal Care** assists individuals to remain with their family members and in their own communities, and provides for the provision of extraordinary care payments to the legal spouse of a recipient for the provision of personal care or similar services. **Extended Personal Care** includes hands-on care of a medical nature that is specific to the needs of an eligible individual and will enable an individual to live at home. This service is provided by a Qualified Service Provider (QSP), and to the extent permitted by State law, is care that would otherwise be provided by a nurse. A nurse, licensed to practice in the state, provides training to a QSP approved by the Department to provide the required care and (the nurse) will provide at a minimum, a review of the clients' needs every six months to determine if additional training is required. Activities of daily living and instrumental activities of daily living are not a part of this service. The purpose of **home delivered meals** is to provide a well-balanced meal to an individual who lives alone and is unable to prepare an adequate meal, or who lives with another person who is unable or not available to prepare an adequate meal for the individual. During the 2007-2009 interim, this service was added to the HCBS Waiver, with a limit of three hot or frozen home delivered meals per week. The Executive Budget request for 2009-2011 includes funding to increase the three meals per week to seven meals per week. This increase would require a change to the HCBS Waiver, and it is expected that the implementation date would be January 1, 2010.

Technology Dependant Waiver

Shortly after the beginning of the current biennium (August 1, 2007), the Department received Centers for Medicare and Medicaid Services (CMS)

approval to operate a Medicaid waiver for individuals who are technology dependent. This waiver has three slots available.

Children's Medically Fragile Waiver

2007 Senate Bill 2326 authorized the implementation of Medically Fragile Waiver for Children. This waiver received approval by CMS on April 1, 2008. The waiver currently serves three children and staff members are working with other families to complete the level of care and level of need documents.

Money Follows the Person Demonstration Grant

In 2007, the Department was awarded a Money Follows the Person (MFP) Grant. The grant funding is provided to North Dakota for the purpose of assisting individuals in nursing facilities and institutions that serve individuals with a developmental disability in transitioning to home and community-based settings. The grant is expected to transition 30 individuals with a developmental disability and 80 individuals who reside in a nursing facility to the community. After receiving CMS approval of the operational protocols for the grant, transitions began in the summer of 2008. Through December 2008, five individuals were transitioned to the community. The transition goal for 2009 is 34 individuals. The grant ends September 30, 2011. We have included two MFP brochures (one for each transition population) to provide additional information and detail.

Program for All-Inclusive Care of the Elderly (PACE)

PACE is a program that provides complete health care coverage to persons who have long-term care needs. To be eligible for PACE, an individual must be at least 55 years of age, live within the PACE service area, meet nursing home level of care, and be able to live safely in the

community. Northland Healthcare Alliance and Medical Services staff worked together to implement this "managed care" approach to delivering services to qualifying individuals. Each month, the Medicaid program pays a capitated rate to Northland, and in turn, Northland is responsible to coordinate and pay for all Medicare and Medicaid services needed by the individual. The goal of the PACE program is to provide the necessary services to individuals to allow them to continue living at home. Each individual has a care plan that details the services needed and all services are reviewed and approved by the PACE care team. Northland Healthcare Alliance identified Bismarck and Dickinson as their PACE service areas. Enrollment in the program began in August 2008 and as of December 1, 2008 there are nine individuals enrolled in the program (seven are Medicare and Medicaid and two are Medicare only). For additional information, a PACE brochure is included with my testimony.

Minimum Data Set (MDS) 3.0

Currently, North Dakota, and other states are using Version 2.0 of the Minimum Data Set (MDS).

The following information is adapted from the CMS website:

In response to changes in nursing home care, resident characteristics, advances in resident assessment methods, and provider and consumer concerns about the performance of the Minimum Data Set (MDS) 2.0, the Centers for Medicare and Medicaid Services (CMS) is undertaking an effort to implement Version 3.0. The expected implementation date is October 1, 2009. This implementation will involve system changes and the Department has assembled a multi-Division workgroup to ensure readiness for the October implementation.

According to CMS, the goals of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, and increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in nursing home care requested that MDS 3.0 revisions focus on improving the tool's clinical utility, clarity, and accuracy. CMS also wanted to shorten the tool while maintaining the ability to use MDS data for quality indicators, quality measures, and payment.

MDS is part of the federally mandated process for clinical assessment of all residents in nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. MDS assessments are completed for all residents in certified nursing homes, regardless of individual's source of payment. MDS assessments are required for residents on admission to the nursing facility and then periodically, within specific guidelines and time frames. MDS information is transmitted electronically by nursing homes to the state Medicaid office, and is used as the cornerstone for establishing the resident's per day cost of care.

Non-Medical Transportation

Funding to add Non-Medical Transportation to Service Payments for the Elderly and Disabled (SPED) and ExSPED is included in the Executive Budget. The total funds are $406,444, of which $387,660 are general funds and $18,784 are county funds. Non-Medical Transportation allows individuals to access essential community resources/services in order to maintain themselves in their home and community. Individuals receiving non-medical transportation service: (1) are unable to provide their own transportation, (2) need a means of obtaining basic necessary community

resources and/or services (i.e. grocery, pharmacy, laundromat), and (3) do not have access to transportation through an informal network.

Revising the SPED Fee Schedule

Through input of stakeholders and advocates, the Department has been urged to revise the SPED Fee Schedule. The schedule was last updated August 1, 2003. The Executive Budget includes the funding to update the fee schedule. This update was based on actual cost of living adjustments (COLA) through January 2008 and an estimated COLA for January 2009.

Removal of the Adult Family Foster Care – Point Split

The purpose of Adult Family Foster Care is to offer a choice within a continuum of care to adults, who could benefit from living in a family environment, as well as to promote independent functioning and provide for a safe and secure environment. Currently, when multiple recipients reside in a Family Foster Care setting, the reimbursement points assigned to laundry, shopping, and housekeeping are split by the number of recipients. This results in less reimbursement for the provider and a greater amount of paperwork. The Executive Budget contains funding to remove the point split. Removing the point split will compensate providers more equitably for services provided and help ensure access to Adult Family Foster Care services for clients. The point split change would be effective January 1, 2010.

Implementing Hospice for Children Waiver

Hospice options for families with terminally ill children are very limited. Today hospice is offered to terminally ill individuals who have elected hospice, which generally requires that they are no longer looking at curative measures. A Medicaid Hospice waiver will allow a child to receive

Hospice services and palliative care within the child's home. In addition, the family can continue to receive Medicaid-reimbursed services, such as curative care, as well as counseling, respite, and expressive therapies. The waiver will have 30 available slots, and is expected to be operational by July 1, 2010, contingent upon the implementation of a new Medicaid Management Information System (MMIS) and approval from the Centers for Medicare and Medicaid Services (CMS).

Personal Care – Third Tier

Personal Care Services assist an individual with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) so that the individual is able to live at home. Personal care services are authorized when service activities are essential either on an intermittent or ongoing basis, and the need for personal care services is expected to continue for a period of time in excess of 30 days. Currently there are two levels of Personal Care (Level A and B). The maximum number of hours available is about eight per day. In order to accommodate those unique cases where recipients are determined to require more than eight hours of personal care per day, the Executive Budget contains the funding to add a third tier of Personal Care called Expanded Medicaid State Plan –Personal Care that would allow a maximum of 10 hours of Personal Care per day. Specific criteria would need to be met and prior authorization by a HCBS Administrator would be required for approval of this service. In addition, the Centers for Medicare and Medicaid Services (CMS) will need to approve the addition of the third tier. Based on the time needed for CMS approval and computer system changes, the estimated start date for this service is January 1, 2010.

ISLA Administrative Funding

Currently, administrative reimbursements for the Individualized Supported Living Arrangement and Family Care Option (FCO) III programs are inadequate to support programs for individuals with high levels of need. Providers of service typically lose money providing services to individuals receiving ISLA and FCO III services. These programs are essential to community placement of individuals from institutions and individuals receiving these services have very high need levels. Currently there is a disincentive in the administrative reimbursements to serve clients receiving these services. The Executive Budget contains $2.4 million (of which $.9 million are general funds for ISLA and $96,108 (of which $35,416 are general funds for FCO III) to increase the administrative reimbursement so it is based on the client level of need. This increase is intended to ensure community placements are available and to prevent additional institutional admissions.

Personal Needs Allowance – SSI Only Individuals

Personal Needs Allowance dollars are used by individuals in an institutional setting (Nursing Home, Intermediate Care Facility for the Mentally Retarded (ICF/MR) and Psychiatric Residential Treatment Facility) for items such as clothing, recreational or social activities, a bottle of pop, or a birthday card. Some individuals in an institution are "SSI only" and their Personal Needs Allowance is paid to them by Social Security. This allowance is limited to $30. Funding to increase the Personal Needs Allowance for these individuals to $50 per month is included in the Executive Budget. The $20 increase per person would be funded with 100% general funds. The Executive Budget includes $148,068 to fund this increase. Based on the effort needed to implement

this change, it is expected that this increase would take effect January 1, 2010.

Intense Medical Needs – Family Homes

Currently Intermediate Care Facilities receive enhanced funding to provide services to children with intense medical needs. The Executive Budget includes funding to increase the wages of In-Home Support staff, who assist families in caring for children at home. The level of reimbursement would be at the same level as Intermediate Care Facility providers serving children with similar intense medical needs.

Intense Medical Needs – Residential Facility

As noted above, currently Intermediate Care Facilities receive enhanced funding to provide services to children with intense medical needs. The Executive Budget includes funding to compensate DD providers serving adults with intense medical needs at the same level as Intermediate Care Facilities providers serving children with similar intense medical needs.

Personal Needs Allowance – Decoupling ICF/MR

Personal Needs Allowance dollars are used for items such as clothing, recreational or social activities, a bottle of pop, or a birthday card. Currently, the amount of Personal Needs Allowance individuals in a Nursing Facility and individuals in an Intermediate Care Facility are allowed to keep is currently set at $50 per person per month. During the interim, the Department has worked with the Centers for Medicare and Medicaid Services (CMS) to secure approval to "decouple" the Personal Needs Allowance for individuals in a Nursing Facility from those in an Intermediate Care Facility. The Executive Budget includes funding to increase the Personal Needs Allowance for individuals in an Intermediate

Care Facility to $60 per month. The change would be effective January 1, 2010.

Medicaid Waiver - Autism Spectrum Disorder – Under 5 Years

The Executive Budget contains the funding to implement a Home and Community-Based Services (HCBS) Waiver to provide intensive supports for young children who have a diagnosis of Autism Spectrum Disorder. The waiver needs to be written, and the Department would need to secure CMS approval; therefore, we are expecting an implementation date of July 1, 2010, which would also be contingent upon the implementation of the new Medicaid Management Information System. The waiver will have 30 slots.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / Decrease
Nursing Homes	370,080,827	422,244,637	52,163,810
Basic Care	14,083,121	17,070,865	2,987,744
Personal Care	19,086,421	23,919,788	4,833,367
HCBS Waiver	4,943,345	9,607,825	4,664,480
Tech Dependent Waiver	762,019	540,744	(221,275)
Children's Medically Fragile Waiver	1,343,070	1,165,293	(177,777)
SPED	11,945,116	17,340,292	5,395,176
Ex-SPED	763,149	717,401	(45,748)
PACE	1,452,310	7,393,711	5,941,401
Targeted Case Management	923,325	1,985,916	1,062,591
DD - Community Based Care	274,423,470	323,056,043	48,632,573
Total	699,806,173	825,042,515	125,236,342
General Funds	257,332,905	313,669,588	56,336,683
Federal Funds	435,566,053	505,155,627	69,589,574
Other Funds	6,907,215	6,217,300	(689,915)
Total	699,806,173	825,042,515	125,236,342

FTE	-	-	-

- Nursing Facility services account for about 51.2 percent of the 2009-2011 budget for the long-term care continuum. (Compare to 52.9 percent for 2007-2009 Budget)

- Basic Care accounts for about 2.1 percent of the 2009-2011 budget for the long-term care continuum. (Compare with 2.0 percent for 2007-2009 Budget)

- Home and Community-Based Services account for 7.6 percent of 2009-2011 Budget for the long-term care continuum. (Compare to 5.9 percent for the 2007-2009 Budget)

- DD Grants account for about 39.2 percent of the 2009-2011 Budget for the long-term care continuum. (Compare to 39.2 percent for the 2007-2009 Budget)

- This portion of the 2009-2011 Budget also contains an inflationary increase for providers at seven percent each year of the Biennium.

- The impact on the 2009-2011 Budget of the decline in the Federal Medical Assistance Percentage on general funds for the Long-Term Continuum is $5.8 million.

Nursing Facilities

- The Executive Budget request for nursing facilities totaled $422.2 million, of which $153.2 million are general funds. The current budget for nursing facility services is $370.1 million of which $132.8 million are general funds. This $52.1 million increase is related to: Caseload and Utilization decreases ($9.8 million), the seven/seven percent inflationary increase ($26.9 million), and cost changes of $35 million. The cost changes include the funds necessary for rebasing the limits ($3.5 million), the funds necessary to sustain the increase to the property limits ($7.8 million), and cost changes

reported on the annual cost reports that need to be covered and sustained ($23.7 million). Attachment D shows historical information on expenditures and average daily Nursing Facility Rates. Earlier in my testimony, I reported that Medicaid is paying for approximately 54 percent of individuals in the nursing facilities. The remaining 46 percent are mostly private pay. The increases noted above are built into the average cost per day which affects both Medicaid and private pay residents. Private pay residents will see an increase of approximately $13 per person per day, each rate year of the 2009-2011 Biennium.

- The Executive Budget for nursing facilities was based on Medicaid occupancy of 3,388 beds per month. The occupancy includes:

  3,132 - Nursing Facility
  16 – Dakota Alpha
  30 – Geropsych Unit
  62 - Swing Bed
  86 – Hospice Room and Board
  62 – Out of State

Basic Care

- The Executive Budget for Basic Care is $17.1 million of which $7.9 million are general funds. This is a $3 million increase over the current budget. The average monthly caseload for the 2009-2011 budget request is 455, and the average utilization for the first 12 months of the biennium is 397. The increase consists of cost and utilization changes ($.8 million net increase) and $2.2 million increase for the seven percent inflation each year of the biennium.

Home and Community- Based Services

This area of the budget includes many funding sources such as the various Medicaid waivers, personal care services, SPED, and PACE. Collectively the net change is an increase of $21.5 million in total funds. The contributing factors to the increase are noted below:

- The Executive Budget includes an increase of $4.8 million for Personal Care Services. The average monthly caseload for Personal Care Services is estimated to be 671 and the caseload for the first 12 months of the biennium was 570. The estimated caseload (671) includes the expected average caseload increase of 20 for Tier III Personal Care. The budget increase in this area accounts for the utilization changes noted during the budget preparation process and also includes cost/utilization changes (net increase of $.6 million), the seven percent inflation each year of the biennium ($ 1.4 million increase) and the addition of Tier III Personal Care ($2.8 million increase). Tier III Personal Care is expected to be effective January 1, 2010, after receiving the necessary federal approval, and making the necessary computer system changes.
- The Executive Budget for the Service Payments to the Elderly and Disabled (SPED) is $17.3 million of which $16.5 million are general funds and $.8 million are county funds. This is a $5.4 million increase over the 2007-2009 Budget. The average monthly caseload is estimated to be 1,597, and the average caseload for the first 12 months of the biennium was 1,434. The estimated caseload includes the addition of 22 individuals expected as a result of revising the SPED fee schedule. The cost increase consists of the seven percent inflationary increase ($1.6 million), funding to revise the SPED fee schedule ($.6 million), the portion of the adult family foster care point split that applies to this area ($32,141), and $3.1

million to cover the cost and utilization increases expected, based on the trends used during the budget preparation process.

- The 2009-2011 Executive Budget request for ExSPED is $717,401, as compared to the 2007-2009 Budget of $763,149. The budget request is built on an average monthly caseload of 129, and the average caseload for the first 12 months of the biennium was 109. The seven percent inflationary increase for this area is $70,441, and the portion of the adult family foster care point split that applies to this area is $2,142. In addition there were cost and utilization decreases which totaled $118,331.
- The Executive Budget request for Targeted Case Management is $2 million, of which $.7 million are general funds. This represents a $1.1 million increase over the 2007-2009 appropriation. The average monthly caseload is expected to be 458. For the first 12 months of the current biennium, the caseload was averaging 427. The increase includes $.2 million for the inflationary increase, and $.9 million increases for cost and utilization. The Medicaid Targeted Case Management regulations are on a moratorium through March 2009; therefore, we await the final implementation direction to determine if there are additional impacts in this area.
- The Executive Budget request for the HCBS Waiver is $9.6 million of which $3.6 million are general funds. The HCBS Waiver includes the waivers previously reported as the TBI (Traumatic Brain Injury) Waiver and the Aged and Disabled Waiver. The average monthly caseload included in the budget request is 349 and for the first 12 months of the biennium, the average caseload was 244. The estimated average caseload includes expected increases for the Adult Family Foster Care Point Split (eight) and for the Hospice Waiver (15). The increase in the projected utilization is a result of

the new services added to the waiver over the interim, which were discussed earlier in my testimony. The overall increase, as compared to the 2007-2009 appropriation, is $4.7 million. This increase consists of $.8 million for the seven percent inflationary increase, $81,156 for the portion of the adult family foster care point split change that affects clients within the waiver, $.9 million to fund the new Hospice Waiver for Children, and an increase of $2.9 million for cost and utilization changes accounted for when preparing the budget. The implementation date for the additional home delivered meals is expected to be January 1, 2010 and the implementation date for the Hospice Waiver for Children is expected to be July 1, 2010.

- The Executive Budget request for the Children's Medically Fragile Waiver is $1.2 million of which $.4 million are general funds. The current appropriation for this waiver is $1.4 million. The 2009-2011 budget request estimates an average monthly case load of 11 for this waiver. Currently there are three children receiving waiver services, and the budget is built with estimates of increasing the caseload gradually over 2009-2011. The wavier has a maximum of 15 slots. This area includes a $.1 million for the seven percent inflationary increase, and a net decrease of $.3 million, related to cost and utilization changes.
- The Executive Budget request for the Technology Dependant Waiver is $.5 million of which $.2 million are general funds. The 2007-2009 budget is $.8 million. This waiver is now serving one individual, and the budget request is based on the expectation that we will provide services to two individuals in SFY 2010 and three for SFY 2011. The waiver has a maximum of three slots. The budget request

includes $55,740 for the seven percent inflationary increase and a net decrease of $277,015 for cost and utilization changes.

- The Executive Budget request for the Program for All-Inclusive Care of the Elderly (PACE) is $7.4 million, of which $2.7 million are general funds. While this presents a $5.9 million increase in the budget, it is actually a "shifting" of dollars from other services. The utilization in the other Medicaid services was reduced for the budgeted PACE utilization. As noted earlier in my testimony, PACE is a capitated long-term care program; therefore, PACE is responsible for all Medicaid services needed by enrolled participants. As a result, it is expected that Medicaid would have fewer direct expenditures for services, such as nursing facility care, personal care and hospital services, as these "bills" would be paid directly by the PACE program. The monthly average enrollment for PACE was budgeted at 76, which includes the additional enrollments Northland Healthcare Alliance is expecting in the Bismarck and Dickinson areas. The PACE budget does not contain funding for the inflationary increase, as the rates are established by an actuary and not subject to inflationary increases.

Developmental Disabilities

The increases of approximately $48.6 million in the DD Grants are from following eight areas:

- $190,195 net decrease in caseload. The decrease consists of $151,145 in general funds and $39,050 in federal funds.

- $17.6 million is due to cost changes that occurred during the 2007-2009 Biennium, which must be sustained during the 2009-2011

Biennium. The cost change increase consists of $6.5 million in general funds and $11.1 million in federal funds.

- $28.5 million is due to a seven percent inflationary increase each year of the 2009-2011 Biennium. The increase consists of $10.5 million in general funds and $18 million in federal funds.

- $103,680, of which $38,341 are general funds, to increase the Personal Needs Allowance for individuals residing in an ICF/MR from $50 per month to $60 per month.

- $805,412, of which $297,842 are general funds, to cover the cost of services provided to adults with intense medical needs who live in a residential facility.

- $644,330, of which $238,274 are general funds, to cover the cost of services provided to children with intense medical needs who are cared for in their family homes.

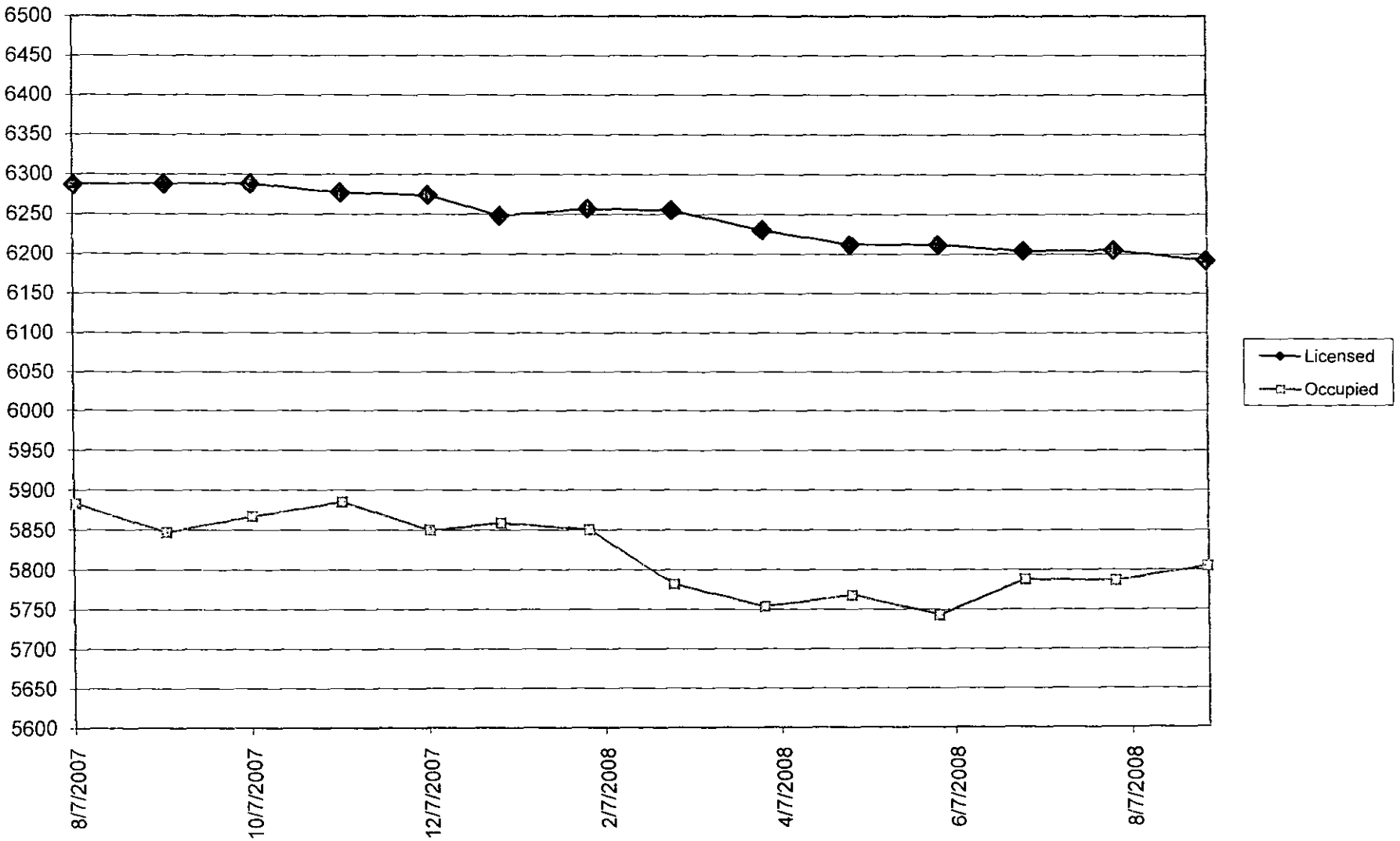
- $57,854 of which $21,394 are general funds, for the portion of the adult family foster care point split change that applies to this area of the budget.

- $1 million, of which $.4 million are general funds, to operate a Medicaid Autism Waiver for one year. The funding is only for one year; it is expected to take one year after legislative approval to write the waiver, secure public input and receive CMS approval.

I would be happy to answer any questions you may have.

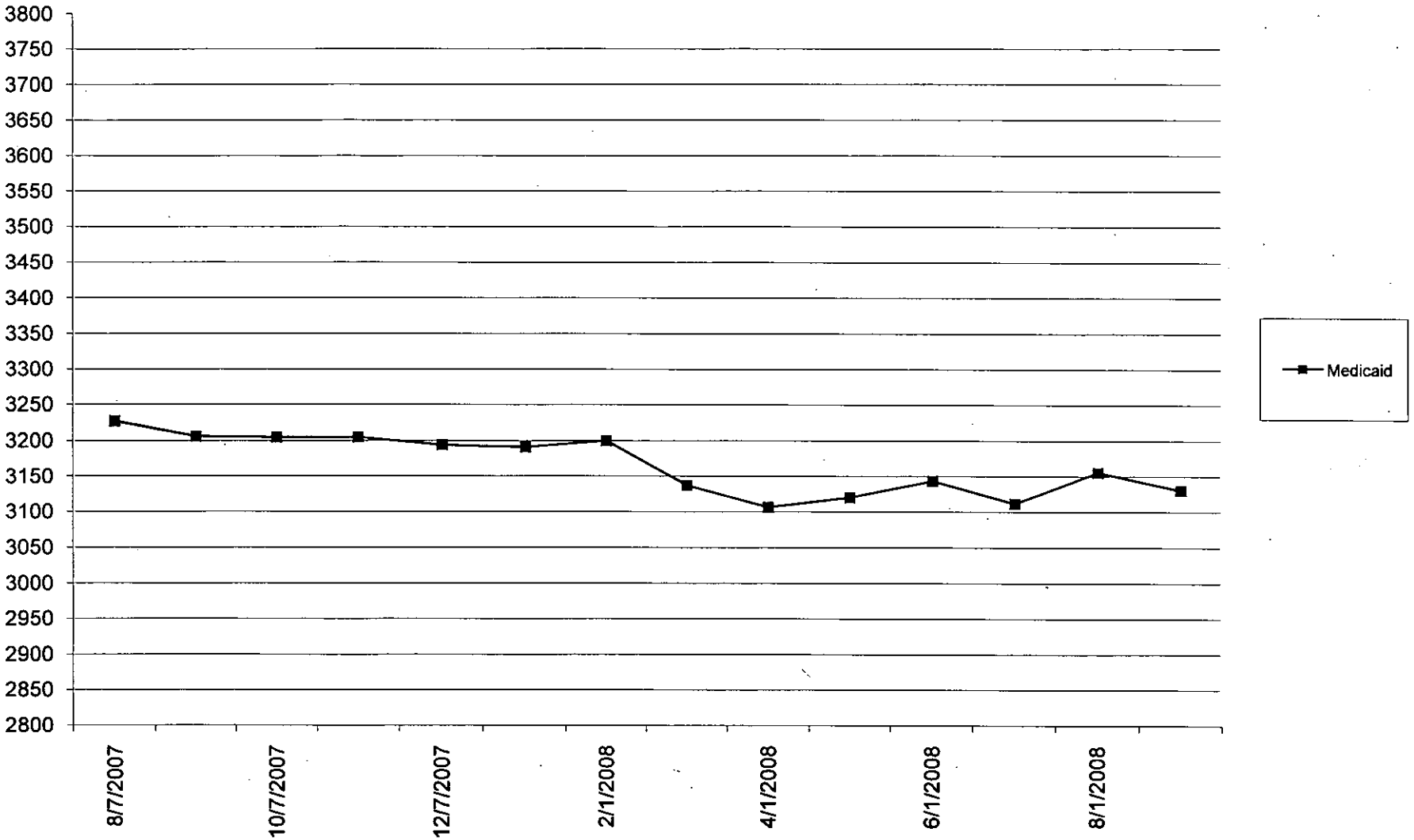
Attachment A

Nursing Facility Occupancy at Month End



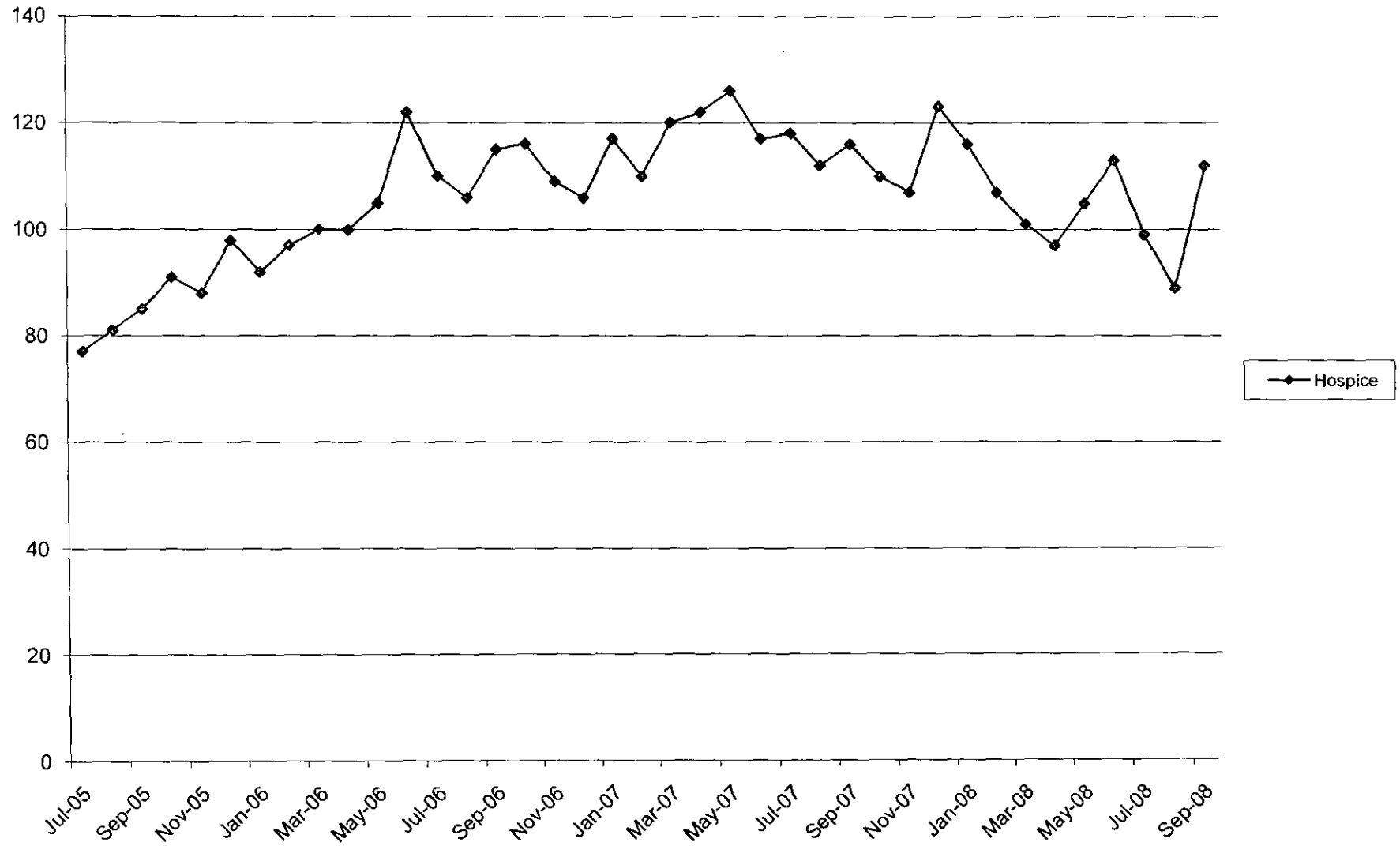
Attachment B

Nursing Facility Occupancy at Month End- Medicaid ONLY



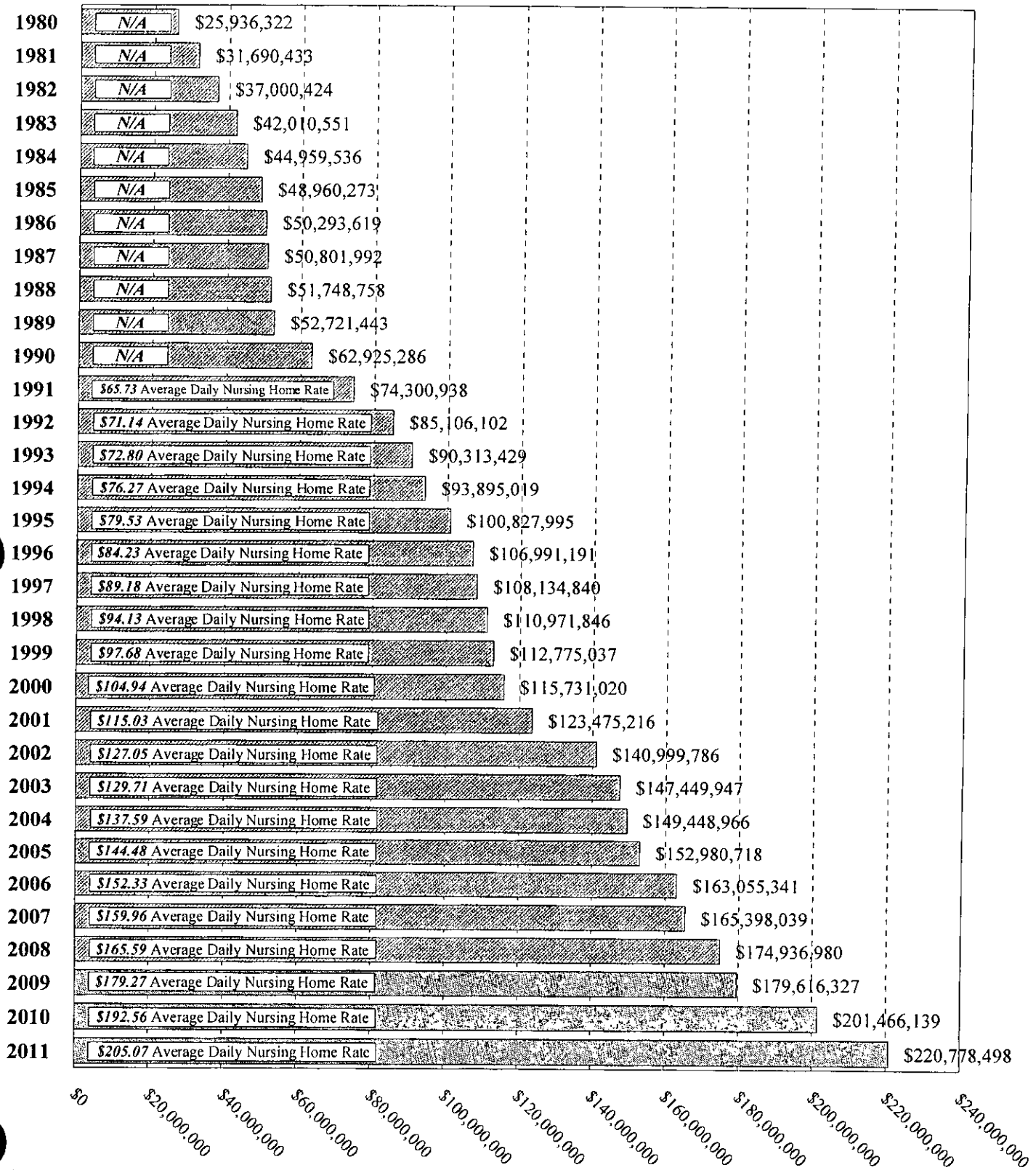
Attachment C

NURSING FACILITY HOSPICE



Attachment D

North Dakota Department of Human Services
Nursing Home Facilities
Fiscal Years 1980 - 2011 *
House Bill 1012
2009 - 2011 Biennium



* 1980 through 2008 represents actual expenditures.
2009 represents four months actual and eight months estimated expenditures.
2010 and 2011 represents estimated expenditures included in the Governor's budget.
The average daily nursing home rate is effective January 1 of each year as indicated.

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North Dakota Department of Human Services
HB 1012 - LTC Continuum
Nursing Facility Rates
To the House

A

Provider Name	City	Licensed Beds	Effective 1/1/09 - Low rate -	Effective 1/1/09-High Rate - SE3
Four Seasons Health Care Center, Inc.	Forman	32	$113.61	$240.06
Oakes Manor Good Samaritan Center	Oakes	102	$116.01	$276.68
Prince of Peace Care Center	Ellendale	55	$120.67	$259.85
Pembilier Nursing Center	Walhalla	37	$116 53	$281.56
Mott Good Samaritan Nursing Center	Mott	51	$120 51	$275.84
Maple Manor Care Center	Langdon	63	$119 56	$285.94
Osnabrock Good Samaritan Center	Osnabrock	24	123.77	273.21
Manor Care of Minot ND, LLC	Minot	106	$122.81	$278.57
Presentation Medical Center	Rolette	46	$123.16	$280.42
Park River Good Samaritan Center	Park River	76	$123 87	$289.33
Larimore Good Samaritan Center	Larimore	45	$125.67	$281.75
Dunseith Community Nursing Home	Dunseith	35	125.82	281.41
St. Catherine's Living Center	Wahpeton	104	$128.14	$280.58
St. Rose Care Center	LaMoure	44	$128.22	$288.21
Prairieview Home-Medcenter One	Underwood	60	$124.35	$307.51
St. Gerard's Community Nursing Home	Hankinson	37	$127.01	$298.14
Souris Valley Care Center	Velva	50	$128.60	$291.59
Crosby Good Samaritan Center	Crosby	42	128.20	295.34
St. Benedict's Health Center	Dickinson	164	$127.95	$299.02
Lakota Good Samaritan Nursing Home	Lakota	49	$128.89	$299.16
Marian Manor Healthcare Center	Glen Ullin	86	$124.59	$322.46
Arthur Good Samaritan Center	Arthur	47	131.40	300.21
Jacobson Memorial Hospital Care Center	Elgin	25	131.74	301.85
Golden Acres Manor Nursing Home	Carrington	60	$131.70	$308.88
Tioga Medical Center	Tioga	30	$133.17	$304.55
Napoleon Care Center	Napoleon	44	$132.37	$310.82
Strasburg Care Center	Strasburg	60	$127.26	$333.47
Parkside Lutheran Home	Lisbon	40	132.85	309.30
Manorcare of Fargo ND, LLC	Fargo	109	133.45	306.84
Benedictine Living Center of Garrison	Garrison	63	$135.15	$304.01
St. Aloisius Medical Center	Harvey	106	$131.99	$319.55
Elm Crest Manor	New Salem	62	$131.94	$320.20
Ashley Medical Center	Ashley	44	134.80	310.40
Elim Home	Fargo	136	$133.35	$319.49
Towner County Medical Center	Cando	45	141.73	287.10
Nelson County Health System Care Center	Mcville	39	$138.84	$299.99
North Central Good Samaritan Center	Mohall	59	$134.66	$318.83
Devils Lake Good Samaritan Center	Devils Lake	66	$133.42	$329.24
Sheyenne Care Center	Valley City	154	$133.84	$328.90
Maryhill Manor	Enderlin	54	$136.44	$328.22
Lutheran Home of the Good Shepherd	New Rockford	80	$135.15	$334.59
Wishek Home for the Aged	Wishek	74	$135.98	$335.60
Bethel Lutheran Home	Williston	174	$138.16	$330.96
Aneta Parkview Health Center	Aneta	39	139.32	329.23
Medcenter One Golden Manor	Steele	50	$137.94	$338.07
St. Luke's Home	Dickinson	84	$138.83	$339.95
Lutheran Sunset Home	Grafton	104	$139.58	$343.76
Medcenter One St. Vincent's Care Center	Bismarck	101	$139.49	$347.07
Wedgewood Manor	Cavalier	60	142.58	333.99
Western Horizons Living Center	Hettinger	62	$141.70	$341.62
Rock View Good Samaritan Center	Parshall	38	143.30	337.60
Luther Memorial Home	Mayville	99	$141.64	$347.79
Bottineau Good Samaritan Center	Bottineau	81	$144.32	$350.28
Baptist Home	Bismarck	141	142.29	366.21
McKenzie County Healthcare System	Watford City	47	143.65	360.34
Mountrail Bethel Home	Stanley	57	144.93	355.74
Westhope Home for the Aged	Westhope	25	147.39	346.92
Bethany Home	Fargo	192	$145.90	$353.50
Garrison Memorial Hospital Nursing Home	Garrison	28	146.42	354.93
Tri County Health Center	Hatton	42	151.44	344.69
Cooperstown Medical Center	Cooperstown	48	$149.03	$355.55
Hill Top Home of Comfort, Inc.	Killdeer	50	150.87	353.39
Valley Eldercare Center	Grand Forks	176	$151.66	$350.10
Rosewood on Broadway	Fargo	111	$153.89	$348.73
Trinity Home	Minot	292	$149.66	$369.44
Hi-Acres Manor Nursing Center	Jamestown	142	149.55	373.47
Heartland Care Center	Devils Lake	88	149.84	373.76
Heart of America Medical Center	Rugby	80	152.14	368.92
Missouri Slope Lutheran Care Center, Inc.	Bismarck	250	152.44	376.36
Villa Maria Healthcare	Fargo	138	$159.90	$348.72
North Dakota Veterans Home	Lisbon	38	153.86	377 78
Northwood Deaconess Health Center	Northwood	61	157 64	369.30
Woodside Village	Grand Forks	118	$158 50	$367.38
Central Dakota Village	Jamestown	100	$157 11	$377.30
Kenmare Community Hospital	Kenmare	12	156 55	380 47
Southwest Healthcare Services	Bowman	61	157 50	381 42
Medcenter One Care Center	Mandan	128	$162 49	$363 29
Knife River Care Center	Beulah	86	173.50	374 40
Hillsboro Medical Center	Hillsboro	36	197 10	421 02

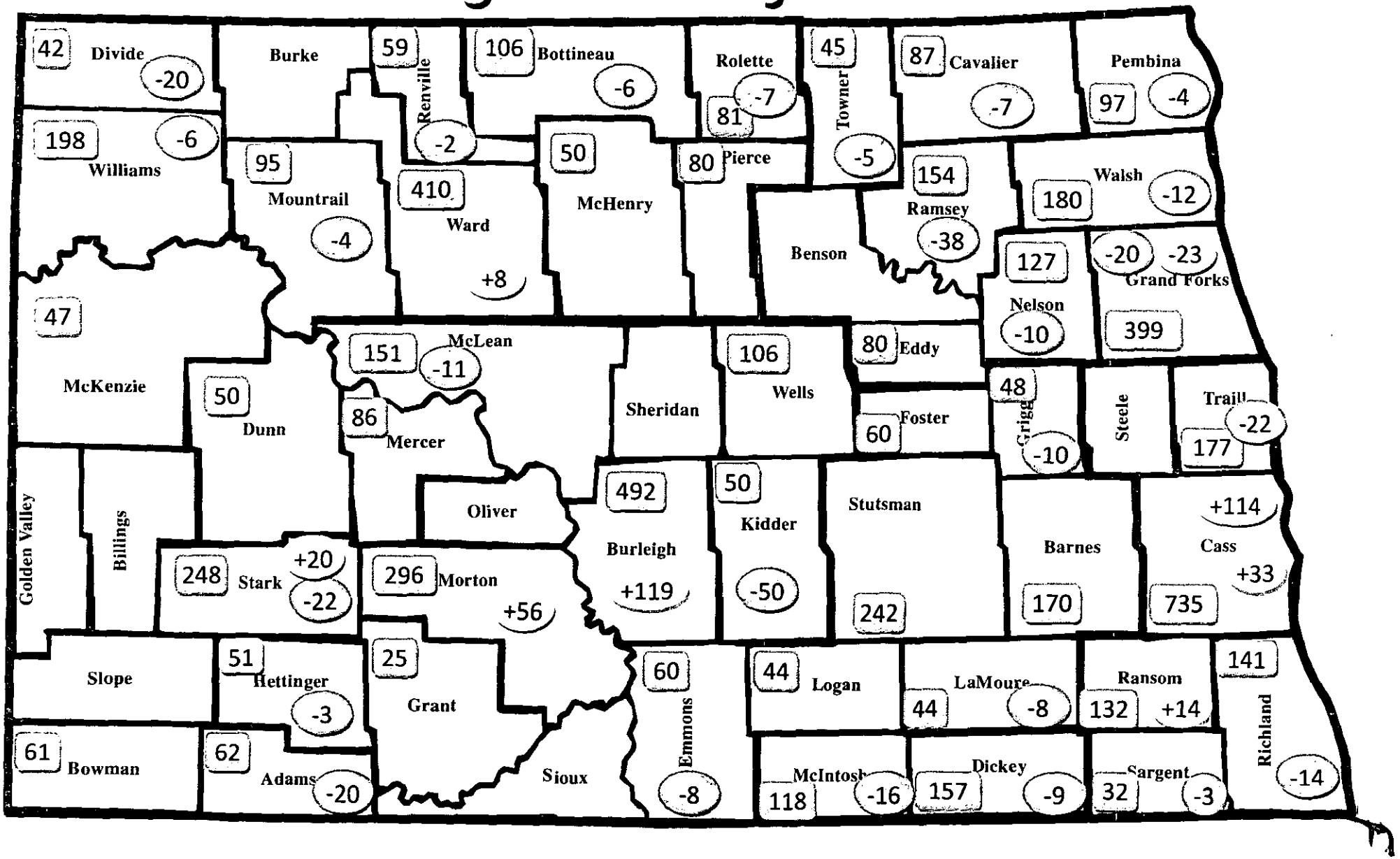
Facilities with 3 limits Facilities with 2 limits Facilities with 1 limits

North Dakota Department of Human Services
HB 1012 - LTC Continuum
Nursing Facility Occupancy Trend Comparison
To the House

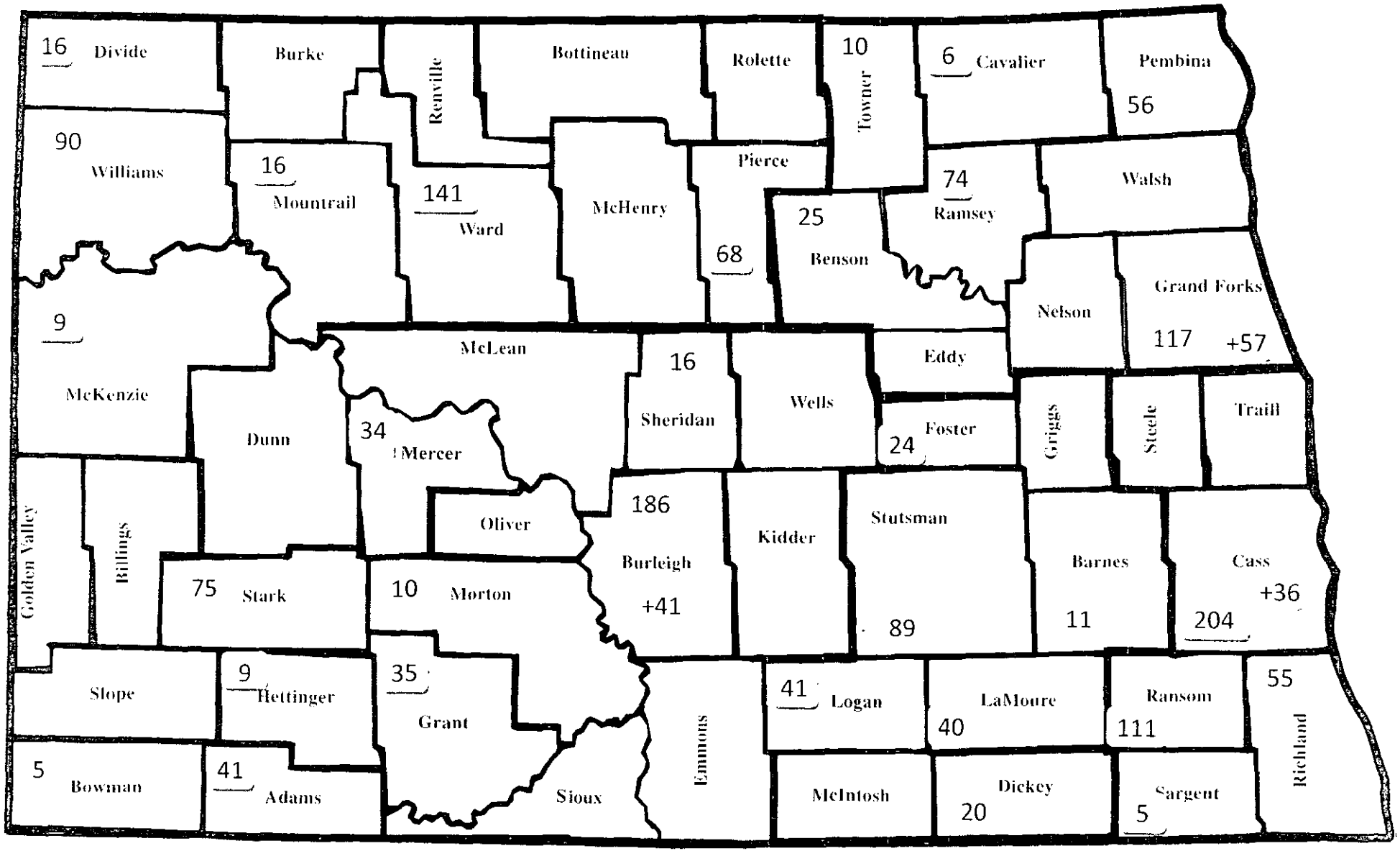
Nursing Facility Occupany
Cost report years 2004 to 2008

Facility	City	County	Licensed capacity			Occupancy percentage				
			6/30/2008	6/30/2004	Pct Chg	6/30/2008	6/30/2007	6/30/2006	6/30/2005	6/30/2004
Presentation Care Center	Rolette	Rollette	46	48	-4.2%	67.5%	55.6%	82.9%	86.8%	87.9%
Hillcrest Care Center	Hettinger	Adams	62	78	-20.5%	77.2%	73.4%	73.9%	78.9%	75.0%
LaMoure Healthcare Manor	LaMoure	LaMoure	44	50	-12.0%	84.0%	84.7%	87.2%	72.1%	89.1%
Osnabrock Good Samaritan Center	Osnabrock	Cavalier	24	31	-22.6%	85.2%	74.6%	60.8%	82.9%	99.4%
Sargent Manor Health Care Center	Forman	Sargent	32	35	-8.6%	85.3%	86.7%	89.4%	94.7%	86.1%
Ashley Medical Center	Ashley	McIntosh	44	44		85.4%	89.8%	95.4%	90.7%	93.9%
Wedgewood Manor	Cavalier	Pembina	60	60		86.0%	88.9%	88.2%	91.7%	96.5%
Pembilier Nursing Center	Walhalla	Pembina	37	41	-9.8%	87.6%	82.4%	90.2%	97.5%	97.5%
Hill Top Home of Comfort, Inc.	Killdeer	Dunn	50	50		87.7%	94.2%	94.8%	95.7%	97.0%
Prince of Peace Ellendale	Ellendale	Dickey	55	64	-14.1%	88.6%	89.9%	89.3%	86.2%	89.4%
Bethel Lutheran Home	Williston	Williams	174	168	3.6%	88.7%	94.4%	93.6%	92.2%	94.0%
Souris Valley Care Center	Velva	McHenry	50	50		89.0%	92.2%	90.2%	97.0%	95.8%
Rock View Good Samaritan Center	Parshall	Mountrail	38	42	-9.5%	89.2%	85.9%	81.6%	80.5%	91.4%
Mott Good Samaritan Nursing Center	Mott	Hettinger	51	54	-5.6%	90.1%	90.3%	94.7%	94.9%	94.5%
Maple Manor Nursing Home	Langdon	Cavalier	63	63		90.2%	95.0%	96.7%	98.0%	99.9%
Villa Maria	Fargo	Cass	138	138		90.3%	96.8%	96.7%	95.1%	95.1%
Aneta Parkview Health Center	Aneta	Nelson	39	39		90.6%	91.1%	82.8%	91.0%	90.0%
Dunseith Community Nursing Home	Dunseith	Rolette	35	42	-16.7%	91.0%	78.9%	81.0%	81.1%	83.5%
Lutheran Sunset Home	Grafton	Walsh	104	113	-8.0%	91.4%	93.8%	90.3%	92.8%	95.5%
Community Nursing Home	Hillsboro	Traill	36	48	-25.0%	91.4%	101.6%	97.4%	82.5%	93.0%
Bottineau Good Samaritan Center	Bottineau	Bottineau	81	81		91.8%	97.2%	97.8%	95.3%	94.5%
Hi-Acres Manor Nursing Center	Jamestown	Stutsman	142	142		91.9%	95.2%	93.1%	96.8%	98.2%
Lake Region Lutheran Home	Devils Lake	Ramsey	88	108	-18.5%	92.5%	93.3%	89.1%	91.3%	93.1%
Devils Lake Good Samaritan Center	Devils Lake	Ramsey	66	79	-16.5%	92.6%	85.3%	89.6%	86.3%	90.9%
Napoleon Care Center	Napoleon	Logan	44	44		92.7%	96.5%	94.7%	92.3%	94.1%
Lakota Good Samaritan Center	Lakota	Nelson	49	54	-9.3%	93.0%	92.6%	90.4%	91.4%	89.6%
Benedictine Living Center Garrison	Garrison	McLean	63	63		93.2%	94.3%	95.7%	92.5%	95.7%
Luther Memorial Home	Mayville	Traill	99	99		93.5%	94.8%	88.4%	86.3%	91.5%
Trinity Nursing Home	Minot	Ward	292	292		93.7%	92.2%	93.3%	95.0%	95.9%
North Central Good Samaritan Center	Mohall	Renville	59	61	-3.3%	93.8%	95.6%	97.1%	96.5%	95.1%
Westhope Home	Westhope	Bottineau	25	32	-21.9%	94.1%	91.7%	99.3%	92.0%	95.7%
St. Catherines Health Care Center	Wahpeton	Richland	104	132	-21.2%	94.2%	88.0%	87.4%	64.7%	78.3%
Jacobson Mem. Hospital Care Center	Elgin	Grant	25	25		94.5%	98.1%	88.9%	98.7%	99.2%
Arthur Good Samaritan	Arthur	Cass	47	47		94.5%	93.6%	94.2%	90.1%	91.4%
Manor Care Health Services Fargo	Fargo	Cass	109	109		94.7%	90.4%	95.4%	94.2%	89.4%
Manor Care Health Services Minot	Minot	Ward	106	106		95.0%	95.8%	97.2%	97.5%	98.8%

Nursing Facility Beds



Basic Care Beds



LTC CONTINUUM FUNCTIONAL & FINANCIAL ELIGIBILITY REQUIREMENTS COMPARISON (1/20[redacted]

North Dakota D[redacted]ent of Human Services

A

Ex[redacted]	MSP-Personal Care (Level A)	SPED	MSP-Personal Care (Level B)	Medicaid Waiver for HCBS (Elderly and Disabled)	PACE (Program of all Inclusive Care of the Elderly)	Nursing Home
Services • Adult Day Care • Adult Foster Care • Chore • Emergency Response System • Environmental Modification • Family Home Care • HCBS Case Management • Homemaker • Respite	**Service** • Personal Care Services	**Service** • Adult Day Care • Adult Foster Care • Chore • Emergency Response System • Environmental Modification • Family Home Care • HCBS Case Management • Homemaker • Respite • Personal Care Services	**Service** • Personal Care Services	**Service** • Adult Day Care • Adult Foster Care • Adult Residential • Chore & ERS Systems • Environmental Modification • HCBS Case Management • Homemaker • Non-Med Transportation • Respite • Specialized Equipment/Supplies • Supported Employment • Transitional Care • Extended Personal Care • Home Delivered Meals • Family Personal Care **Technology Dependent Medicaid Waiver** **Service** • Attendant Care Service	**Service** • All Medicare and Medicaid Services • Primary Medical Care • Meals • Nutritional Counseling • Home Health Care • Personal Care • Dentistry • Prescription Drugs • Social Services • Adult Day Care • Therapies • Transportation • Hospital Care • Hospital ER • Nursing Service • Nursing Home Care • Other services as determined by the team	**Service** 24 hour care, including; personal care, nursing care, restorative services, social service, recreational activities, room and board etc.
Personal Care Service: Assistance with activities of daily living such as bathing, dressing, toileting, transferring, eating, mobility and incontinence care. Assistance with instrumental activities of daily living may also be provided in conjunction with the tasks for activities of daily living. Personal Care Services allow individuals to live as independently as possible.						
Functional Eligibility Not severely impaired in ADLs: Toileting, Transferring, Eating **And** Impaired in 3 of the 4 following IADLs: • Meal Preparation • Housework • Laundry • Medication Assistance Or Have health, welfare, or safety needs, requiring supervision or structured environment	**Functional Eligibility** Impaired in 1 ADL **Or** Impaired in 3 of the 4 following IADL's • Meal Preparation • Housework • Laundry • Medication Assistance	**Functional Eligibility** Impaired in 4 ADLs, OR in at least 5 IADLs, totaling eight (8) or more points or if living alone totaling at least six (6) points **Or** If under age 18, meet **LOC** screening criteria **And** Impairments must have lasted or are expected to last 3 months or more	**Functional Eligibility** Impaired in 1 ADL **Or** Impaired in 3 of the following 4 IADL's • Meal Preparation • Housework • Laundry • Medication Assistance **And** Meet **LOC** screening criteria	**Functional Eligibility** Meet **LOC** screening criteria	**Functional Eligibility** Be 55 years of age or older **And** Be able to live safely in the community **And** Meet **LOC** screening criteria	**Functional Eligibility** Meet **LOC** screening criteria
Nursing Facility Level of Care Screening- **(LOC)** Eligibility may include a medical need, example: vent dependent, unstable medical condition, dementia; or an individual may qualify by needing assistance with 2 ADLs 60 % or more of the time. Complete criteria for LOC Screening - NDAC 75-02-02-09.						
Financial Eligibility Medicaid Eligible	**Financial Eligibility** Medicaid Eligible	**Financial Eligibility** Income & Asset Based Sliding Fee Scale Resources $50,000 or less	**Financial Eligibility** Medicaid Eligible	**Financial Eligibility** Medicaid Eligible	**Financial Eligibility** Medicaid and/or Medicare Eligible	**Financial Eligibility** Medicaid Eligible
Program Cap $1602.00 per month	**Program Cap** 480 units per month	**Program Cap** $1602.00 per month	**Program Cap** 960 units per month	**Program Cap** Limited to the highest monthly rate allowed to a nursing facility within the rate setting structure of the Dept.	**Program Cap** Managed care rate per/ member per/month	**Program Cap** Average rate: $5453.00 per/mo. Range $116.01-$415.56 per day

North Dakota Department of Human Services
Medical Services Division – LTC Continuum
List of ADLs and IADLs
To the House

ADLs (Activities of Daily Living

- Bathing
- Dressing
- Eating
- Toileting
- Transferring
- Mobility (inside)
- Continence

IADLs (Instrumental Activities of Daily Living)

- Meal Preparation
- Housekeeping
- Laundry
- Shopping
- Medication Assistance
- Outside Mobility
- Transportation
- Money Management
- Communication/Telephone/Correspondence

B

North Dakota Department of Human Services
HB 1012 - LTC Continuum (HCBS)
Estimated Implementation Dates of Program Changes in Executive Budget To the House

	Contingencies			
Program Change	**Requires CMS Approval**	**Requires Computer System Changes to Current Systems**	**New MMIS Implementation**	**Expected Implementation Date**
Increase Home Delivered Meals (HCBS Waiver)	Yes	No		January 1, 2010
Non Medical Transportation (SPED/ExSPED)	No	No		July 1, 2009
SPED Fee Schedule (Revision)	No	No		July 1, 2009
AFFC Point Split	Yes	No		January 1, 2010
Hospice Waiver for Children	Yes		Yes	July 1, 2010
Personal Care 3rd Tier (State Plan)	Yes	Yes		January 1, 2010

C

North Dakota Department of Human Services
HB 1012 - LTC Continuum (DD)
Estimated Implementation Dates of Program Changes in Executive Budget To the House

	Contingencies			
Program Change	**Requires CMS Approval**	**Requires Computer System Changes to Current Systems**	**New MMIS Implementation**	**Expected Implementation Date**
ISLA/FCO III Admin. Reimb. Change	In waiver submission	Yes		July 1, 2009
SSI Personal Needs Allowance	No	Yes		January 1, 2010
Intense Medical Needs - Family Homes	No	No		July 1, 2009
Intense Medical Needs - Residential Facilities	No	No		July 1, 2009
ICF/MR Personal Needs Allowance	Received	Yes		January 1, 2010
Medicaid Autism Waiver for 0 to 5	Yes		Yes	July 1, 2010

DEPARTMENT OF HUMAN SERVICES

Summary by Subdivision and Bgt_Acct with Funding Sources

2009 - 2011

Class	FB	Budget Account Code		Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-10 LONG TERM CARE									
S101		FULL-TIME EQUIVALENTS (FTEs)		0.000	0.000	0.000	0.000	0.000	0.000
32573	B	712000	Grants, Benefits & Claims	578,938,755	699,806,173	313,965,276	125,236,342	0	825,042,515
			Subtotal:	578,938,755	699,806,173	313,965,276	125,236,342	0	825,042,515
32573	F	F_7391	MA Grants - General Fund	204,345,061	257,332,905	117,550,303	56,336,683	0	313,669,588
32573	F	F_7392	MA Grants - Federal Funds	370,295,634	435,566,053	194,694,803	69,589,574	0	505,155,627
32573	F	F_7393	MA Grants - Other Funds	0	3,500,000	0	(3,404,000)	0	96,000
32573	F	F_7394	MA Grants - Swap Funds	1,686,215	2,284,362	1,142,181	0	0	2,284,362
32573	F	F_7395	MA Grants - County Funds	471,964	597,256	315,190	239,682	0	836,938
32573	F	F_7396	MA Grants - IGT Funds	2,139,881	525,597	262,799	2,474,403	0	3,000,000
			Subtotal:	578,938,755	699,806,173	313,965,276	125,236,342	0	825,042,515
			Subdivision Budget Total:	578,938,755	699,806,173	313,965,276	125,236,342	0	825,042,515
300-10 LONG TERM CARE			**General Funds:**	204,345,061	257,332,905	117,550,303	56,336,683	0	313,669,588
			Federal Funds:	370,295,634	435,566,053	194,694,803	69,589,574	0	505,155,627
			Other Funds:	0	3,500,000	0	(3,404,000)	0	96,000
			SWAP Funds:	1,686,215	2,284,362	1,142,181	0	0	2,284,362
			County Funds:	471,964	597,256	315,190	239,682	0	836,938
			IGT Funds:	2,139,881	525,597	262,799	2,474,403	0	3,000,000
			Subdivision Funding Total:	578,938,755	699,806,173	313,965,276	125,236,342	0	825,042,515

GRANT SUMMARY
2009-2011 Biennium
To House

Description	2007-2009 Appropriation				2009-2011 Budget To House				Increase / (Decrease)					
	Average Monthly Caseload / Recipient	Average Monthly Cost	Total Expenditures	General Fund Expenditures	Average Monthly Caseload / Recipient	Average Monthly Cost	Total Expenditures	General Fund Expenditures	Average Monthly Caseload / Recipient	Average Monthly Cost	2.77% Inflation Included in Avg Monthly Cost	Total Expenditures	General Fund Expenditures	
Long-Term Care Continuum			425,382,703	161,380,305			501,986,472	194,783,855				76,603,769	33,403,550	
Nursing Homes (rate includes hospice room & board)	3,482	145.69	370,080,827	132,817,907	3,388	170.78	422,244,637	153,236,194	(94)	25.09	10.89	52,163,810	20,418,287	Average cost per bed per day.
Basic Care (rate includes room & board and personal care)	458	42.17	14,083,121	6,097,305	455	51.32	17,070,865	7,859,036	(3)	9.15	6.50	2,987,744	1,761,731	Average cost per bed per day.
Personal Care Option	627	1,270.86	19,086,421	6,876,755	671	1,481.71	23,919,788	8,845,373	44	210.85	86.02	4,833,367	1,968,618	Average cost per recipient per month.
* Home & Community Based Services Waiver Aged & Disabled	137	956.56	3,133,824	1,203,466	322	949.03	7,417,057	2,742,845	185	(7.53)	79.79	4,283,233	1,539,379	Average cost per recipient per month.
* Home & Community Based Services Waiver TBI	27	2,793.94	1,809,521	651,999	27	3,380.82	2,190,768	810,114	-	586.88	328.03	381,247	158,115	Average cost per recipient per month.
Technology Dependent Waiver	3	10,581.14	762,019	274,479	3	8,951.80	540,744	199,978	-	(1,629.34)	868.55	(221,275)	(74,501)	Average cost per recipient per month.
Children's Medically Fragile Waiver	15	3,730.68	1,343,070	492,720	11	4,337.48	1,165,293	430,961	(4)	606.80	420.84	(177,777)	(61,759)	Average cost per recipient per month.
SPED	1,345	369.90	11,945,116	11,347,860	1,597	451.87	17,340,292	16,473,277	252	81.97	42.24	5,395,176	5,125,417	Average cost per recipient per month.
ExSPED	141	225.51	763,149	763,149	129	232.08	717,401	717,401	(12)	6.57	22.45	(45,748)	(45,748)	Average cost per recipient per month.
Payments for All-Inclusive Care of Elderly (PACE)	16	3,801.88	1,452,310	521,973	76	4,053.57	7,393,711	2,734,308	60	251.69		5,941,401	2,212,335	Average cost per recipient per month.
TCM Aged & Disabled	340	113.22	923,325	332,692	458	180.67	1,985,916	734,368	118	67.45	17.53	1,062,591	401,676	Average cost per recipient per month.

* These two services combined are the Home & Community Based Services Waiver. The amounts previously provided for the combined waiver are as follows:

Home & Community Based Services Waiver	164	1,263.19	4,943,345	1,855,465	349	1,139.32	9,607,825	3,552,959	185	(123.87)	98.49	4,664,480	1,697,494	Average cost per recipient per month.

D

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2009-2011 Budget to House

	Budget	% of Budget
Long Term Care Continuum		
Selected Services		
Nursing Homes	422,244,637	84.11%
Personal Care Community	23,919,788	4.77%
SPED	17,340,292	3.45%
Basic Care	17,070,865	3.40%
HCBS Waiver	9,607,825	1.91%
Aged & Disabled Waiver	7,417,057	
Traumatically Brain Injured Waiver	2,190,768	
PACE	7,393,711	1.47%
TCM - A & D Waiver	1,985,916	0.40%
Children's Medically Fragile Waiver	1,165,293	0.23%
Ex-SPED	717,401	0.14%
Tech Dependent Waiver	540,744	0.12%
Total of Selected Services	**501,986,472**	**100.00%**
Total 2009-2011 Budget	**501,986,472**	**100.00%**

North Dakota Dept of Human Services
Medical Services
Detail of Selected Services
2007-2009 Actual

Nursing Homes

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	3,422	$ 4,755.80	133,156	$ 122.22	$ 16,274,333
September-07	3,317	4,409.55	109,104	134.06	14,626,481
October-07	3,419	4,328.73	111,050	133.27	14,799,921
November-07	3,188	4,202.48	98,707	135.73	13,397,517
December-07	3,206	4,298.43	102,140	134.92	13,780,770
January-08	3,267	4,465.89	107,924	135.19	14,590,071
February-08	3,236	4,577.32	109,032	135.85	14,812,206
March-08	3,397	4,264.29	107,901	134.25	14,485,803
April-08	3,450	4,399.94	119,648	126.87	15,179,781
May-08	3,356	4,228.31	104,232	136.14	14,190,199
June-08	3,098	4,425.77	98,713	138.90	13,711,036
July-08	3,305	4,565.47	108,580	138.97	15,088,862
August-08	3,161	4,423.36	99,954	139.89	13,982,227
September-08	3,300	4,580.08	109,220	138.38	15,114,253
October-08	3,293	4,413.40	103,590	140.30	14,533,322
November-08	3,248	4,371.62	102,476	138.56	14,199,031
Monthly Averages	3,291	$4,419.40	107,839	$ 135.22	$14,547,863

Nursing facility rates are established annually from a cost report.

Swing Bed Rates are based on the average Medicaid Nursing Facility Rates from the previous year.

Out of State is the average paid.

Limits were increased effective 1/1/09. ($1.39 per day)

Nursing facility rates were also increased for related property costs. ($3.15 per day)

Increased 125 nursing facility beds to correspond with the known bed movement, 16 geropsych beds added for the 2007-2009 Biennium, which became operational in the fall of 2008, and are occupied as of December 2008; 9 beds for at Dakota Alpha for Long-Term TBI clients; and 19 beds for the utliziation increase in hospice.

Decreased 63 beds to correspond with the expected growth in the PACE program.

7/7 Inflation (10.89 per day)

In-state NF	3,132	
Dakota Alpha	16	
Geropscyh	30	
Swing Bed	62	
Hospice	86	
Out of State	62	
Total	**3,388**	**170.78**

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2007-2009 Actual

Personal Care Community

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	599	$ 1,160.73	203,381	$ 3.42	$ 695,279
September-07	589	1,098.55	178,046	3.63	647,045
October-07	576	1,204.88	210,737	3.29	694,010
November-07	540	1,257.84	194,471	3.49	679,233
December-07	551	1,236.41	198,412	3.43	681,262
January-08	560	1,223.97	198,700	3.45	685,421
February-08	569	1,247.39	204,900	3.46	709,765
March-08	567	1,165.31	192,480	3.43	660,731
April-08	574	1,256.83	206,050	3.50	721,423
May-08	572	1,209.89	201,689	3.43	692,059
June-08	567	1,265.14	207,996	3.45	717,333
July-08	574	1,215.37	203,346	3.43	697,621
August-08	577	1,261.52	200,856	3.62	727,898
September-08	557	1,303.63	199,203	3.65	726,123
October-08	559	1,270.46	195,316	3.64	710,187
November-08	547	1,349.80	202,990	3.64	738,338
Monthly Averages	567	$1,232.98	199,911	$3.50	$698,983

Avg Aug 07-April 08	569	$1,205.77
Growth May 08 - July 09 (Approx 2 per month)	24	
5% Inflation (7-1-08)		$60.29
Growth 09-11 (5 per month)	63	
Remove PACE	-5	
Personal Care III	20	$129.63
7/7 Inflation		$86.02
Total	**671**	**$1,481.71**

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2007-2009 Actual

SPED

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	1,371	$ 384.59	75,543	$ 6.98	$ 527,271
September-07	1,391	370.54	70,845	7.28	515,422
October-07	1,484	389.16	78,615	7.35	577,514
November-07	1,424	354.46	65,486	7.71	504,751
December-07	1,471	360.60	71,258	7.44	530,447
January-08	1,406	377.72	73,373	7.24	531,080
February-08	1,448	372.35	73,735	7.31	539,166
March-08	1,457	344.31	70,132	7.15	501,655
April-08	1,476	382.73	77,822	7.26	564,903
May-08	1,459	368.16	73,522	7.31	537,147
June-08	1,407	358.74	68,871	7.33	504,750
July-08	1,415	362.46	71,809	7.14	512,877
August-08	1,396	391.55	74,713	7.32	546,600
September-08	1,452	374.61	68,742	7.91	543,930
October-08	1,331	372.20	66,963	7.40	495,395
November-08	1,363	373.78	66,907	7.61	509,457
Monthly Averages	1,422	$371.12	71,771	$7.36	$527,648

Avg Aug 07 - April 08	1,436	$370.72
Growth May 08 thru July 09 (Approx 1 per month)	14	
Growth 09-11 (10 per month)	125	
5% Inflation (7-1-08)		$18.54
Non-Medical Transp.		$9.32
Point Split		$0.83
SPED Fee Schedule	22	$10.22
7/7 Inflation		$42.24
09-11 Average	**1,597**	**$451.87**

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2007-2009 Actual

Basic Care (Room & Board & Personal Care Services)

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	410	$ 1,338.09	26,876	$ 31.69	$ 548,618
September-07	404	1,429.38	26,030	51.91	577,471
October-07	408	1,374.45	25,420	38.23	560,774
November-07	404	1,428.82	25,566	35.42	577,244
December-07	393	1,370.92	24,424	44.35	538,773
January-08	351	1,478.75	22,106	18.99	519,042
February-08	372	1,555.66	25,176	51.28	578,704
March-08	374	1,363.23	22,425	55.34	509,848
April-08	409	1,621.08	29,841	49.81	663,020
May-08	419	1,669.27	29,328	17.22	699,426
June-08	407	1,441.12	25,557	50.90	586,535
July-08	418	1,426.15	26,388	38.24	596,131
August-08	420	1,542.60	26,134	32.17	647,892
September-08	440	1,673.31	29,365	53.32	736,256
October-08	409	1,494.79	24,791	43.37	611,370
November-08	429	1,632.47	27,961	25.05	700,331
Monthly Averages	404	$1,490.01	26,087	$39.83	$603,215

Avg August 07 through April 08 392 41.89

Facility specific rates are established annually from a cost report.

Basic Care includes room and board AND personal care services.

Includes beds to correspond with known bed movement and additions throughout the state during the second year of the current biennium and during 2009-2011.

7/7 Inflation (6.50 per day)

09-11 Average 455 51.32

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2007-2009 Actual

Aged & Disabled Waiver

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	223	$ 563.88	13,682	$ 9.19	$ 125,746
September-07	207	645.51	12,565	10.63	133,621
October-07	229	613.23	14,859	9.45	140,430
November-07	219	616.66	13,121	10.29	135,048
December-07	226	621.60	13,393	10.49	140,482
January-08	199	586.12	13,503	8.64	116,637
February-08	218	527.67	12,398	9.28	115,031
March-08	220	520.28	12,860	8.90	114,462
April-08	224	869.87	16,449	11.85	194,850
May-08	217	580.54	12,373	10.18	125,978
June-08	212	587.18	11,727	10.61	124,482
July-08	208	588.68	11,543	10.61	122,445
August-08	217	694.38	15,673	9.61	150,681
September-08	227	653.23	12,025	12.33	148,283
October-08	218	725.90	9,512	16.64	158,246
November-08	237	698.30	12,298	13.46	165,498
Monthly Averages	219	$630.81	12,999	$10.76	$138,245

Avg Aug 07 - April 08	218	$618.31	
Growth May 08 thru July 09 (approx. 2 per month)	36		
April 08 Spenddown - used cost per person (appropriation)		$768.76	**See Note 1**
5% Inflation 7-1-08		$38.44	
Home Delivered Meals		$6.59	
Remove PACE	-1		
Growth 09-11 (approx. 4 per month)	46		
Hospice Waiver	15	$65.92	
Removal of HCBS Cap - Point Split	8	-$10.47	**See Note 2**
7/7 Inflation		$79.79	
Total	**322**	**$949.03**	

Note 1 - The appropriation was used because the new services added for the 2007-09 Budget were approved by CMS in the spring of 2008. These services were Home Delivered Meals, Family Personal Care and Extended Personal Care. The additional costs for these services were not reflected in the actual costs of services in the months typically used for budgeting.

Note 2 - Due to the cost of the Point Split being smaller (409.33 per individual per month) than the current average cost of this service, it results in a decrease to the average cost per person.

North Dakota Dept of Human Services
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Traumatically Brain Injured Waiver

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	28	$ 2,472.96	780	$ 88.77	$ 69,243
September-07	28	2,909.11	542	150.29	81,455
October-07	20	2,271.95	741	61.32	45,439
November-07	21	2,173.71	459	99.45	45,648
December-07	28	4,815.86	1,334	101.08	134,844
January-08	28	2,784.39	723	107.83	77,963
February-08	29	2,836.00	761	108.07	82,244
March-08	29	2,730.48	758	104.46	79,184
April-08	28	2,816.18	815	96.75	78,853
May-08	30	2,894.17	1,584	54.81	86,825
June-08	28	2,848.18	767	103.98	79,749
July-08	28	2,748.14	735	104.69	76,948
August-08	27	3,215.59	(87)	(997.94)	86,821
September-08	27	3,053.59	769	107.21	82,447
October-08	27	3,120.15	771	109.27	84,244
November-08	27	3,264.04	806	109.34	88,129
Monthly Averages	27	$2,934.66	766	$31.84	$80,002

Avg Aug 07- April 08	27	$2,867.85
Average Cost recalculated to normalize the outliers, such as December *See Note*		$2,907.42
5% Inflation 7-1-08		$145.37
7/7 Inflation		$328.03
Total	**27**	**$3,380.82**

Note:
Expenditures Thru April 2008 divided by Persons Receiving thru April 2008
694,873 / 239 = 2,907.42

North Dakota Dept of Human Services
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Targeted Case Management for Aged & Disabled

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	470	$ 97.92	510	$ 90.24	$ 46,021
September-07	441	107.51	511	92.78	47,410
October-07	551	107.05	634	93.04	58,987
November-07	340	103.61	352	100.07	35,226
December-07	445	106.91	536	88.76	47,576
January-08	410	95.52	459	85.32	39,164
February-08	390	100.96	422	93.31	39,375
March-08	366	103.54	394	96.19	37,897
April-08	464	109.19	574	88.27	50,665
May-08	432	110.66	518	92.28	47,803
June-08	409	118.63	533	91.03	48,519
July-08	409	105.65	469	92.14	43,212
August-08	477	106.69	533	95.48	50,893
September-08	465	113.91	522	101.47	52,969
October-08	359	113.88	389	105.10	40,883
November-08	380	108.56	418	98.69	41,254
Monthly Averages	426	$106.89	486	$94.01	$45,491

Avg Aug 07-April 08	431	$103.58
Growth May 2008 - July 2009 (Approx. 2 per month)	27	
Inc. Rate - TCM Regs		$51.79
5% Inflation 7-1-08		$7.77
7/7 Inflation		$17.53
Total	**458**	**$180.67**

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2007-2009 Actual

Ex-SPED

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	110	$ 206.80	3,853	$ 5.90	$ 22,748
September-07	105	206.14	3,495	6.19	21,645
October-07	111	181.14	3,505	5.74	20,106
November-07	115	152.03	3,659	4.78	17,483
December-07	102	192.11	3,146	6.23	19,595
January-08	106	196.37	3,412	6.10	20,815
February-08	112	197.53	3,480	6.36	22,123
March-08	108	188.56	3,302	6.17	20,365
April-08	113	192.48	3,542	6.14	21,750
May-08	111	201.70	3,760	5.95	22,389
June-08	107	176.40	3,057	6.17	18,875
July-08	109	173.49	3,040	6.22	18,910
August-08	108	144.33	3,459	4.51	15,588
September-08	114	185.80	3,437	6.16	21,181
October-08	108	173.57	3,012	6.22	18,746
November-08	107	168.36	3,036	5.93	18,015
Monthly Averages	109	$183.55	3,387	$5.92	$20,021

Avg Aug 07-April 08	109	190.35
Growth May 2008 - July 2009 (Approx. 1 every other month)	8	
5% Inflation 7-1-08		9.52
Non-Medical Trans.		9.08
Growth for 09-11 (1 per month)	12	
AFFC Point Split		0.68
7/7 Inflation		22.45
09-11 Average	**129**	**232.08**

North Dakota Dept of Human Services
Long Term Care Continuum
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2007-2009 Actual

Technology Dependent Waiver

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	1	$ 7,553.00	3	$ 2,517.67	$ 7,553
September-07	1	8,270.00	3	2,756.67	8,270
October-07	1	7,427.00	3	2,475.67	7,427
November-07	1	7,993.00	3	2,664.33	7,993
December-07	1	7,275.00	3	2,425.00	7,275
January-08	1	8,145.00	3	2,715.00	8,145
February-08	1	6,614.00	3	2,204.67	6,614
March-08	1	8,327.00	3	2,775.67	8,327
April-08	1	7,681.00	3	2,560.33	7,681
May-08	-	-	-	-	-
June-08	1	7,234.00	3	2,411.33	7,234
July-08	1	6,360.00	1	6,360.00	6,360
August-08	1	9,218.00	1	9,218.00	9,218
September-08	1	8,017.00	2	4,008.50	8,017
October-08	1	7,645.00	1	7,645.00	7,645
November-08	1	8,068.00	2	4,034.00	8,068
Monthly Averages	1	$7,239.19	2	$3,548.24	$7,239
Avg Aug 07-April 08	1	$7,698.33			
5% Inflation 7-1-08		$384.92			
Growth Year 1	1				
Growth Year 2	1				
7/7 Inflation		$868.55			
09-11 Average	**3**	**$8,951.80**			

D

Developmental Disabilities Grants

Salary Increase	Total Fiscal Impact	General Funds	Federal Funds
$0.50	$10,819,554	$4,001,071	$6,818,483
$1.00	$21,639,106	$8,002,141	$13,636,965
$1.50	$32,258,296	$11,929,118	$20,329,178
$2.00	see oar		

Nursing Homes / Basic Care

Salary Increase	Total Fiscal Impact	General Funds	Federal Funds
$0.50	$7,369,565	$2,975,225	$4,394,340
$1.00	$14,739,128	$5,950,451	$8,788,677
$1.50	$22,108,693	$8,925,676	$13,183,017
$2.00	$44,943,784	$17,615,425	$27,328,359
	37,128,713	15,000,000	22,128,713

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations Committee
Senator Holmberg, Chairman
March 3, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, I am Maggie Anderson, Director of Medical Services, for the Department of Human Services. I am here today to provide you with an overview of the Long-Term Care Continuum budget.

Programs

The long-term care services included in this area of the budget are Nursing Facilities, Basic Care Facilities, Developmentally Disabled Community-Based Care, and the Home and Community-Based Services Programs which have the following funding sources: Service Payments for the Elderly and Disabled (SPED); Expanded SPED; Personal Care; the Program for All-Inclusive Care of the Elderly (PACE); Targeted Case Management; and the Medicaid Home and Community-Based Services Waiver.

The Long-Term Care Continuum encompasses a wide range of medical and support services for individuals who lack some capacity for self-care, and are expected to need care for an extended period of time.

Program Trends

Nursing Facilities

As of September 30, 2008, the percentage of Medicaid-eligible individuals in nursing facilities was 54 percent, which has been fairly consistent for many years. Attachment A shows the Licensed and Occupied Nursing Facility Beds for the current biennium, and Attachment B shows the

Medicaid occupied beds. Based on the September 30, 2008, occupancy reports, 23 facilities were below 90 percent occupancy. The average occupancy for these 23 facilities is 83 percent. The Department continues to believe that a moratorium on the number of nursing facility beds should remain. Throughout the interim, the Department has been in contact with the North Dakota Long Term Care Association for the purpose of tracking the nursing facility beds that are being shifted through the state. The Department's 2009-2011 Budget takes the "bed shifting" into account and is predicated on the moratorium continuing.

During the 2007 Legislative Session, approval was provided for the expansion of Geropsychiatric Services. As of December 2008, the additional 16 Geropsych beds are filled. We expect these beds to be filled throughout the 2009-2011 biennium.

The number of individuals receiving hospice service in Nursing Facilities is reported on Attachment C (Nursing Facility Hospice). As you can see, this number, which includes individuals receiving hospice from all funding sources, has significant fluctuation; however, it has trended higher since July 2005.

Basic Care

Overall, the Basic Care program has seen very little change over the interim. The Department continues to believe that a moratorium on the number of basic care beds should also remain. The process in place for requested exceptions to come before the Department of Health and the Department of Human Services appears to be working well to manage the number of Basic Care beds. Similar to Nursing Facility beds, the Department has been in contact with the North Dakota Long Term Care

Association for the purpose of tracking the basic care beds that are being shifted and added through the state.

Home and Community-Based Services (HCBS)

Home and Community-Based Services continue to provide options for clients who find a need for long-term care services. Staff members work closely with county case managers and providers to ensure clients have the services needed. Often times, it takes a considerable amount of collaboration between formal and informal supports, as well as programs and funding streams, to wrap the necessary services around those who need care. The HCBS staff members are committed to continuous program review to ensure clients and their families have the information needed to make the best choice for their care needs. You will hear throughout this testimony about program changes that have occurred during the interim and those that are funded in the Executive Budget.

Developmental Disabilities

As you will hear from JoAnne Hoesel when she provides the overview testimony for the Developmental Disabilities (DD) programs, there continues to be various areas for program focus. These range from the renewal of the DD waivers, consumer choice, transitions of individuals from the Developmental Center and increased oversight from the Centers for Medicare and Medicaid Services. I will cover the DD Community Grant expenditures later in this testimony.

Major Program Changes

HCBS Waiver

The 2007-2009 Appropriation for the Home and Community-Based Services Waiver included funding to add Family Personal Care, Extended

Personal Care and Home Delivered Meals. **Family Personal Care** assists individuals to remain with their family members and in their own communities, and provides for the provision of extraordinary care payments to the legal spouse of a recipient for the provision of personal care or similar services. **Extended Personal Care** includes hands-on care of a medical nature that is specific to the needs of an eligible individual and will enable an individual to live at home. This service is provided by a Qualified Service Provider (QSP), and to the extent permitted by State law, is care that would otherwise be provided by a nurse. A nurse, licensed to practice in the state, provides training to a QSP approved by the Department to provide the required care and (the nurse) will provide at a minimum, a review of the clients' needs every six months to determine if additional training is required. Activities of daily living and instrumental activities of daily living are not a part of this service. The purpose of **home delivered meals** is to provide a well-balanced meal to an individual who lives alone and is unable to prepare an adequate meal, or who lives with another person who is unable or not available to prepare an adequate meal for the individual. During the 2007-2009 interim, this service was added to the HCBS Waiver, with a limit of three hot or frozen home delivered meals per week. The Executive Budget request for 2009-2011 includes funding to increase the three meals per week to seven meals per week. This increase would require a change to the HCBS Waiver, and it is expected that the implementation date would be January 1, 2010.

Technology Dependant Waiver

Shortly after the beginning of the current biennium (August 1, 2007), the Department received Centers for Medicare and Medicaid Services (CMS)

approval to operate a Medicaid waiver for individuals who are technology dependent. This waiver has three slots available.

Children's Medically Fragile Waiver

2007 Senate Bill 2326 authorized the implementation of Medically Fragile Waiver for Children. This waiver received approval by CMS on April 1, 2008. The waiver currently serves four children and staff members are working with other families to complete the level of care and level of need documents.

Money Follows the Person Demonstration Grant

In 2007, the Department was awarded a Money Follows the Person (MFP) Grant. The grant funding is provided to North Dakota for the purpose of assisting individuals in nursing facilities and institutions that serve individuals with a developmental disability in transitioning to home and community-based settings. The grant is expected to transition 30 individuals with a developmental disability and 80 individuals who reside in a nursing facility to the community. After receiving CMS approval of the operational protocols for the grant, transitions began in the summer of 2008. Through December 2008, five individuals were transitioned to the community. The transition goal for 2009 is 34 individuals. The grant ends September 30, 2011. We have included two MFP brochures (one for each transition population) to provide additional information and detail.

Program for All-Inclusive Care of the Elderly (PACE)

PACE is a program that provides complete health care coverage to persons who have long-term care needs. To be eligible for PACE, an individual must be at least 55 years of age, live within the PACE service area, meet nursing home level of care, and be able to live safely in the

community. Northland Healthcare Alliance and Medical Services staff worked together to implement this "managed care" approach to delivering services to qualifying individuals. Each month, the Medicaid program pays a capitated rate to Northland, and in turn, Northland is responsible to coordinate and pay for all Medicare and Medicaid services needed by the individual. The goal of the PACE program is to provide the necessary services to individuals to allow them to continue living at home. Each individual has a care plan that details the services needed and all services are reviewed and approved by the PACE care team. Northland Healthcare Alliance identified Bismarck and Dickinson as their PACE service areas. Enrollment in the program began in August 2008 and as of December 1, 2008 there are nine individuals enrolled in the program (seven are Medicare and Medicaid and two are Medicare only). For additional information, a PACE brochure is included with my testimony.

Minimum Data Set (MDS) 3.0

Currently, North Dakota, and other states are using Version 2.0 of the Minimum Data Set (MDS).

The following information is adapted from the CMS website:

In response to changes in nursing home care, resident characteristics, advances in resident assessment methods, and provider and consumer concerns about the performance of the Minimum Data Set (MDS) 2.0, the Centers for Medicare and Medicaid Services (CMS) is undertaking an effort to implement Version 3.0. The expected implementation date is October 1, 2009. This implementation will involve system changes and the Department has assembled a multi-Division workgroup to ensure readiness for the October implementation.

According to CMS, the goals of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, and increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in nursing home care requested that MDS 3.0 revisions focus on improving the tool's clinical utility, clarity, and accuracy. CMS also wanted to shorten the tool while maintaining the ability to use MDS data for quality indicators, quality measures, and payment.

MDS is part of the federally mandated process for clinical assessment of all residents in nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. MDS assessments are completed for all residents in certified nursing homes, regardless of individual's source of payment. MDS assessments are required for residents on admission to the nursing facility and then periodically, within specific guidelines and time frames. MDS information is transmitted electronically by nursing homes to the state Medicaid office, and is used as the cornerstone for establishing the resident's per day cost of care.

Non-Medical Transportation

Funding to add Non-Medical Transportation to Service Payments for the Elderly and Disabled (SPED) and ExSPED is included in the Executive Budget. The total funds are $406,444, of which $387,660 are general funds and $18,784 are county funds. Non-Medical Transportation allows individuals to access essential community resources/services in order to maintain themselves in their home and community. Individuals receiving non-medical transportation service: (1) are unable to provide their own transportation, (2) need a means of obtaining basic necessary community

resources and/or services (i.e. grocery, pharmacy, laundromat), and (3) do not have access to transportation through an informal network.

Revising the SPED Fee Schedule

Through input of stakeholders and advocates, the Department has been urged to revise the SPED Fee Schedule. The schedule was last updated August 1, 2003. The Executive Budget includes the funding to update the fee schedule. This update was based on actual cost of living adjustments (COLA) through January 2008 and an estimated COLA for January 2009.

Removal of the Adult Family Foster Care – Point Split

The purpose of Adult Family Foster Care is to offer a choice within a continuum of care to adults, who could benefit from living in a family environment, as well as to promote independent functioning and provide for a safe and secure environment. Currently, when multiple recipients reside in a Family Foster Care setting, the reimbursement points assigned to laundry, shopping, and housekeeping are split by the number of recipients. This results in less reimbursement for the provider and a greater amount of paperwork. The Executive Budget contains funding to remove the point split. Removing the point split will compensate providers more equitably for services provided and help ensure access to Adult Family Foster Care services for clients. The point split change would be effective January 1, 2010.

Implementing Hospice for Children Waiver

Hospice options for families with terminally ill children are very limited. Today hospice is offered to terminally ill individuals who have elected hospice, which generally requires that they are no longer looking at curative measures. A Medicaid Hospice waiver will allow a child to receive

Hospice services and palliative care within the child's home. In addition, the family can continue to receive Medicaid-reimbursed services, such as curative care, as well as counseling, respite, and expressive therapies. The waiver will have 30 available slots, and is expected to be operational by July 1, 2010, contingent upon the implementation of a new Medicaid Management Information System (MMIS) and approval from the Centers for Medicare and Medicaid Services (CMS).

Personal Care – Third Tier

Personal Care Services assist an individual with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) so that the individual is able to live at home. Personal care services are authorized when service activities are essential either on an intermittent or ongoing basis, and the need for personal care services is expected to continue for a period of time in excess of 30 days. Currently there are two levels of Personal Care (Level A and B). The maximum number of hours available is about eight per day. In order to accommodate those unique cases where recipients are determined to require more than eight hours of personal care per day, the Executive Budget contains the funding to add a third tier of Personal Care called Expanded Medicaid State Plan –Personal Care that would allow a maximum of 10 hours of Personal Care per day. Specific criteria would need to be met and prior authorization by a HCBS Administrator would be required for approval of this service. In addition, the Centers for Medicare and Medicaid Services (CMS) will need to approve the addition of the third tier. Based on the time needed for CMS approval and computer system changes, the estimated start date for this service is January 1, 2010.

ISLA Administrative Funding

Currently, administrative reimbursements for the Individualized Supported Living Arrangement and Family Care Option (FCO) III programs are inadequate to support programs for individuals with high levels of need. Providers of service typically lose money providing services to individuals receiving ISLA and FCO III services. These programs are essential to community placement of individuals from institutions and individuals receiving these services have very high need levels. Currently there is a disincentive in the administrative reimbursements to serve clients receiving these services. The Executive Budget contains $2.4 million (of which $.9 million are general funds for ISLA and $96,108 (of which $35,416 are general funds for FCO III) to increase the administrative reimbursement so it is based on the client level of need. This increase is intended to ensure community placements are available and to prevent additional institutional admissions.

Personal Needs Allowance – SSI Only Individuals

Personal Needs Allowance dollars are used by individuals in an institutional setting (Nursing Home, Intermediate Care Facility for the Mentally Retarded (ICF/MR) and Psychiatric Residential Treatment Facility) for items such as clothing, recreational or social activities, a bottle of pop, or a birthday card. Some individuals in an institution are "SSI only" and their Personal Needs Allowance is paid to them by Social Security. This allowance is limited to $30. Funding to increase the Personal Needs Allowance for these individuals to $50 per month is included in the Executive Budget. The $20 increase per person would be funded with 100% general funds. The Executive Budget includes $148,068 to fund this increase. Based on the effort needed to implement

this change, it is expected that this increase would take effect January 1, 2010.

Intense Medical Needs – Family Homes

Currently Intermediate Care Facilities receive enhanced funding to provide services to children with intense medical needs. The Executive Budget includes funding to increase the wages of In-Home Support staff, who assist families in caring for children at home. The level of reimbursement would be at the same level as Intermediate Care Facility providers serving children with similar intense medical needs.

Intense Medical Needs – Residential Facility

As noted above, currently Intermediate Care Facilities receive enhanced funding to provide services to children with intense medical needs. The Executive Budget includes funding to compensate DD providers serving adults with intense medical needs at the same level as Intermediate Care Facilities providers serving children with similar intense medical needs.

Personal Needs Allowance – Decoupling ICF/MR

Personal Needs Allowance dollars are used for items such as clothing, recreational or social activities, a bottle of pop, or a birthday card. Currently, the amount of Personal Needs Allowance individuals in a Nursing Facility and individuals in an Intermediate Care Facility are allowed to keep is currently set at $50 per person per month. During the interim, the Department has worked with the Centers for Medicare and Medicaid Services (CMS) to secure approval to "decouple" the Personal Needs Allowance for individuals in a Nursing Facility from those in an Intermediate Care Facility. The Executive Budget includes funding to increase the Personal Needs Allowance for individuals in an Intermediate

Care Facility to $60 per month. The change would be effective January 1, 2010.

Medicaid Waiver - Autism Spectrum Disorder – Under 5 Years

The Executive Budget contains the funding to implement a Home and Community-Based Services (HCBS) Waiver to provide intensive supports for young children who have a diagnosis of Autism Spectrum Disorder. The waiver needs to be written, and the Department would need to secure CMS approval; therefore, we are expecting an implementation date of July 1, 2010, which would also be contingent upon the implementation of the new Medicaid Management Information System. The waiver will have 30 slots.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget	House Changes	To Senate
Nursing Homes	370,080,827	52,163,810	422,244,637	7,573,519	429,818,156
Basic Care	14,083,121	2,987,744	17,070,865	1,268,272	18,339,137
Personal Care	19,086,421	4,833,367	23,919,788	(2,961,171)	20,958,617
HCBS Waiver	4,943,345	4,664,480	9,607,825	(123,978)	9,483,847
Tech Dependent Waiver	762,019	(221,275)	540,744	(8,136)	532,608
Childrens' Medically Fragile Waiver	1,343,070	(177,777)	1,165,293	(17,449)	1,147,844
SPED	11,945,116	5,395,176	17,340,292	(239,113)	17,101,179
Ex-SPED	763,149	(45,748)	717,401	(10,264)	707,137
PACE	1,452,310	5,941,401	7,393,711	0	7,393,711
Targeted Case Management	923,325	1,062,591	1,985,916	(28,020)	1,957,896
Overall Decrease for Caseload/Utilization Not SPED			0	(15,143,320)	(15,143,320)
DD - Community Based Care	274,423,470	48,632,573	323,056,043	16,135,512	339,191,555
Overall Decrease for Caseload/Utilization			0	(6,695,511)	(6,695,511)
Total	699,806,173	125,236,342	825,042,515	(249,659)	824,792,856
General Funds	257,332,905	56,336,683	313,669,588	(1,083,324)	312,586,264
Federal Funds	435,566,053	69,589,574	505,155,627	(478,886)	504,676,741
Other Funds	6,907,215	(689,915)	6,217,300	1,312,551	7,529,851
Total	699,806,173	125,236,342	825,042,515	(249,659)	824,792,856

FTE	0	0	0	0	0

Budget Changes from Current Budget to Executive Budget:

- Nursing Facility services account for about 51.2 percent of the 2009-2011 Budget for the long-term care continuum. (Compare to 52.9 percent for 2007-2009 Budget)

- Basic Care accounts for about 2.1 percent of the 2009-2011 Budget for the long-term care continuum. (Compare with 2.0 percent for 2007-2009 Budget)

- Home and Community-Based Services account for 7.6 percent of the 2009-2011 Budget for the long-term care continuum. (Compare to 5.9 percent for the 2007-2009 Budget)

- DD Grants account for about 39.2 percent of the 2009-2011 Budget for the long-term care continuum. (Compare to 39.2 percent for the 2007-2009 Budget)

- This portion of the 2009-2011 Budget also contains an inflationary increase for providers at seven percent each year of the Biennium.

- The impact on the 2009-2011 Budget of the decline in the Federal Medical Assistance Percentage on general funds for the Long-Term Continuum is $5.8 million.

Nursing Facilities

- The Executive Budget request for nursing facilities totaled $422.2 million, of which $153.2 million are general funds. The current budget for nursing facility services is $370.1 million of which $132.8 million are general funds. This $52.1 million increase is related to: Caseload and Utilization decreases ($9.8 million), the seven/seven percent inflationary increase ($26.9 million), and cost changes of $35 million. The cost changes include the funds necessary for rebasing the limits ($3.5 million), the funds necessary to sustain the increase to the property limits ($7.8 million), and cost changes reported on the annual cost reports that need to be covered and sustained ($23.7 million). Attachment D shows historical information on expenditures and average daily Nursing Facility Rates. Earlier in my testimony, I reported that Medicaid is paying

for approximately 54 percent of individuals in the nursing facilities. The remaining 46 percent are mostly private pay. The increases noted above are built into the average cost per day which affects both Medicaid and private pay residents. Private pay residents will see an increase of approximately $13 per person per day, each rate year of the 2009-2011 Biennium.

- The Executive Budget for nursing facilities was based on Medicaid occupancy of 3,388 beds per month. The occupancy includes:

  3,132 – Nursing Facility
  16 – Dakota Alpha
  30 – Geropsych Unit
  62 – Swing Bed
  86 – Hospice Room and Board
  62 – Out of State

Basic Care

- The Executive Budget for Basic Care is $17.1 million of which $7.9 million are general funds. This is a $3 million increase over the current budget. The average monthly caseload for the 2009-2011 budget request is 455, and the average utilization for the first 12 months of the biennium is 397. The increase consists of cost and utilization changes ($.8 million net increase) and $2.2 million increase for the seven percent inflation each year of the biennium.

Home and Community- Based Services

This area of the budget includes many funding sources such as the various Medicaid waivers, personal care services, SPED, and PACE.

Collectively the net change is an increase of $21.5 million in total funds. The contributing factors to the increase are noted below:

- The Executive Budget includes an increase of $4.8 million for Personal Care Services. The average monthly caseload for Personal Care Services is estimated to be 671 and the caseload for the first 12 months of the biennium was 570. The estimated caseload (671) includes the expected average caseload increase of 20 for Tier III Personal Care. The budget increase in this area accounts for the utilization changes noted during the budget preparation process and also includes cost/utilization changes (net increase of $.6 million), the seven percent inflation each year of the biennium ($ 1.4 million increase) and the addition of Tier III Personal Care ($2.8 million increase). Tier III Personal Care is expected to be effective January 1, 2010, after receiving the necessary federal approval, and making the necessary computer system changes.

- The Executive Budget for the Service Payments to the Elderly and Disabled (SPED) is $17.3 million of which $16.5 million are general funds and $.8 million are county funds. This is a $5.4 million increase over the 2007-2009 Budget. The average monthly caseload is estimated to be 1,597, and the average caseload for the first 12 months of the biennium was 1,434. The estimated caseload includes the addition of 22 individuals expected as a result of revising the SPED fee schedule. The cost increase consists of the seven percent inflationary increase ($1.6 million), funding to revise the SPED fee schedule ($.6 million), the portion of the adult family foster care point split that applies to this area ($32,141), and $3.1 million to cover the cost and utilization increases expected, based on the trends used during the budget preparation process.

- The 2009-2011 Executive Budget request for ExSPED is $717,401, as compared to the 2007-2009 Budget of $763,149. The budget request is built on an average monthly caseload of 129, and the average caseload for the first 12 months of the biennium was 109. The seven percent inflationary increase for this area is $70,441, and the portion of the adult family foster care point split that applies to this area is $2,142. In addition there were cost and utilization decreases which totaled $118,331.

- The Executive Budget request for Targeted Case Management is $2 million, of which $.7 million are general funds. This represents a $1.1 million increase over the 2007-2009 appropriation. The average monthly caseload is expected to be 458. For the first 12 months of the current biennium, the caseload was averaging 427. The increase includes $.2 million for the inflationary increase, and $.9 million increases for cost and utilization. With the signing of the Economic Stimulus Package, the Medicaid Targeted Case Management regulations are on a moratorium through June 30, 2009; therefore, we await the final implementation direction to determine if there are additional impacts in this area.

- The Executive Budget request for the HCBS Waiver is $9.6 million of which $3.6 million are general funds. The HCBS Waiver includes the waivers previously reported as the TBI (Traumatic Brain Injury) Waiver and the Aged and Disabled Waiver. The average monthly caseload included in the budget request is 349 and for the first 12 months of the biennium, the average caseload was 244. The estimated average caseload includes expected increases for the Adult Family Foster Care Point Split (eight) and for the Hospice

Waiver (15). The increase in the projected utilization is a result of the new services added to the waiver over the interim, which were discussed earlier in my testimony. The overall increase, as compared to the 2007-2009 appropriation, is $4.7 million. This increase consists of $.8 million for the seven percent inflationary increase, $81,156 for the portion of the adult family foster care point split change that affects clients within the waiver, $.9 million to fund the new Hospice Waiver for Children, and an increase of $2.9 million for cost and utilization changes accounted for when preparing the budget. The implementation date for the additional home delivered meals is expected to be January 1, 2010 and the implementation date for the Hospice Waiver for Children is expected to be July 1, 2010.

- The Executive Budget request for the Children's Medically Fragile Waiver is $1.2 million of which $.4 million are general funds. The current appropriation for this waiver is $1.4 million. The 2009-2011 budget request estimates an average monthly case load of 11 for this waiver. Currently there are four children receiving waiver services, and the budget is built with estimates of increasing the caseload gradually over 2009-2011. The wavier has a maximum of 15 slots. This area includes a $.1 million for the seven percent inflationary increase, and a net decrease of $.3 million, related to cost and utilization changes.

- The Executive Budget request for the Technology Dependant Waiver is $.5 million of which $.2 million are general funds. The 2007-2009 budget is $.8 million. This waiver is now serving one individual, and the budget request is based on the expectation that we will provide

services to two individuals in SFY 2010 and three for SFY 2011. The waiver has a maximum of three slots. The budget request includes $55,740 for the seven percent inflationary increase and a net decrease of $277,015 for cost and utilization changes.

- The Executive Budget request for the Program for All-Inclusive Care of the Elderly (PACE) is $7.4 million, of which $2.7 million are general funds. While this presents a $5.9 million increase in the budget, it is actually a "shifting" of dollars from other services. The utilization in the other Medicaid services was reduced for the budgeted PACE utilization. As noted earlier in my testimony, PACE is a managed care long-term care program; therefore, PACE is responsible for all Medicaid services needed by enrolled participants. As a result, it is expected that Medicaid would have fewer direct expenditures for services, such as nursing facility care, personal care and hospital services, as these "bills" would be paid directly by the PACE program. The monthly average enrollment for PACE was budgeted at 76, which includes the additional enrollments Northland Healthcare Alliance is expecting in the Bismarck and Dickinson areas. The PACE budget does not contain funding for the inflationary increase, as the rates are established by an actuary and not subject to inflationary increases.

Developmental Disabilities

The increases of approximately $48.6 million in the DD Grants are from following eight areas:

- $190,195 net decrease in caseload. The decrease consists of $151,145 in general funds and $39,050 in federal funds.

- $17.6 million is due to cost changes that occurred during the 2007-2009 Biennium, which must be sustained during the 2009-2011 Biennium. The cost change increase consists of $6.5 million in general funds and $11.1 million in federal funds.

- $28.5 million is due to a seven percent inflationary increase each year of the 2009-2011 Biennium. The increase consists of $10.5 million in general funds and $18 million in federal funds.

- $103,680, of which $38,341 are general funds, to increase the Personal Needs Allowance for individuals residing in an ICF/MR from $50 per month to $60 per month.

- $805,412, of which $297,842 are general funds, to cover the cost of services provided to adults with intense medical needs who live in a residential facility.

- $644,330, of which $238,274 are general funds, to cover the cost of services provided to children with intense medical needs who are cared for in their family homes.

- $57,854 of which $21,394 are general funds, for the portion of the adult family foster care point split change that applies to this area of the budget.

- $1 million, of which $.4 million are general funds, to operate a Medicaid Autism Waiver for one year. The funding is only for one year; it is expected to take one year after legislative approval to write the waiver, secure public input and receive CMS approval.

House Changes

- Increased the Personal Needs Allowance for individuals in Basic Care Facilities from $60 per month to $75 per month. The cost of this change is $112,320, all of which are general funds. This change also requires a change in statute. The necessary language is included in the engrossed version of House Bill 1012.

- Increased the Personal Needs Allowance for individuals in an ICF/MR from $60 per month to $75 per month. The increase for this change is $155,520 of which $57,511 are general funds.

- Added $14.7 million in total funds, of which $4.95 million are general funds, $1.0 million is from the health care trust fund, and $8.79 million are federal funds to provide supplemental salary payments to staff working in basic care and skilled nursing facilities. The supplemental payment will be provided to staff earning less than the eightieth percentile of the salary range at each facility.

- Removed funding for Personal Care Tier III. This change reduced the long-term care grants by $2.76 million of which $1 million are general funds.

- The House included language that would amend NDCC Section 50-30-02 relating to the Health Care Trust Fund. The language would prohibit the executive branch from including Health Care Trust Funds in appropriation bills.

- The House also included language that would require Legislative Council to study the long-term care payment system and the long-term care survey and inspection programs and processes.

- Decreased funding for long-term care grants by $5.6 million in general funds for caseload and utilization. This decrease also reduced the federal match by $9.5 million for a total of $15.1 million.

- Added $18.9 million in total funds, of which $7.0 million are general funds and $11.9 million are federal funds to provide supplemental salary payments to staff working for developmental disability (DD) providers. The supplemental payment will be provided to staff earning less than the ninetieth percentile of the salary range for each DD provider.

- Added funding to increase the payment rates for children and adults who are severely medically fragile and behaviorally challenged receiving services through the DD system. This increase is estimated to cost $1.2 million of which $438,900 are general funds.

- Decreased funding for DD grants based on caseload and utilization estimates by $6.7 million, of which $2.5 million are general funds.

- Decreased funding for inflationary increases for all services in the Long-Term Care Continuum from 7% each year to 6% each year. This reduction is estimated to save $11.6 million of which $4.5 million are general funds.

I would be happy to answer any questions you may have.

Same attachments given to House on 1-13-09

F

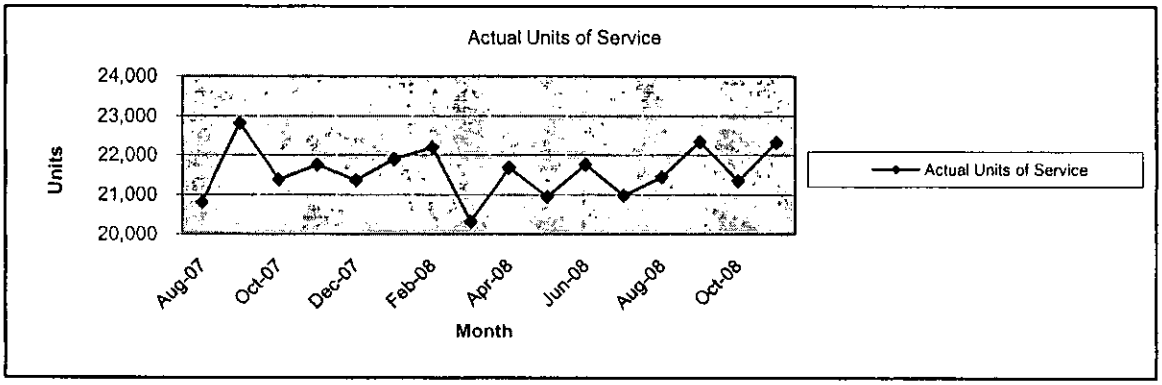
North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2009-2011 Budget to House

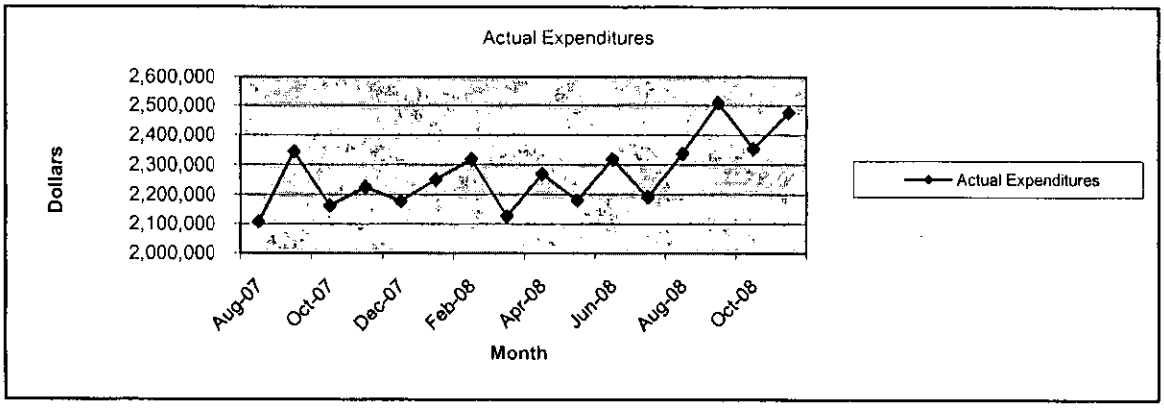
	Budget	% of Budget
DD Community Based Care		
Selected Services		
ISLA	72,055,512	22.30%
ICF/MR Adult	55,313,493	17.12%
Day Supports	47,954,136	14.84%
ICF/MR Children	29,926,453	6.17%
ICF/MR Physically Handicapped	29,659,067	9.18%
Minimally Supervised Living Arrangement	19,939,163	5.07%
Transitional Community Living - Training	16,382,881	4.15%
Infant Development	13,407,625	3.73%
Family Support Services - In Home Support	12,048,919	3.73%
Total of Selected Services	**296,687,249**	**91.84%**
Remaining Services	**26,368,794**	**8.16%**
Total 2009-2011 Budget	**323,056,043**	**100.00%**

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

ISLA

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	667	$ 3,161.15	20,807	$ 101.34	2,108,484
September-07	701	3,345.05	22,816	102.77	2,344,879
October-07	704	3,072.61	21,383	101.16	2,163,117
November-07	700	3,179.73	21,759	102.29	2,225,812
December-07	705	3,090.54	21,372	101.95	2,178,834
January-08	704	3,198.18	21,900	102.81	2,251,520
February-08	708	3,275.26	22,198	104.46	2,318,885
March-08	701	3,035.10	20,318	104.72	2,127,607
April-08	699	3,247.00	21,687	104.65	2,269,650
May-08	689	3,165.84	20,949	104.12	2,181,261
June-08	698	3,323.00	21,767	106.56	2,319,452
July-08	692	3,167.70	20,985	104.46	2,192,051
August-08	687	3,402.91	21,449	108.99	2,337,799
September-08	700	3,583.80	22,341	112.29	2,508,661
October-08	710	3,314.48	21,355	110.20	2,353,281
November-08	714	3,467.93	22,325	110.91	2,476,102
Monthly Averages	699	$3,251.89	21,588	$ 105.23	$ 2,272,337

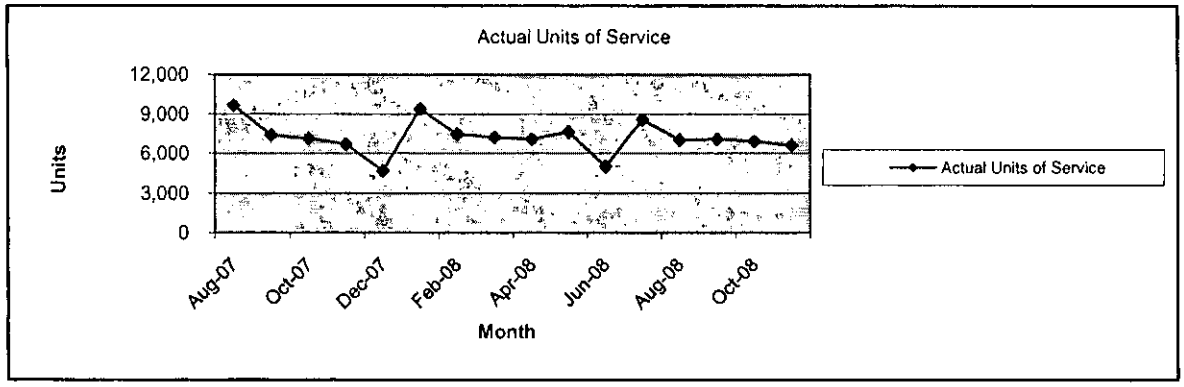


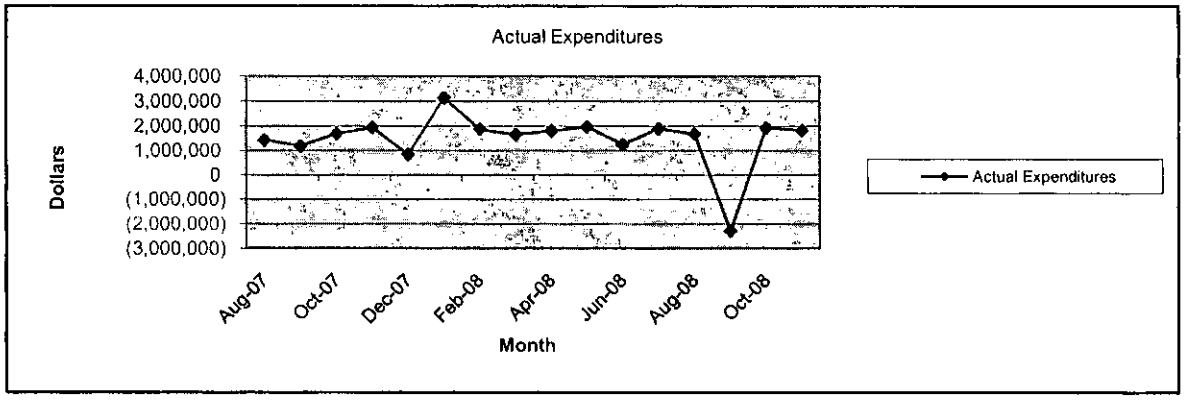


North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

ICF/MR Adult

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	223	$ 6,433.02	9,660	$ 148.51	1,434,563
September-07	232	5,122.33	7,392	160.77	1,188,380
October-07	235	7,209.63	7,126	237.76	1,694,263
November-07	212	9,197.80	6,689	291.51	1,949,933
December-07	162	5,214.83	4,679	180.55	844,803
January-08	223	14,114.51	9,384	335.42	3,147,536
February-08	222	8,446.44	7,462	251.29	1,875,109
March-08	227	7,320.89	7,223	230.08	1,661,843
April-08	230	7,897.40	7,081	256.52	1,816,403
May-08	230	8,593.41	7,650	258.36	1,976,484
June-08	179	7,009.37	5,001	250.89	1,254,678
July-08	225	8,423.44	8,574	221.05	1,895,273
August-08	229	7,334.48	7,008	239.67	1,679,597
September-08	226	(10,062.54)	7,076	(321.39)	(2,274,135)
October-08	227	8,519.39	6,905	280.07	1,933,901
November-08	216	8,433.67	6,608	275.68	1,821,673
Monthly Averages	219	$6,825.50	7,220	$206.05	$1,493,769

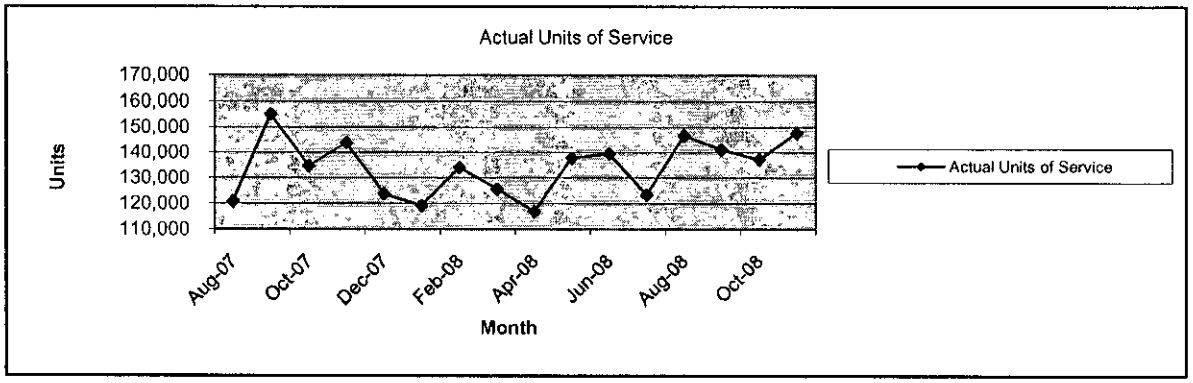


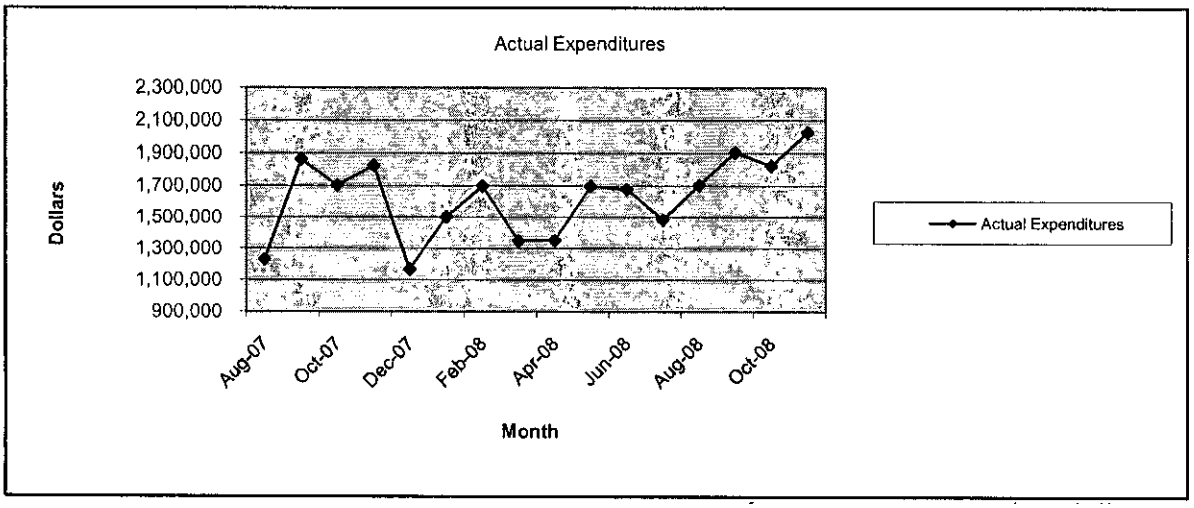


North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

Day Supports

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	896	$ 1,374.86	120,743	$ 10.20	1,231,876
September-07	955	1,951.02	155,080	12.01	1,863,222
October-07	957	1,780.21	134,640	12.65	1,703,663
November-07	948	1,924.94	143,829	12.69	1,824,844
December-07	938	1,245.60	123,755	9.44	1,168,376
January-08	928	1,618.87	119,074	12.62	1,502,310
February-08	933	1,820.57	134,016	12.67	1,698,588
March-08	921	1,463.83	125,548	10.74	1,348,184
April-08	868	1,557.43	116,765	11.58	1,351,846
May-08	948	1,790.34	137,836	12.31	1,697,247
June-08	950	1,766.84	139,536	12.03	1,678,499
July-08	912	1,629.29	123,306	12.05	1,485,910
August-08	961	1,772.60	146,714	11.61	1,703,469
September-08	966	1,972.60	141,115	13.50	1,905,535
October-08	968	1,882.69	137,230	13.28	1,822,442
November-08	962	2,107.08	147,704	13.72	2,027,009
Monthly Averages	938	$1,728.67	134,181	$12.07	$1,625,814

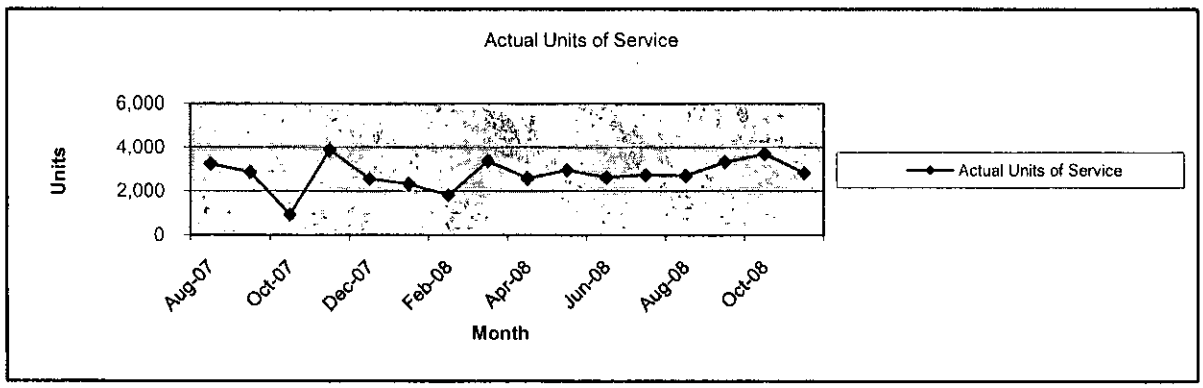


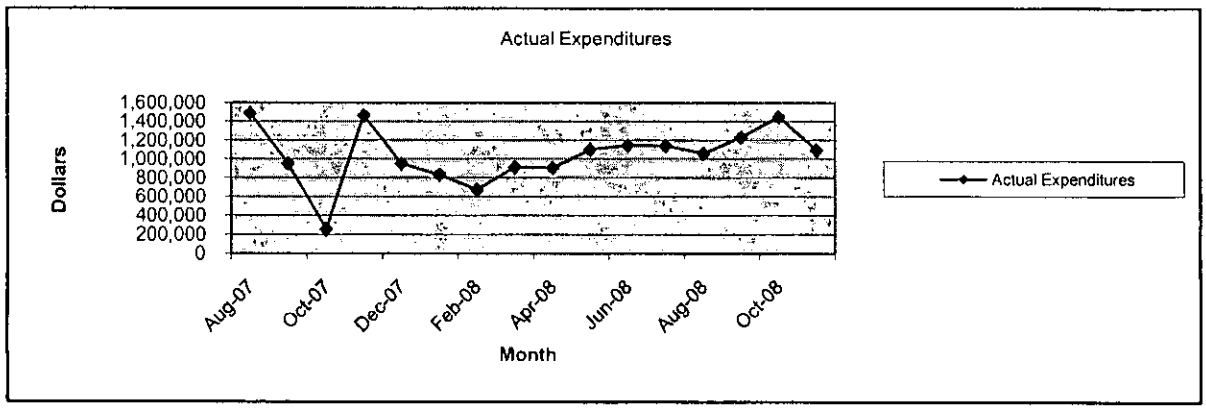


North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

ICF/MR Children

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	86	$ 17,333.24	3,237	$ 460.51	1,490,659
September-07	85	11,202.32	2,866	332.24	952,197
October-07	31	8,289.48	925	277.81	256,974
November-07	82	17,881.61	3,873	378.59	1,466,292
December-07	83	11,463.11	2,562	371.37	951,438
January-08	84	9,951.17	2,330	358.75	835,898
February-08	84	8,039.89	1,818	371.48	675,351
March-08	100	9,132.62	3,369	271.08	913,262
April-08	84	10,796.06	2,585	350.82	906,869
May-08	90	12,241.14	2,955	372.83	1,101,703
June-08	102	11,235.20	2,626	436.40	1,145,990
July-08	92	12,413.46	2,737	417.26	1,142,038
August-08	91	11,679.24	2,700	393.63	1,062,811
September-08	95	12,979.35	3,323	371.06	1,233,038
October-08	93	15,576.00	3,683	393.31	1,448,568
November-08	93	11,764.24	2,820	387.97	1,094,074
Monthly Averages	86	$11,998.63	2,776	$371.57	$1,042,323

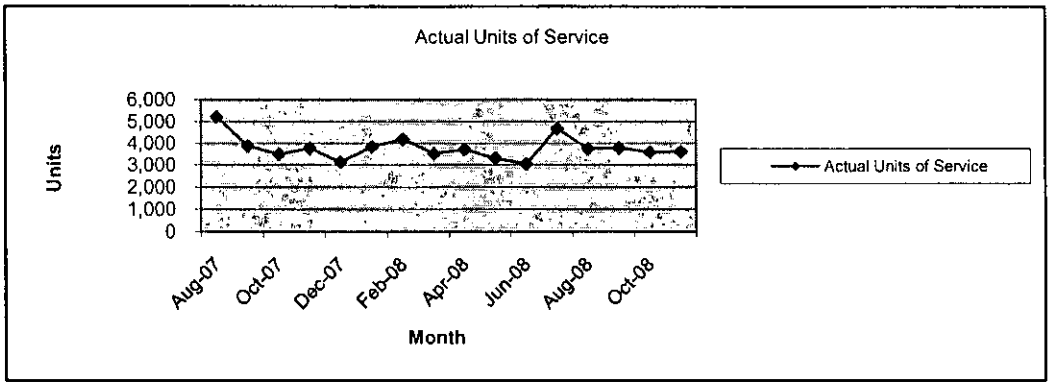


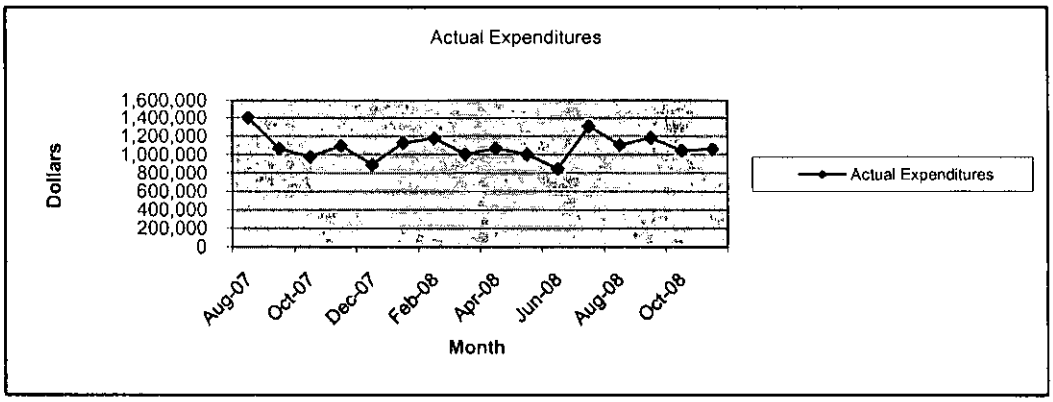


North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

ICF/MR Physically Handicapped

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	119	$ 11,811.72	5,222	$ 269.17	1,405,595
September-07	116	9,198.60	3,879	275.08	1,067,038
October-07	120	8,153.82	3,504	279.24	978,458
November-07	121	9,053.78	3,773	290.35	1,095,507
December-07	103	8,662.86	3,135	284.62	892,275
January-08	114	9,916.92	3,838	294.56	1,130,529
February-08	122	9,673.66	4,194	281.40	1,180,187
March-08	122	8,243.95	3,520	285.73	1,005,762
April-08	123	8,687.70	3,724	286.95	1,068,587
May-08	115	8,732.33	3,314	303.02	1,004,218
June-08	108	7,845.75	3,045	278.27	847,341
July-08	124	10,567.16	4,677	280.16	1,310,328
August-08	125	8,847.02	3,749	294.98	1,105,877
September-08	122	9,722.11	3,787	313.20	1,186,098
October-08	120	8,712.28	3,590	291.22	1,045,474
November-08	119	8,909.85	3,616	293.22	1,060,272
Monthly Averages	118	$9,171.22	3,785	$287.57	$1,086,472

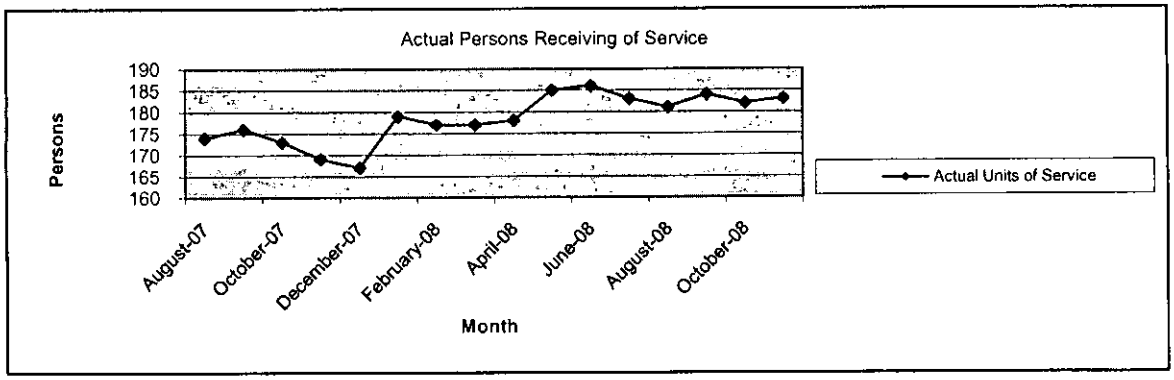


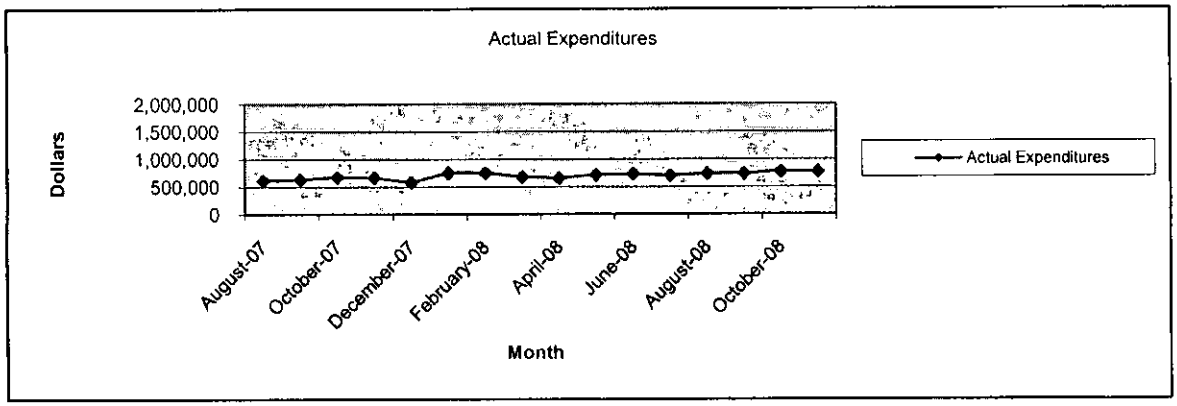


North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

Minimally Supervised Living Arrangement

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	174	$ 3,538.33	5,326	$ 115.60	615,670
September-07	176	3,609.79	5,444	116.70	635,323
October-07	173	3,922.41	5,480	123.83	678,577
November-07	169	3,949.62	5,178	128.91	667,486
December-07	167	3,477.55	5,000	116.15	580,751
January-08	179	4,225.35	6,173	122.52	756,337
February-08	177	4,250.84	6,047	124.43	752,399
March-08	177	3,841.65	5,219	130.29	679,972
April-08	178	3,707.48	5,573	118.42	659,931
May-08	185	3,870.09	5,282	135.55	715,967
June-08	186	3,928.05	5,585	130.82	730,618
July-08	183	3,857.70	5,411	130.47	705,959
August-08	181	4,067.17	5,565	132.28	736,158
September-08	184	4,027.92	5,664	130.85	741,138
October-08	182	4,269.18	5,571	139.47	776,991
November-08	183	4,226.72	5,890	131.32	773,490
Monthly Averages	178	$3,923.12	5,526	$126.73	$700,423

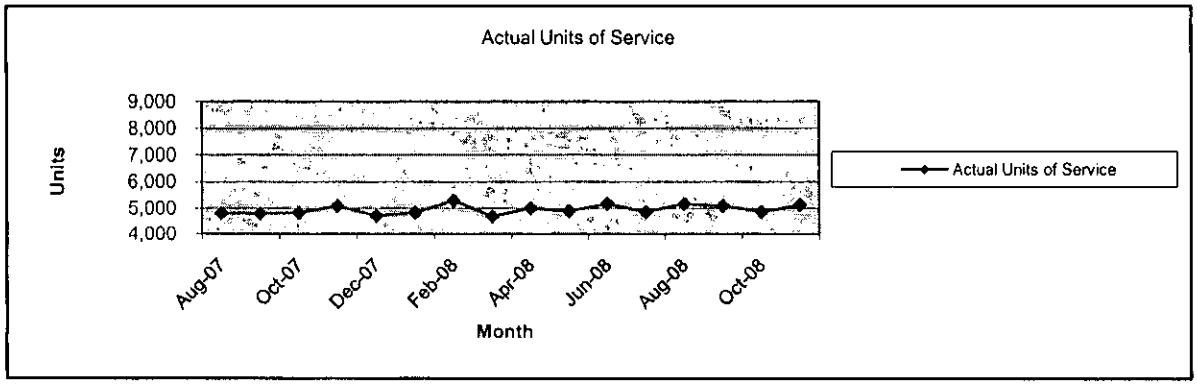


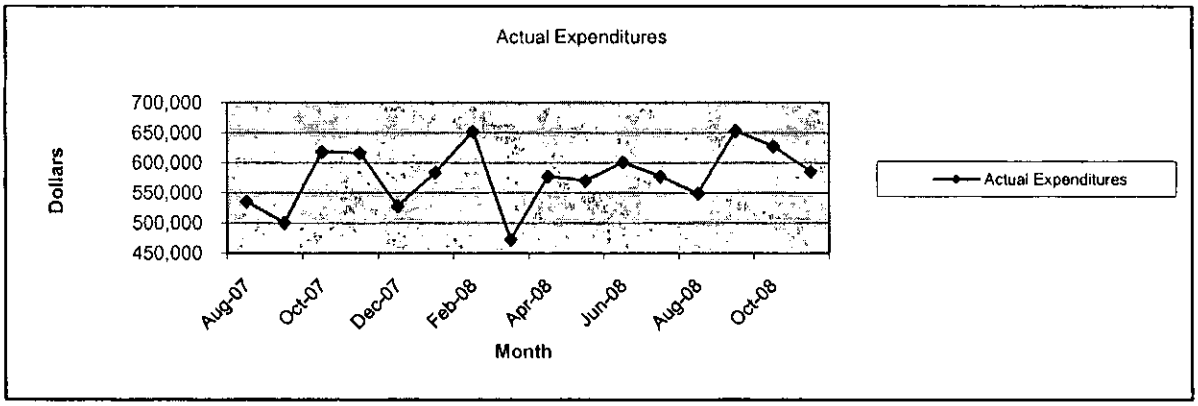


North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

Transitional Community Living - Training

Month	Actual Number of Premiums	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	158	$ 3,392.22	4,803	$ 111.59	535,970
September-07	159	3,148.28	4,789	104.53	500,576
October-07	164	3,773.92	4,825	128.27	618,923
November-07	161	3,830.73	5,084	121.31	616,748
December-07	161	3,280.27	4,710	112.13	528,124
January-08	156	3,743.33	4,834	120.80	583,959
February-08	161	4,052.04	5,293	123.25	652,378
March-08	160	2,955.94	4,682	101.01	472,951
April-08	161	3,588.25	5,008	115.36	577,709
May-08	165	3,457.62	4,895	116.55	570,508
June-08	165	3,644.67	5,174	116.23	601,370
July-08	162	3,567.38	4,861	118.89	577,915
August-08	165	3,329.48	5,173	106.20	549,364
September-08	164	3,985.99	5,089	128.45	653,702
October-08	165	3,806.96	4,861	129.22	628,148
November-08	165	3,551.67	5,126	114.32	586,026
Monthly Averages	162	3,569.30	4,950	$116.76	$578,398

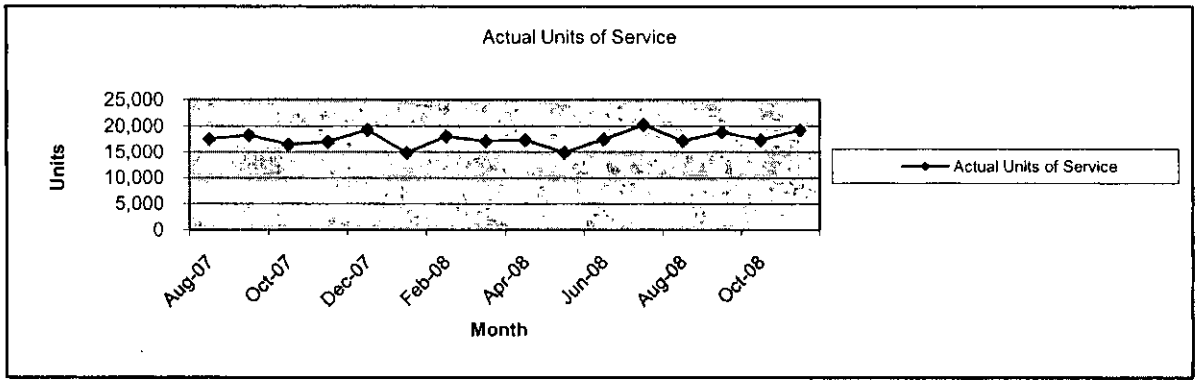


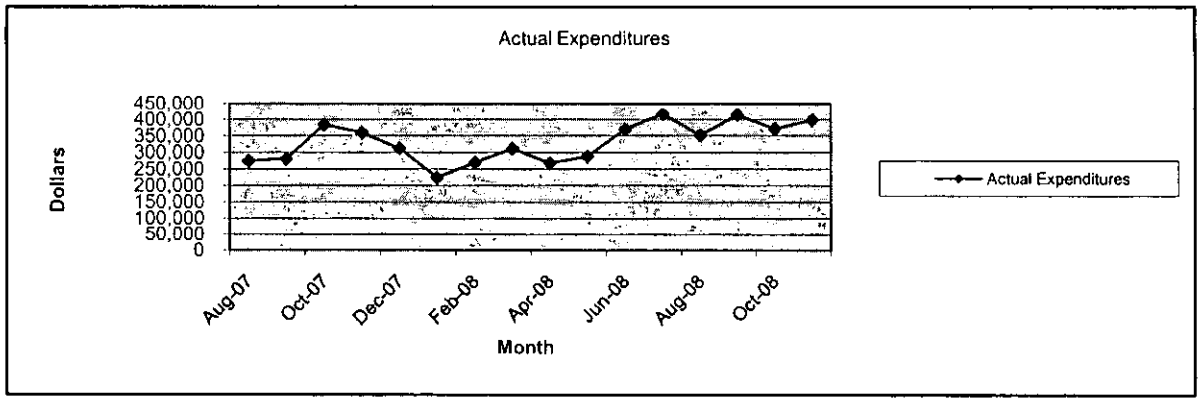


North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

Infant Development

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	812	$ 338.75	17,578	$ 15.65	275,067
September-07	820	342.45	18,316	15.33	280,808
October-07	824	465.57	16,504	23.24	383,629
November-07	758	474.55	17,029	21.12	359,707
December-07	819	382.19	19,318	16.20	313,015
January-08	726	310.12	14,934	15.08	225,144
February-08	794	340.64	18,107	14.94	270,470
March-08	796	391.89	17,185	18.15	311,946
April-08	783	341.81	17,394	15.39	267,639
May-08	765	377.25	14,967	19.28	288,595
June-08	768	481.76	17,523	21.11	369,989
July-08	880	474.08	20,276	20.58	417,191
August-08	731	481.01	17,232	20.40	351,615
September-08	913	454.03	18,870	21.97	414,528
October-08	832	446.12	17,397	21.34	371,174
November-08	903	441.25	19,239	20.71	398,446
Monthly Averages	808	$408.97	17,617	$18.78	$331,185

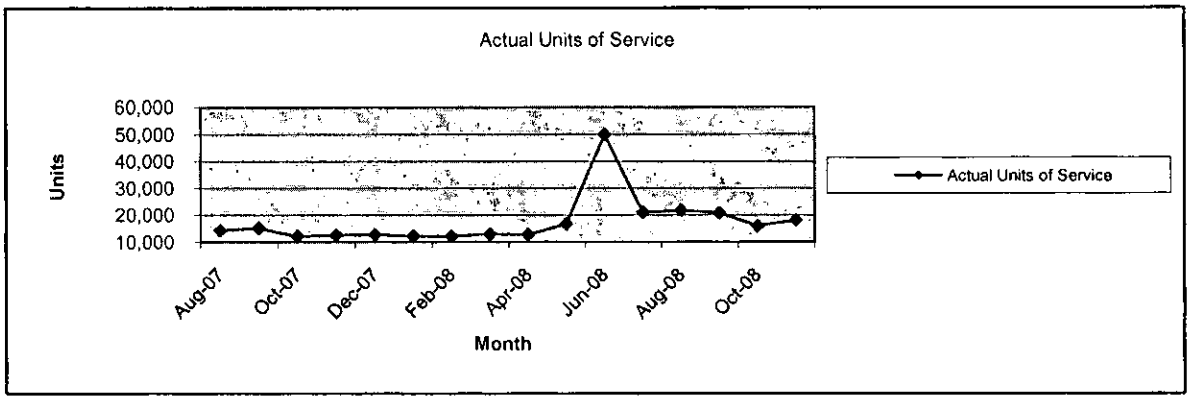


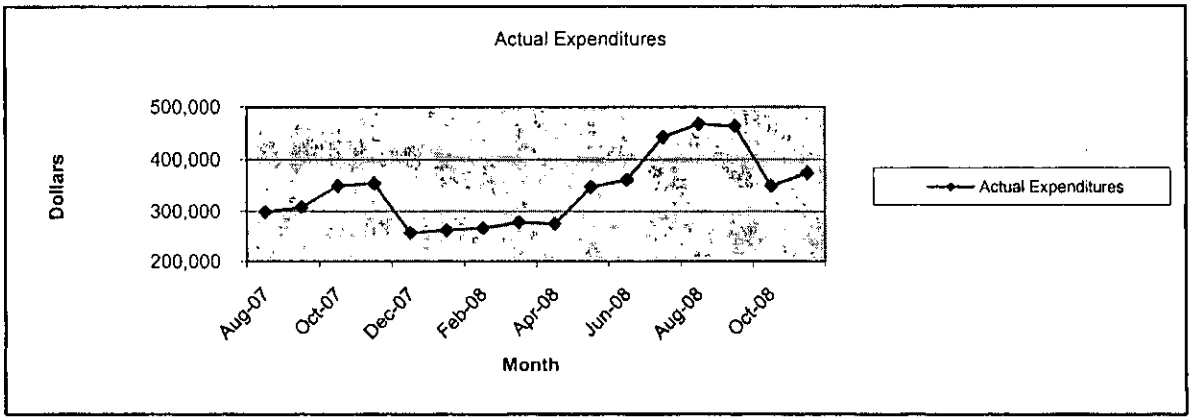


North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

Family Support Services - In-Home Support

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	307	$ 974.84	14,376	$ 20.82	299,277
September-07	332	928.73	15,223	20.25	308,339
October-07	323	1,085.01	12,167	28.80	350,458
November-07	338	1,049.29	12,682	27.97	354,660
December-07	338	761.82	12,830	20.07	257,496
January-08	327	803.98	12,283	21.40	262,900
February-08	324	823.02	12,223	21.82	266,660
March-08	333	836.67	13,053	21.34	278,611
April-08	338	814.71	12,806	21.50	275,373
May-08	440	791.34	16,755	20.78	348,190
June-08	430	840.69	50,063	7.22	361,498
July-08	453	977.30	21,057	21.02	442,715
August-08	440	1,061.19	21,776	21.44	466,924
September-08	449	1,031.03	20,821	22.23	462,934
October-08	426	821.75	15,995	21.89	350,066
November-08	443	845.12	18,028	20.77	374,386
Monthly Averages	378	$902.91	17,634	$21.21	$341,280





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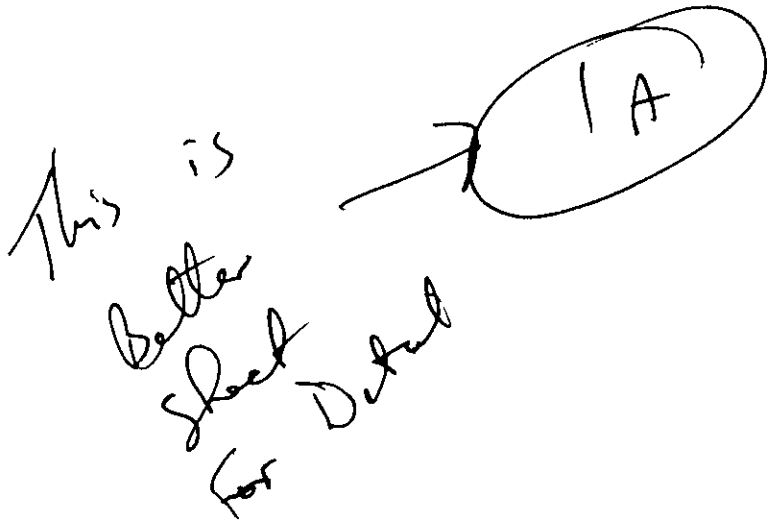
North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2009-2011 Budget to House

DD Community Based Care	Budget	% of Budget
Selected Services		
ISLA	72,055,512	22.30%
ICF/MR Adult	55,313,493	17.12%
Day Supports	47,954,136	14.84%
ICF/MR Children	29,926,453	6.17%
ICF/MR Physically Handicapped	29,659,067	9.18%
Minimally Supervised Living Arrangement	19,939,163	5.07%
Transitional Community Living - Training	16,382,881	4.15%
Infant Development	13,407,625	3.73%
Family Support Services - In Home Support	12,048,919	3.73%
Total of Selected Services	**296,687,249**	**91.84%**
Remaining Services	**26,368,794**	**8.16%**
Total 2009-2011 Budget	**323,056,043**	**100.00%**

Explanation of Delayed Provider Billing Adjustments reflected on following pages:

When two billings are processed in the same month for the same person, the system does not count the person twice. Therefore, the persons receiving are understated; actual units of service are accurate.



North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

ISLA

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	667	$ 3,161.15	20,807	$ 101.34	$ 2,108,484
September-07	701	$ 3,345.05	22,816	$ 102.77	$ 2,344,879
October-07	704	$ 3,072.61	21,383	$ 101.16	$ 2,163,117
November-07	700	$ 3,179.73	21,759	$ 102.29	$ 2,225,812
December-07	705	$ 3,090.54	21,372	$ 101.95	$ 2,178,834
January-08	704	$ 3,198.18	21,900	$ 102.81	$ 2,251,520
February-08	708	$ 3,275.26	22,198	$ 104.46	$ 2,318,885
March-08	701	$ 3,035.10	20,318	$ 104.72	$ 2,127,607
April-08	699	$ 3,247.00	21,687	$ 104.65	$ 2,269,650
May-08	689	$ 3,165.84	20,949	$ 104.12	$ 2,181,261
June-08	698	$ 3,323.00	21,767	$ 106.56	$ 2,319,452
July-08	692	$ 3,167.70	20,985	$ 104.46	$ 2,192,051
August-08	687	$ 3,402.91	21,449	$ 108.99	$ 2,337,799
September-08	700	$ 3,583.80	22,341	$ 112.29	$ 2,508,661
October-08	710	$ 3,314.48	21,355	$ 110.20	$ 2,353,281
November-08	714	$ 3,467.93	22,325	$ 110.91	$ 2,476,102
Monthly Averages	699	$ 3,251.89	21,588	$ 105.23	$ 2,272,337

Ave., Aug '07 - April '08	699	$ 102.91
Adjust to 9-month averages per DD program administrator's database to account for delayed provider billings	19	$ 0.30
Growth May 08 - July 2009:		
• high school graduates	14	
• Family Care Option III transitions	12	
5% Inflation 7/1/08		$ 5.16
09-11 Caseload Growth:		
• high school graduates	33	
• transitions from the Developmental Center	13	$ 4.27
Increase in administrative reimbursement levels		$ 4.12
7%/7% Inflation (09/11)		$ 8.18
Total	790	$ 124.94

+5% (2nd year biennium '07-'09

Base budget on 2.4 Million Increase

4 5ths = 115

+7%

+7%

= 124.94

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

ICF/MR Adult (Revised) *

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	223	$ 10,903	9,746	$ 249.46	$ 2,431,257
September-07	232	$ 8,257	7,429	$ 257.87	$ 1,915,723
October-07	235	$ 8,090	7,189	$ 264.46	$ 1,901,171
November-07	212	$ 8,219	6,689	$ 260.50	$ 1,742,462
December-07	162	$ 7,342	4,706	$ 252.74	$ 1,189,418
January-08	223	$ 11,313	9,487	$ 265.92	$ 2,522,784
February-08	222	$ 9,421	7,648	$ 273.45	$ 2,091,353
March-08	227	$ 8,933	7,277	$ 278.65	$ 2,027,759
April-08	230	$ 8,499	7,153	$ 273.29	$ 1,954,864
May-08	230	$ 9,479	7,677	$ 284.00	$ 2,180,278
June-08	179	$ 7,417	5,048	$ 263.00	$ 1,327,642
July-08	225	$ 10,073	8,637	$ 262.41	$ 2,266,444
August-08	229	$ 8,591	7,008	$ 280.71	$ 1,967,234
September-08	226	$ 8,807	7,076	$ 281.29	$ 1,990,373
October-08	227	$ 8,388	6,905	$ 275.74	$ 1,904,014
November-08	216	$ 8,434	6,608	$ 275.68	$ 1,821,673
Monthly Averages	219	$ 8,885	7,268	$ 268.70	$ 1,952,153

Ave., Aug '07 - April '08	218	$ 264.06
Adjustment for delayed provider billings	18	
Adjustment for rate changes (delayed rate sheet/mass adj necessary)		$ 8.18
5% Inflation 7/1/08		$ 13.61
ICF/MR provider assessment increase		$ 0.17
09/11 caseload changes:		
• Belcourt (Aug '10)	4	
7%/7% Inflation (09/11)		$ 29.70
Total	240	$ 315.72

* The department recently began using a new computer program to generate spenddown information. At present the department is working the "kinks" out of this new computer program -- some of the DD Grants information generated by the new computer program differs from the mainframe DD Expenditure Reports. Since the mainframe DD Expenditure Reports reflect reimbursements to providers for billed services, the mainframe DD Expenditure Report data is reflected above for August '07 through November '08.

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

Day Supports

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	896	$ 1,374.86	120,743	$ 10.20	$ 1,231,876
September-07	955	$ 1,951.02	155,080	$ 12.01	$ 1,863,222
October-07	957	$ 1,780.21	134,640	$ 12.65	$ 1,703,663
November-07	948	$ 1,924.94	143,829	$ 12.69	$ 1,824,844
December-07	938	$ 1,245.60	123,755	$ 9.44	$ 1,168,376
January-08	928	$ 1,618.87	119,074	$ 12.62	$ 1,502,310
February-08	933	$ 1,820.57	134,016	$ 12.67	$ 1,698,588
March-08	921	$ 1,463.83	125,548	$ 10.74	$ 1,348,184
April-08	868	$ 1,557.43	116,765	$ 11.58	$ 1,351,846
May-08	948	$ 1,790.34	137,836	$ 12.31	$ 1,697,247
June-08	950	$ 1,766.84	139,536	$ 12.03	$ 1,678,499
July-08	912	$ 1,629.29	123,306	$ 12.05	$ 1,485,910
August-08	961	$ 1,772.60	146,714	$ 11.61	$ 1,703,469
September-08	966	$ 1,972.60	141,115	$ 13.50	$ 1,905,535
October-08	968	$ 1,882.69	137,230	$ 13.28	$ 1,822,442
November-08	962	$ 2,107.08	147,704	$ 13.72	$ 2,027,009
Monthly Averages	938	$ 1,728.67	134,181	$ 12.07	$ 1,625,814

Ave., Aug '07 - April '08	927	$ 11.67
Adjustment for delayed provider billings	23	
Growth May 08 - July 2009:		
• high school graduates	14	
• new provider programs	13	
• increased caseload	8	
• Family Care Option III transitions	12	
5% inflation 7/1/08		$ 0.59
09-11 Caseload Growth:		
• high school graduates	33	
• transitions from the Developmental Center	13	
7%/7% Inflation (09-11)		$ 1.33
Total	1,043	$ 13.59

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

ICF/MR Children (Revised) *

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	102	$ 10,083.98	5,653	$ 181.95	$ 1,028,566
September-07	100	$ 10,544.06	3,449	$ 305.71	$ 1,054,406
October-07	100	$ 18,498.30	3,237	$ 571.46	$ 1,849,830
November-07	97	$ 11,284.98	2,866	$ 381.94	$ 1,094,644
December-07	35	$ 8,523.31	938	$ 318.03	$ 298,316
January-08	94	$ 17,948.13	4,440	$ 379.98	$ 1,687,125
February-08	93	$ 11,503.45	2,871	$ 372.63	$ 1,069,821
March-08	95	$ 10,213.87	2,635	$ 368.24	$ 970,317
April-08	97	$ 8,392.57	2,099	$ 387.84	$ 814,080
May-08	100	$ 9,026.66	2,765	$ 326.46	$ 902,666
June-08	87	$ 10,319.29	2,263	$ 396.72	$ 897,779
July-08	90	$ 12,241.14	2,955	$ 372.83	$ 1,101,703
August-08	102	$ 11,235.20	2,626	$ 436.40	$ 1,145,990
September-08	92	$ 11,826.50	2,737	$ 397.53	$ 1,088,038
October-08	91	$ 11,679.25	2,700	$ 393.63	$ 1,062,812
November-08	93	$ 11,764.24	2,820	$ 387.97	$ 1,094,074
Monthly Averages	92	$ 11,567.81	2,941	$ 373.71	$ 1,072,510

Ave., Aug '07 - April '08	90	$ 363.09
Adjustment for delayed provider billings	4	
Adjustment for rate changes (delayed rate sheet/mass adj necessary)		$ 12.83
5% Inflation 7/1/08		$ 18.80
ICF/MR provider assessment increase		$ 0.17
7%/7% Inflation (09/11)		$ 41.23
Total	94	$ 436.12

* The department recently began using a new computer program to generate spenddown information. At present the department is working the "kinks" out of this new computer program -- some of the DD Grants information generated by the new computer program differs from the mainframe DD Expenditure Reports. Since the mainframe DD Expenditure Reports reflect reimbursements to providers for billed services, the mainframe DD Expenditure Report data is reflected above for August '07 through November '08.

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

ICF/MR Physically Handicapped

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	119	$ 11,811.72	5,222	$ 269.17	$ 1,405,595
September-07	116	$ 9,198.60	3,879	$ 275.08	$ 1,067,038
October-07	120	$ 8,153.82	3,504	$ 279.24	$ 978,458
November-07	121	$ 9,053.78	3,773	$ 290.35	$ 1,095,507
December-07	103	$ 8,662.86	3,135	$ 284.62	$ 892,275
January-08	114	$ 9,916.92	3,838	$ 294.56	$ 1,130,529
February-08	122	$ 9,673.66	4,194	$ 281.40	$ 1,180,187
March-08	122	$ 8,243.95	3,520	$ 285.73	$ 1,005,762
April-08	123	$ 8,687.70	3,724	$ 286.95	$ 1,068,587
May-08	115	$ 8,732.33	3,314	$ 303.02	$ 1,004,218
June-08	108	$ 7,845.75	3,045	$ 278.27	$ 847,341
July-08	124	$ 10,567.16	4,677	$ 280.16	$ 1,310,328
August-08	125	$ 8,847.02	3,749	$ 294.98	$ 1,105,877
September-08	122	$ 9,722.11	3,787	$ 313.20	$ 1,186,098
October-08	120	$ 8,712.28	3,590	$ 291.22	$ 1,045,474
November-08	119	$ 8,909.85	3,616	$ 293.22	$ 1,060,272
Monthly Averages	118	$ 9,171.22	3,785	$ 287.57	$ 1,086,472

Ave., Aug '07 - April '08	118	$ 282.42
Adjustment for delayed provider billings	4	
Adjustment for rate changes (delayed rate sheet/mass adj necessary)		$ 4.85
5% Inflation 7/1/08		$ 14.36
ICF/MR provider assessment increase		$ 0.17
7%/7% Inflation (09/11)		$ 31.22
Total	122	$ 333.02

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

Minimally Supervised Living Arrangement

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	174	$ 3,538.33	5,326	$ 115.60	$ 615,670
September-07	176	$ 3,609.79	5,444	$ 116.70	$ 635,323
October-07	173	$ 3,922.41	5,480	$ 123.83	$ 678,577
November-07	169	$ 3,949.62	5,178	$ 128.91	$ 667,486
December-07	167	$ 3,477.55	5,000	$ 116.15	$ 580,751
January-08	179	$ 4,225.35	6,173	$ 122.52	$ 756,337
February-08	177	$ 4,250.84	6,047	$ 124.43	$ 752,399
March-08	177	$ 3,841.65	5,219	$ 130.29	$ 679,972
April-08	178	$ 3,707.48	5,573	$ 118.42	$ 659,931
May-08	185	$ 3,870.09	5,282	$ 135.55	$ 715,967
June-08	186	$ 3,928.05	5,585	$ 130.82	$ 730,618
July-08	183	$ 3,857.70	5,411	$ 130.47	$ 705,959
August-08	181	$ 4,067.17	5,565	$ 132.28	$ 736,158
September-08	184	$ 4,027.92	5,664	$ 130.85	$ 741,138
October-08	182	$ 4,269.18	5,571	$ 139.47	$ 776,991
November-08	183	$ 4,226.72	5,890	$ 131.32	$ 773,490
Monthly Averages	178	$ 3,923.12	5,526	$ 126.73	$ 700,423
Ave., Aug '07 - April '08	174			$ 121.90	
Adjustment for rate changes (delayed rate sheet/mass adj necessary)				$ 0.44	
Growth May 08 - July 2009:					
• new provider programs	13				
• increased caseload	5				
5% Inflation 7/1/08				$ 6.12	
7%/7% Inflation (09/11)				$ 13.80	
Total	192			$ 142.26	

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

Transitional Community Living - Training

Month	Actual Number of Premiums	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	158	$ 3,392.22	4,803	$ 111.59	$ 535,970
September-07	159	$ 3,148.28	4,789	$ 104.53	$ 500,576
October-07	164	$ 3,773.92	4,825	$ 128.27	$ 618,923
November-07	161	$ 3,830.73	5,084	$ 121.31	$ 616,748
December-07	161	$ 3,280.27	4,710	$ 112.13	$ 528,124
January-08	156	$ 3,743.33	4,834	$ 120.80	$ 583,959
February-08	161	$ 4,052.04	5,293	$ 123.25	$ 652,378
March-08	160	$ 2,955.94	4,682	$ 101.01	$ 472,951
April-08	161	$ 3,588.25	5,008	$ 115.36	$ 577,709
May-08	165	$ 3,457.62	4,895	$ 116.55	$ 570,508
June-08	165	$ 3,644.67	5,174	$ 116.23	$ 601,370
July-08	162	$ 3,567.38	4,861	$ 118.89	$ 577,915
August-08	165	$ 3,329.48	5,173	$ 106.20	$ 549,364
September-08	164	$ 3,985.99	5,089	$ 128.45	$ 653,702
October-08	165	$ 3,806.96	4,861	$ 129.22	$ 628,148
November-08	165	$ 3,551.67	5,126	$ 114.32	$ 586,026
Monthly Averages	162	$ 3,569.30	4,950	$ 116.76	$ 578,398

Ave., Aug '07 - April '08	160	$ 115.57
Adjustment for delayed provider billings	1	
Growth May 08 - July 2009:		
• new Lisbon program	6	
5% Inflation 7/1/08		$ 5.78
7%/7% Inflation (09-11)		$ 13.04
Total	167	$ 134.39

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

Infant Development

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	812	$ 338.75	17,578	$ 15.65	$ 275,067
September-07	820	$ 342.45	18,316	$ 15.33	$ 280,808
October-07	824	$ 465.57	16,504	$ 23.24	$ 383,629
November-07	758	$ 474.55	17,029	$ 21.12	$ 359,707
December-07	819	$ 382.19	19,318	$ 16.20	$ 313,015
January-08	726	$ 310.12	14,934	$ 15.08	$ 225,144
February-08	794	$ 340.64	18,107	$ 14.94	$ 270,470
March-08	796	$ 391.89	17,185	$ 18.15	$ 311,946
April-08	783	$ 341.81	17,394	$ 15.39	$ 267,639
May-08	765	$ 377.25	14,967	$ 19.28	$ 288,595
June-08	768	$ 481.76	17,523	$ 21.11	$ 369,989
July-08	880	$ 474.08	20,276	$ 20.58	$ 417,191
August-08	731	$ 481.01	17,232	$ 20.40	$ 351,615
September-08	913	$ 454.03	18,870	$ 21.97	$ 414,528
October-08	832	$ 446.12	17,397	$ 21.34	$ 371,174
November-08	903	$ 441.25	19,239	$ 20.71	$ 398,446
Monthly Averages	808	$ 408.97	17,617	$ 18.78	$ 331,185
Ave., Aug '07 - April '08	792			$ 17.19	
Adjustment for rate changes (delayed rate sheet/mass adj necessary)				$5.48	
Growth May 08 - July 2009 (approx. 7 per month):	108				
5% Inflation 7/1/08				$ 1.13	
09-11 Caseload Growth - 5 per month	63				
7%/7% Inflation (09-11)				$ 2.58	
Total	963			$ 26.38	

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2007-2009 Actual

Family Support Services - In-Home Support (Revised) *

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-07	429	$ 931.16	19,226	$ 20.78	$ 399,467
September-07	455	$ 896.16	20,191	$ 20.19	$ 407,752
October-07	442	$ 963.89	16,549	$ 25.74	$ 426,040
November-07	452	$ 979.63	16,959	$ 26.11	$ 442,792
December-07	448	$ 780.73	17,005	$ 20.57	$ 349,768
January-08	447	$ 783.04	16,790	$ 20.85	$ 350,018
February-08	438	$ 787.36	16,523	$ 20.87	$ 344,863
March-08	447	$ 819.87	17,521	$ 20.92	$ 366,484
April-08	458	$ 788.05	17,352	$ 20.80	$ 360,929
May-08	440	$ 766.04	16,755	$ 20.12	$ 337,059
June-08	456	$ 792.76	17,837	$ 20.27	$ 361,497
July-08	453	$ 977.30	21,057	$ 21.02	$ 442,715
August-08	440	$ 1,061.24	21,776	$ 21.44	$ 466,943
September-08	449	$ 1,022.57	20,821	$ 22.05	$ 459,132
October-08	426	$ 815.54	15,995	$ 21.72	$ 347,420
November-08	443	$ 845.11	18,028	$ 20.77	$ 374,386
Monthly Averages	445	$ 875.65	18,149	$ 21.51	$ 389,829

Ave., Aug '07 - April '08	446	$ 21.85
Growth May 08 - July 2009:	27	
5% Inflation 7/1/08		$ 1.09
09-11 Caseload Growth (approx 2 per month)	24	
7%/7% Inflation (09-11)		$ 2.48
Total	497	$ 25.42

* The department recently began using a new computer program to generate spenddown information. At present the department is working the "kinks" out of this new computer program -- some of the DD Grants information generated by the new computer program differs from the mainframe DD Expenditure Reports. Since the mainframe DD Expenditure Reports reflect reimbursements to providers for billed services, the mainframe DD Expenditure Report data is reflected above for August '07 through November '08.

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North Dakota Department of Human Services
Developmental Disabilities Community Based ICF/MR Interim Rates

Note: these rates do not include Medical costs that are covered by Medicaid such as Drugs, Dental, Physician costs, Hospitalization, etc.

ICF/MR Provider	Residence Address	Location	Type	Interim Rate	Effective
4th Corporation	1510 1st Street South	Carrington	Adult	$295.21	04/01/08
4th Corporation	927 3rd Street Northeast	Fessenden	Adult	$307.06	04/01/08
ABLE, Inc.	1304 2nd Avenue S.	Hettinger	Adult	$251.26	10/01/08
ABLE, Inc.	1297 23rd Street West	Dickinson	Adult	$263.06	10/01/08
ABLE, Inc.	1387 24th Street West	Dickinson	Adult	$290.08	10/01/08
ABLE, Inc.	632 23rd Street West	Dickinson	Adult	$333.44	10/01/08
Alpha Opportunities, Inc.	112 6th Avenue SE	Jamestown	Adult	$253.02	07/01/08
Development Homes, Inc.	2720 17th Street South	Grand Forks	Adult	$319.64	01/01/08
Enable, Inc.	3656 East Princeton	Bismarck	Adult	$291.54	10/01/08
Enable, Inc.	3665 West Princeton	Bismarck	Adult	$345.98	10/01/08
Enable, Inc.	2100-12th Avenue SE	Mandan	Adult	$294.74	10/01/08
Enable, Inc.	2004 8th Avenue SE	Mandan	Adult	$306.17	10/01/08
Enable, Inc.	1549 South Washington	Bismarck	Adult	$319.94	10/01/08
Fraser, LTD.	631 22nd Street East	West Fargo	Adult	$208.60	07/01/07
Fraser, LTD.	2726 18th Street South	Fargo	Adult	$249.93	07/01/07
Fraser, LTD.	2574 Arrowhead Road	Fargo	Adult	$250.98	07/01/07
Friendship, Inc.	2302 18th Street South	Fargo	Adult	$409.79	07/01/08
Friendship, Inc.	1635 34th Avenue S.	Fargo	Adult	$364.57	07/01/08
Friendship, Inc.	412 East 10th Street	Grafton	Adult	$259.34	07/01/08
Friendship, Inc.	503 Hilltop Drive	Park River	Adult	$292.98	07/01/08
Friendship, Inc.	605 Hilltop Drive	Park River	Adult	$305.51	07/01/08
Housing, Industry, Training, Inc.	1004 27th Street N. W.	Mandan	Adult	$317.70	07/01/08
Minot Vocational Adj. Workshop	1007 11th Avenue SE	Minot	Adult	$367.95	07/01/08
Minot Vocational Adj. Workshop	1005 11th Avenue SE	Minot	Adult	$387.41	07/01/08
Opportunity Foundation, Inc.	1808 17th Court West	Williston	Adult	$233.14	04/01/08
Red River Human Services Found.	821 Western Road	Wahpeton	Adult	$265.95	07/01/08
Red River Human Services Found.	1348 15th Avenue North	Wahpeton	Adult	$237.64	07/01/08
REM-North Dakota, Inc.	1405 32nd Avenue SW	Minot	Adult	$261.31	10/01/07
REM-North Dakota, Inc.	415 North 51st Street	Grand Forks	Adult	$286.96	10/01/07
REM-North Dakota, Inc.	5017 7th Avenue North	Grand Forks	Adult	$283.86	10/01/07
REM-North Dakota, Inc.	730 Summit Avenue	Grafton	Adult	$274.85	10/01/07
Tri-City Cares, Inc.	723 2nd Street SW	Stanley	Adult	$260.11	10/01/08
Tri-City Cares, Inc.	220 North Gilbertson St.	Tioga	Adult	$280.27	10/01/08
Tri-City Cares, Inc.	709 Eagle Drive	New Town	Adult	$239.34	10/01/08
Anne Carlsen Center *	701-3rd St N.W.	Jamestown	Children's	$493.12	01/01/08
Anne Carlsen Center *	603 -3rd St N.W.	Jamestown	Children's	$315.30	01/01/08
Anne Carlsen Center *	605 -3rd St N.W.	Jamestown	Children's	$307.33	01/01/08
Anne Carlsen Center *	601-3rd St N.W.	Jamestown	Children's	$311.37	01/01/08
Development Homes, Inc.	2585 South 19th Street	Grand Forks	Children's	$430.07	07/01/08
Friendship, Inc.	2424 18th Street South	Fargo	Children's	$363.41	07/01/08
Housing, Industry, Training, Inc.	324 West Apollo Ave.	Bismarck	Children's	$274.75	07/01/08
Housing, Industry, Training, Inc.	1901 2nd Street N. E.	Mandan	Children's	$286.13	07/01/08
Open Door Center	240 4th Avenue SE	Valley City	Children's	$478.37	07/01/08
REM-North Dakota, Inc.	1824 1st Street SE	Minot	Children's	$330.04	10/01/07

* the provider has not agreed to the listed rate as of 1/27/09.

North Dakota Department of Human Services
Developmental Disabilities Community Based ICF/MR Interim Rates

Note: these rates do not include Medical costs that are covered by Medicaid such as Drugs, Dental, Physician costs, Hospitalization, etc.

ICF/MR Provider	Residence Address	Location	Type	Interim Rate	Effective
4th Corporation	1110 Central Avenue	New Rockford	PH	$286.26	04/01/08
ABLE, Inc.	847 24th Street West	Dickinson	PH	$378.36	10/01/08
Alpha Opportunities, Inc.	1510 8th Avenue NE	Jamestown	PH	$242.22	07/01/08
Development Homes, Inc.	1551 24th Avenue South	Grand Forks	PH	$382.48	01/01/08
Fraser, LTD.	651 12 1/2 Avenue East	West Fargo	PH	$284.11	07/01/07
Friendship, Inc.	2502 33rd Avenue S.	Fargo	PH	$360.85	07/01/08
Housing, Industry, Training, Inc.	1417 S. Washington St.	Bismarck	PH	$324.82	07/01/08
Housing, Industry, Training, Inc.	304 11th Street N.E.	Mandan	PH	$317.45	07/01/08
Lake Region Corporation	923 6th Avenue	Devils Lake	PH	$370.17	07/01/08
Open Door Center	220 5th Avenue SW	Valley City	PH	$383.67	07/01/08
Open Door Center	491 2nd Avenue NE	Valley City	PH	$308.92	07/01/08
Open Door Center	664 10th Avenue SE	Valley City	PH	$301.25	07/01/08
Opportunity Foundation, Inc.	821 5th Avenue West	Williston	PH	$250.26	04/01/08
Red River Human Services Found.	348 14th Street North	Wahpeton	PH	$241.20	07/01/08
REM-North Dakota, Inc.	1404 18th Avenue SW	Minot	PH	$306.33	10/01/07
REM-North Dakota, Inc.	301 39th Avenue South	Grand Forks	PH	$262.98	10/01/07
REM-North Dakota, Inc.	506 13th Street West	Devils Lake	PH	$262.56	10/01/07
REM-North Dakota, Inc.	1575 Manvel Avenue	Grafton	PH	$322.20	10/01/07
REM-North Dakota, Inc.	1104 15th Street South	Devils Lake	PH	$290.54	10/01/07

Schedule 1
For assets $0 - $24,999

SPED Program Sliding Fee Schedule
Effective August 1, 2003

Family Size	100% Discount or No Fee		90% Discount or 10%		80% Discount or 20%		70% Discount or 30%		60% Discount or 40%		50% Discount or 50%		40% Discount or 60%		30% Discount or 70%		20% Discount or 80%		10% Discount or 90%		Discount or 100%
1	0	850	851	926	927	1002	1003	1077	1078	1153	1154	1227	1228	1304	1305	1379	1380	1455	1456	1530	1531
2	0	1142	1143	1241	1242	1339	1340	1438	1439	1536	1537	1635	1636	1734	1735	1832	1833	1931	1932	2030	2031
3	0	1435	1436	1557	1558	1679	1680	1801	1802	1923	1924	2045	2046	2167	2168	2289	2290	2411	2412	2533	2534
4	0	1727	1728	1873	1874	2018	2019	2163	2164	2308	2309	2453	2454	2599	2600	2744	2745	2889	2890	3034	3035
5	0	2020	2021	2189	2190	2357	2358	2525	2526	2693	2694	2862	2863	3030	3031	3198	3199	3367	3368	3536	3537
6	0	2313	2314	2505	2506	2696	2697	2888	2889	3080	3081	3272	3273	3463	3464	3655	3656	3846	3847	4038	4039
7	0	2367	2368	2563	2564	2759	2760	2955	2956	3151	3152	3347	3348	3543	3544	3739	3740	3935	3936	4131	4132
8	0	2423	2424	2623	2624	2824	2825	3024	3025	3225	3226	3425	2426	3625	3626	3825	3826	4026	4027	4226	4227
9	0	2477	2478	2681	2682	2886	2887	3091	3092	3296	3297	3501	3502	3706	3707	3911	3912	4116	4117	4320	4321
10	0	2532	2533	2741	2742	2950	2951	3159	3160	3368	3369	3577	3578	3786	3787	3995	3996	4204	4205	4413	4414
11	0	2587	2588	2801	2802	3014	3015	3227	3228	3441	3442	3654	3655	3868	3869	4081	4082	4294	4295	4508	4509
12	0	2642	2643	2859	2860	3077	3078	3295	3296	3513	3514	3731	3732	3949	3950	4167	4168	4385	4386	4602	4603

Schedule 2
For assets $25,000 - $50,000

SPED Program Sliding Fee Schedule
Effective August 1, 2003

Family Size	100% Discount or No Fee		90% Discount or 10%		80% Discount or 20%		70% Discount or 30%		60% Discount or 40%		50% Discount or 50%		40% Discount or 60%		30% Discount or 70%		20% Discount or 80%		10% Discount or 90%		Discount or 100%
1	0	700	701	776	777	852	853	927	928	1003	1004	1078	1079	1154	1155	1229	1230	1305	1306	1380	1381
2	0	992	993	1091	1092	1189	1190	1288	1289	1386	1387	1485	1486	1584	1585	1682	1683	1781	1782	1880	1881
3	0	1285	1286	1407	1408	1529	1530	1651	1652	1773	1774	1895	1896	2017	2018	2139	2140	2261	2262	2383	2384
4	0	1577	1578	1723	1724	1868	1869	2013	2014	2158	2159	2303	2304	2449	2450	2594	2595	2739	2740	2884	2885
5	0	1870	1871	2039	2040	2207	2208	2375	2376	2543	2544	2712	2713	2880	2881	3048	3049	3217	3218	3386	3387
6	0	2163	2164	2355	2356	2546	2547	2738	2739	2930	2931	3122	3123	3313	3314	3505	3506	3696	3697	3888	3889
7	0	2217	2218	2413	2414	2609	2610	2805	2806	3001	3002	3197	3198	3393	3394	3589	3590	3785	3786	3981	3982
8	0	2273	2274	2473	2474	2674	2675	2874	2875	3075	3076	3275	3276	3475	3476	3675	3676	3876	3877	4076	4077
9	0	2327	2328	2531	2532	2736	2737	2941	2942	3146	3147	3351	3352	3556	3557	3761	3762	3966	3967	4170	4171
10	0	2382	2383	2591	2592	2800	2801	3009	3010	3218	3219	3427	3428	3636	3637	3845	3846	4054	4055	4263	4264
11	0	2437	2438	2651	2652	2864	2865	3077	3078	3291	3292	3504	3505	3718	3719	3931	3932	4144	4145	4358	4359
12	0	2492	2493	2709	2710	2927	2928	3145	3146	3363	3364	3581	3582	3799	3800	4017	4018	4235	4236	4452	4453

Schedule 1
For assets $0 - $24,999

SPED Program Sliding Fee Schedule

Family Size	100% Discount or No Fee		90% Discount or 10%		80% Discount or 20%		70% Discount or 30%		60% Discount or 40%		50% Discount or 50%		40% Discount or 60%		30% Discount or 70%		20% Discount or 80%		10% Discount or 90%		Discount or 100%
1	0	1038	1039	1131	1132	1224	1225	1316	1317	1408	1409	1499	1500	1593	1594	1685	1686	1777	1778	1869	1870
2	0	1395	1396	1516	1517	1636	1637	1757	1758	1876	1877	1997	1998	2118	2119	2238	2239	2359	2360	2480	2481
3	0	1753	1754	1902	1903	2051	2052	2200	2201	2349	2350	2498	2499	2647	2648	2796	2797	2945	2946	3094	3095
4	0	2110	2111	2288	2289	2465	2466	2642	2643	2819	2820	2997	2998	3175	3176	3352	3353	3529	3530	3706	3707
5	0	2468	2469	2674	2675	2879	2880	3084	3085	3290	3291	3496	3497	3701	3702	3907	3908	4113	4114	4319	4320
6	0	2825	2826	3060	3061	3293	3294	3528	3529	3762	3763	3997	3998	4230	4231	4465	4466	4698	4699	4933	4934
7	0	2891	2892	3131	3132	3370	3371	3610	3611	3849	3850	4089	4090	4328	4329	4567	4568	4807	4808	5046	5047
8	0	2960	2961	3204	3205	3450	3451	3694	3695	3940	3941	4184	4185	4428	4429	4673	4674	4918	4919	5162	5163
9	0	3026	3027	3275	3276	3525	3526	3776	3777	4026	4027	4277	4278	4527	4528	4778	4779	5028	5029	5277	5278
10	0	3093	3094	3348	3349	3604	3605	3859	3860	4114	4115	4370	4371	4625	4626	4880	4881	5135	5136	5391	5392
11	0	3160	3161	3422	3423	3682	3683	3942	3943	4203	4204	4464	4465	4725	4726	4985	4986	5245	5246	5507	5508
12	0	3227	3228	3492	3493	3759	3760	4025	4026	4291	4292	4558	4559	4824	4825	5090	5091	5357	5358	5622	5623

Schedule 2
For assets $25,000 - $50,000

SPED Program Sliding Fee Schedule

Family Size	100% Discount or No Fee		90% Discount or 10%		80% Discount or 20%		70% Discount or 30%		60% Discount or 40%		50% Discount or 50%		40% Discount or 60%		30% Discount or 70%		20% Discount or 80%		10% Discount or 90%		Discount or 100%
1	0	855	856	948	949	1041	1042	1132	1133	1225	1226	1317	1318	1410	1411	1501	1502	1594	1595	1686	1687
2	0	1212	1213	1333	1334	1452	1453	1573	1574	1693	1694	1814	1815	1935	1936	2055	2056	2176	2177	2297	2298
3	0	1570	1571	1719	1720	1868	1869	2017	2018	2166	2167	2315	2316	2464	2465	2613	2614	2762	2763	2911	2912
4	0	1926	1927	2105	2106	2282	2283	2459	2460	2636	2637	2813	2814	2992	2993	3169	3170	3346	3347	3523	3524
5	0	2284	2285	2491	2492	2696	2697	2901	2902	3106	3107	3313	3314	3518	3519	3723	3724	3930	3931	4136	4137
6	0	2642	2643	2877	2878	3110	3111	3345	3346	3579	3580	3814	3815	4047	4048	4282	4283	4515	4516	4749	4750
7	0	2708	2709	2948	2949	3187	3188	3427	3428	3666	3667	3905	3906	4145	4146	4384	4385	4624	4625	4863	4864
8	0	2777	2778	3021	3022	3266	3267	3511	3512	3756	3757	4001	4002	4245	4246	4489	4490	4735	4736	4979	4980
9	0	2843	2844	3092	3093	3342	3343	3593	3594	3843	3844	4093	4094	4344	4345	4594	4595	4845	4846	5094	5095
10	0	2910	2911	3165	3166	3420	3421	3676	3677	3931	3932	4186	4187	4442	4443	4697	4698	4952	4953	5208	5209
11	0	2977	2978	3238	3239	3499	3500	3759	3760	4020	4021	4280	4281	4542	4543	4802	4803	5062	5063	5324	5325
12	0	3044	3045	3309	3310	3576	3577	3842	3843	4108	4109	4374	4375	4641	4642	4907	4908	5173	5174	5438	5439

B

With exception of these attachments - Save attachments given to H and Sent

Testimony on HB 1012
House Appropriation - Human Resource Division
January 26, 2009

Good Afternoon Chairman Pollert and members of the House Appropriations – Human Resource Division. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. I am here today to testify on behalf of long term care facilities.

HB 1012 touches the lives of many individuals. I would like to address the funding for individuals in need of basic and skilled nursing care. We have identified five items of priority that we would like you to support. Two of the five items are currently in HB 1012 and we request that you consider three additional items. The two items in the budget that we request you keep intact are:

1. Seven percent inflator for all Medicaid providers.
2. Increases the Personal Needs Allowance for SSI recipients in nursing facilities from $30 to $50.

Three additional items we ask you to consider are:

1. A $2.00 an hour wage/benefit pass-through for all staff, except administrators that work in a licensed basic care and nursing facility.
2. Increase the nursing facility asset limits from $92,604 to $112,732 for a double room and from $138,907 to $169,098 for a single room.
3. Increase the Personal Needs Allowance for basic care residents from $60 to $100.

Please see Attachment A for the cost breakdown on funding these priorities.

First, I'd like to address the annual inflator (7%) and the wage/benefit pass-through. We are in the worst staffing crisis anyone can recall. Consider these facts:

- Certified Nurse Assistant (CNA) turnover is 51%.
- 49% of nursing facilities contracted with agencies in 2008 to deliver daily resident care because they did not have enough staff. Spending over $3.5 million on contract staff in 2008.

- It takes 8 months on average to fill an open nursing position in a rural nursing facility.
- Nursing facilities reported over 1,000 open positions in April 2008, 733 openings were for CNA's
- 17% of nursing facilities stopped admissions in 2008 because of insufficient staffing.
- Our oldest caregiver is a 94-year-old dietary aide and over 14% of long term care staff is at retirement age.
- Long term care wages are at the bottom of the barrel when compared to other entities in North Dakota. (See Attachment B)

Most nursing and basic care facilities do not have the cash reserves to make the salary adjustments they need to make. Consider this, our new 2009 rates were just updated to the 2006 cost report, inflated by 4% and 5% as passed in 2007 session. Still nearly 40% of all facilities are exceeding at least one limit, spending $3.7 million in unreimbursed costs. (See Attachment C)

We estimate basic care and nursing facilities employ around 13,000 full and part time people. What can you do to help?

Provide a salary/benefit enhancement that is effective July 1, 2009. This will go into the pockets and purses of 13,000 staff. This money will be spent in communities throughout North Dakota to buy groceries, shoes, repair homes, and fill the family car with gas. For every dollar you appropriate to this salary/benefit adjustment, the federal government through FMAP matching will provide an additional two dollars.

Think of the economic boost to North Dakota's economy, thirteen thousand North Dakotans spending an additional $45 million and being better able to take care for their families. Of this total amount, almost $28 million would be covered by federal funds. $17.5 million in state general funds would need to be appropriated to access the federal funds. We believe this is the solution to help assure a workforce for the future. Without an infusion of dollars, surely our workforce crisis will grow. We want our sons and daughters to live and work in North Dakota, and to attract others to consider North Dakota. This salary/benefit boost will help secure that future caregiving workforce. (See Attachment D)

The annual inflator is necessary because our costs are going up faster than our revenue. In 2008, our health insurance increased on average 9.71%. Food has gone up tremendously. The seven percent adjustment will help us better met our increasing costs and we urge that you keep it intact on HB 1012.

Next I'd like to address the cost of construction and renovation for nursing facilities. In the last session, you increased this limit and we are grateful; however it is not sufficient to cover today's costs. For life safety concerns, the Centers for Medicare and Medicaid Services is requiring all nursing facilities be equipped with automatic sprinkler systems. Nursing facilities still have 3½ years to achieve compliance, with approximately one-quarter still needing to upgrade. Many physical plants are forty and fifty years old, not efficient and in need of upgrades. Many facilities are trying to go with more private rooms to better meet the needs of their frail resident population. If the limit is not adjusted, the vast majority of all current and future projects will have not sufficient "property funds" to pay their mortgage obligations. Please consider increasing the limit as outline on the first page of my testimony at a cost of $324,506 in state general funds.

Personal needs allowance for SSI and basic care residents. HB 1012 contains the funding for all nursing facility residents to receive $50 per month. A small minority are only receiving $30 and this has not been sufficient for many years. The other population we are requesting you consider an increase is for basic care residents. Since July 1, 2001, they have been receiving $60 per month. In almost eight years, they have not had an increase, not even the CPI. See the five letters I received from residents in the new facility in Fargo that opened in February 2008. I encourage you to take the time to read all letters – note the one from the 92 year-old women "requesting a greater allowance." (See Attachment E)

In summary, we need your help. With Equalization of Rates, you control the rate system in North Dakota. Funding can not increase without your support and approval! As you consider and fund your priorities, please consider the care to the 14,000 people that will receive care in a long term care facility, as a priority as you have in past sessions. They need caregivers and we need your support to get them the care they need.

Thank you very much for your consideration of our request. I would be happy to answer any questions you may have.

Shelly Peterson, President
North Dakota Long Term Care Association
1900 North 11th Street • Bismarck, ND 58501
(701) 222-0660 • www.ndltca.org • E-mail: shelly@ndltca.org

Long Term Care 2009-2011 Budget Priorities

ATTACHMENT A

	Type of Expenditure	Funding Sources General	Funding Sources Federal	Total Increase
1	Wage/Benefit Pass-Through Basic & Nursing Faciltiies	$17,500,000	$27,700,000	$45,200,000
2	Nursing Facility Asset Limit	$324,506	$553,012	$877,518
3	Basic Care - Personal Needs Allowance - $60 to $100	$299,520		$299,520

North Dakota Long Term Care ASSOCIATION

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Job Service Average Wage Data 2008

Type of Employment	Average Annual Wage 2008	Percentage Higher than LTC
Nursing Home, BC/AL, DD	$21,112	This is us!
Retail Trade	$22,464	6% Higher
ND Average Wage	$34,008	61% Higher
State Government	$37,752	79% Higher
Hospitals	$46,072	118% Higher

Nursing Facility Average Employee Entry & Highest Salaries October 2008

Position	Average Entry Salary	Average Highest Salary
Resident/Feeding Asst	$8.03—$16,702	$10.89—$22,651
Certified Nurse Assistants	$9.71—$20,197	$13.73—$28,558
Certified Medication Assistant	$10.74—$22,339	$14.50—$30,160
Laundry Aide	$8.06—$16,765	$11.28—$23,462
Activity Aide	$8.47—$17,618	$11.56—$24,045
Receptionist	$8.74—$18,179	$11.49—$23,899
Maintenance Staff	$9.98—$20,758	$14.04—$29,203
Groundskeeper	$8.91—$18,533	$12.20—$25,376
Housekeeping Staff	$8.06—$16,765	$11.19—$23,275
Dietary Aide	$8.09—$16,827	$11.14—$23,171

Average Health Insurance Benefit for Nursing Facility Staff

Single Plan	Cover 77% of cost
Single Plus Dependent Plan	Cover 63% of cost
Family Plan	Cover 58% of cost

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Long Term Care Wages in Four Categories

	# of Staff	Percentage	Types of Staff
Less than $10/hour	2,990	23%	Dietary Aides, Housekeepers, Laundry Asst, Universal Workers, CNA's, Cooks, Receptionists, Nurse Assistants
$10.01 to $15.00/hour	6,890	53%	CNA's, Medication Aides, Activity Staff, Cooks, Case Managers
$15.01 to $20.00/hour	1,820	14%	LPN's, Staff RN's
More than $20.01/hour	1,300	10%	RN's, Director of Nursing, Department Heads and Directors, Chaplain, Administrator
Total	13,000	100%	

Assisted living, basic care and nursing facilities employ 14,000 individuals, it is projected basic care and nursing facilities employ 13,000, equating to 9,000 to 9,720 FTE's. Seventy-five percent or 9,880 staff earn between minimum wage and $15.00. Only 10% of those employed in long term care facilities earn over $20.01 per hour.

The salary data and classification of employees was taken from 21 long term care facilities representing 1,305 licensed beds and 2,243 staff persons. The data from these facilities was then estimated to all basic care and nursing facilities using the same percentage splits into the four salary categories.

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ATTAC ENT C

BASED ON RATES SET BEGINNING JANUARY 1, 2009

						ACTUAL										$109.23	$20.70	$52.28	DIFFERENCE					
Provider Name	Provider No.	City	Census	90%	Licensed Beds	Direct	Other Direct	Indirect	Case-Mix Direct Rate	Other Direct Rate	Indirect Rate	Property Rate	Incentive	Operating Margin	Total Rate	DIRECT	OTHER DIRECT	IN-DIRECT	# of LIMITS	ONE LIMIT	TWO LIMITS	THREE LIMITS	Direct	Other Direct	Indirect
Kenmare Community Hospital	30459	Kenmare	4,224	3,963	12	$116.13	$26.73	$87.60	109.23	20.70	52.28	12.26	-	3.50	198.06				3		2	1	$5.90	$6.03	$35.32
North Dakota Veterans Home	39293	Lisbon	13,687	12,517	38	$138.68	$23.08	$24.60	109.23	20.70	52.28	19.76	-	3.47	195.97				3			1	$29.45	$2.36	$22.32
Ashley Medical Center	30188	Ashley	13,718	14,494	44	$85.66	$23.17	$56.00	85.66	20.70	52.28	5.94	-	2.77	167.35		1	1	2		1			$2.47	$3.72
Tri County Health Center	30018	Hatton	14,573	13,835	42	$94.27	$21.20	$74.49	94.27	20.70	52.28	16.74	-	3.27	187.26		1	1	2		1			$0.50	$22.21
Southwest Healthcare Services	30403	Bowman	21,726	20,093	61	$113.16	$17.19	$57.27	109.23	17.19	52.28	16.89	-	3.42	199.01	1		1	2		1		$3.93		$4.99
Wedgewood Manor	30194	Cavalier	18,840	19,764	60	$93.37	$20.80	$58.06	93.37	20.70	52.28	8.38	-	3.33	178.06		1	1	2		1			$0.10	$5.78
Northwood Deaconess Health Center	30031	Northwood	21,495	20,093	61	$103.25	$20.78	$56.06	103.25	20.70	52.28	17.13	-	3.51	196.87		1	1	2		1			$0.08	$3.78
Westhope Home for the Aged	30037	Westhope	8,591	8,235	25	$97.33	$20.85	$64.31	97.33	20.70	52.28	10.85	-	3.22	184.38		1	1	2		1			$0.15	$12.03
Hillsboro Medical Center	30019	Hillsboro	12,014	11,858	36	$113.22	$19.69	$55.84	109.23	19.69	52.28	54.18	-	3.23	238.61	1		1	2		1		$3.99		$3.56
Missouri Slope Lutheran Care Center, Inc.	30004	Bismarck	91,236	82,350	250	$110.07	$19.92	$50.41	109.23	19.92	50.41	10.52	0.20	3.67	193.95	1			1	1			$0.84		
Towner County Medical Center	30379	Cando	15,685	14,823	45	$70.91	$19.60	$57.95	70.91	19.60	52.28	23.06	-	2.83	168.68			1	1	1					$5.67
Heartland Care Center	30010	Devils Lake	29,698	28,987	88	$113.91	$19.13	$51.54	109.23	19.13	51.54	7.58	-	3.87	191.35	1			1	1			$4.68		
Jacobson Memorial Hospital Care Center	30077	Elgin	8,625	8,235	25	$82.98	$17.19	$64.32	82.98	17.19	52.28	7.87	-	2.95	163.27			1	1	1					$12.04
Garrison Memorial Hospital Nursing Home	30134	Garrison	10,166	9,223	28	$101.71	$14.57	$53.91	101.71	14.57	52.28	13.46	-	3.05	185.07			1	1	1					$1.63
Aneta Parkview Health Center	30322	Aneta	12,895	12,847	39	$92.64	$16.27	$54.10	92.64	16.27	52.28	10.42	-	2.91	174.52			1	1	1					$1.82
Arthur Good Samaritan Center	30058	Arthur	16,215	15,482	47	$82.35	$14.83	$54.32	82.35	14.83	52.28	10.39	-	2.84	162.69			1	1	1					$2.04
Baptist Home	30003	Bismarck	50,680	46,445	141	$110.51	$19.50	$44.95	109.23	19.50	44.95	3.91	2.60	3.61	183.80	1			1	1			$1.28		
Crosby Good Samaritan Center	30122	Crosby	15,125	13,835	42	$81.53	$14.74	$57.20	81.53	14.74	52.28	7.90	-	2.73	159.18			1	1	1					$4.92
Dunseith Community Nursing Home	30052	Dunseith	11,629	11,529	35	$75.90	$19.06	$57.80	75.90	19.06	52.28	4.78	-	2.64	154.66			1	1	1					$5.52
Hi-Acres Manor Nursing Center	30021	Jamestown	47,606	46,775	142	$113.65	$17.78	$46.47	109.23	17.78	46.47	11.38	2.60	3.60	191.06	1			1	1			$4.42		
Osnabrock Good Samaritan Center	30117	Osnabrock	7,466	7,906	24	$72.90	$15.97	$55.40	72.90	15.97	52.28	7.58	-	2.74	151.47				1	1					$3.12
Rock View Good Samaritan Center	30155	Parshall	12,376	12,517	38	$94.78	$18.40	$61.67	94.78	18.40	52.28	10.59	-	3.27	179.32				1	1					$9.39
Mountrail Bethel Home	30032	Stanley	19,901	18,776	57	$102.83	$17.63	$54.03	102.83	17.63	52.28	7.99	-	3.28	184.01				1	1					$1.75
McKenzie County Healthcare System	30449	Watford City	16,982	15,482	47	$105.70	$18.21	$54.11	105.70	18.21	52.28	4.29	-	3.34	183.82				1	1					$1.83
Manorcare of Fargo ND, LLC	30478	Fargo	37,666	35,905	109	$84.58	$15.04	$52.41	84.58	15.04	52.28	10.22	-	3.47	165.59				1	1					$0.13
Knife River Care Center	30002	Beulah	30,834	28,328	86	$98.00	$19.13	$52.80	98.00	19.13	52.28	37.93	-	3.40	210.74				1	1					$0.52
Heart of America Medical Center	30135	Rugby	28,347	26,352	80	$105.75	$20.23	$53.30	105.75	20.23	52.28	10.37	-	3.69	192.32				1	1					$1.02
Parkside Lutheran Home	30109	Lisbon	14,311	13,176	40	$86.07	$16.48	$56.78	86.07	16.48	52.28	7.82	-	2.81	165.56				1	1					$4.50
Hill Top Home of Comfort, Inc.	30271	Killdeer	16,011	16,470	50	$98.79	$19.98	$53.73	98.79	19.98	52.28	13.70	-	3.66	188.41				1	1					$1.45
Presentation Medical Center	30466	Rolette	11,341	15,152	46	$76.71	$18.93	$47.01	76.71	18.93	47.01	4.15	2.46	3.05	152.31										
St. Rose Care Center	30119	LaMoure	13,486	14,494	44	$78.04	$15.35	$50.93	78.04	15.35	50.93	10.67	-	2.89	157.88										
Bethel Lutheran Home	30038	Williston	56,342	57,316	174	$94.05	$19.28	$43.78	94.05	19.28	43.78	11.09	2.60	3.10	173.90										
Four Seasons Health Care Center, Inc.	30406	Forman	9,964	10,541	32	$61.68	$14.79	$43.87	61.68	14.79	43.87	11.81	2.60	2.30	137.05										
Prince of Peace Care Center	30012	Ellendale	17,778	18,117	55	$67.89	$11.71	$51.29	67.89	11.71	51.29	13.12	-	2.46	146.47										
Pembiller Nursing Center	30035	Walhalla	11,832	12,188	37	$80.50	$12.19	$46.52	80.50	12.19	46.52	2.82	2.60	2.49	147.12										
Souris Valley Care Center	30216	Velva	16,242	16,470	50	$79.51	$16.85	$51.35	79.51	16.85	51.35	8.27	-	2.83	158.81										
Mott Good Samaritan Nursing Center	30142	Mott	16,781	16,799	51	$75.77	$16.48	$46.09	75.77	16.48	46.09	5.79	2.60	2.57	149.30										
Maple Manor Care Center	30083	Langdon	20,747	20,752	63	$81.16	$15.93	$42.16	81.16	15.93	42.16	5.83	2.60	2.72	150.40										
Medcenter One St. Vincent's Care Center	30005	Bismarck	36,837	33,269	101	$101.26	$15.93	$42.86	101.26	15.93	42.86	11.67	2.60	3.65	177.97										
Golden Acres Manor Nursing Home	30008	Carrington	21,368	19,764	60	$86.43	$17.64	$42.55	86.43	17.64	42.55	12.45	2.60	2.87	164.54										
Cooperstown Medical Center	30095	Cooperstown	16,680	15,811	48	$100.74	$16.71	$48.12	100.74	16.71	48.12	16.82	1.73	3.19	187.31										
Marian Manor Healthcare Center	30067	Glen Ullin	31,401	28,328	86	$96.52	$15.82	$37.72	96.52	15.82	37.72	5.51	2.60	3.10	161.27										
St. Gerard's Community Nursing Home	30163	Hankinson	13,154	12,188	37	$83.48	$18.79	$50.09	83.48	18.79	50.09	3.21	0.41	2.75	158.73										
Western Horizons Living Center	30477	Hettinger	17,469	16,963	62	$97.52	$13.62	$52.10	97.52	13.62	52.10	12.36	-	3.16	178.76										
Nelson County Health System Care Center	30384	Mcville	14,025	12,812	39	$78.61	$20.63	$49.69	78.61	20.63	49.69	16.34	0.67	2.77	168.71										
Trinity Home	30028	Minot	99,830	96,185	292	$107.21	$17.49	$49.47	107.21	17.49	49.47	11.78	0.82	3.63	190.40										
Medcenter One Golden Manor	30106	Steele	17,364	16,470	50	$97.62	$18.05	$47.12	97.62	18.05	47.12	6.57	2.39	3.29	175.04										
Strasburg Care Center	30033	Strasburg	21,239	19,764	60	$100.59	$18.79	$38.53	100.59	18.79	38.53	2.00	2.60	2.97	165.48										
Tioga Medical Center	30176	Tioga	10,629	9,882	30	$83.60	$19.34	$48.23	83.60	19.34	48.23	9.18	1.65	2.94	164.94										
Prairieview Home-Medcenter One	30053	Underwood	21,849	19,764	60	$89.35	$17.92	$41.93	89.35	17.92	41.93	3.58	2.60	2.92	158.30										
Wishek Home for the Aged	30039	Wishek	26,200	24,376	74	$97.38	$18.85	$49.62	97.38	18.85	49.62	3.22	0.72	3.19	172.98										
Bottineau Good Samaritan Center	30118	Bottineau	27,142	26,681	81	$100.47	$17.89	$51.10	100.47	17.89	51.10	9.76	-	3.28	182.50										
Devils Lake Good Samaritan Center	30115	Devils Lake	22,303	21,740	66	$95.52	$14.76	$47.08	95.52	14.76	47.08	6.67	2.42	3.27	169.72										
St. Benedict's Health Center	30237	Dickinson	58,384	54,022	164	$83.45	$19.06	$42.05	83.45	19.06	42.05	9.44	2.60	3.06	159.66										
St. Luke's Home	30011	Dickinson	30,358	27,670	84	$98.11	$19.66	$47.92	98.11	19.66	47.92	5.11	1.86	3.45	176.11										
Maryhill Manor	30108	Enderlin	19,018	17,788	54	$93.55	$15.73	$49.91	93.55	15.73	49.91	9.37	0.53	2.90	171.99										
Bethany Home	30060	Fargo	69,584	63,245	192	$101.27	$20.39	$50.08	101.27	20.39	50.08	8.70	0.42	3.52	184.38										
Elim Home	30051	Fargo	47,846	44,798	136	$90.80	$18.52	$46.67	90.80	18.52	46.67	5.82	2.60	3.44	167.85										
Rosewood on Broadway	30015	Fargo	40,053	36,563	111	$95.04	$18.81	$49.35	95.04	18.81	49.35	22.29	0.90	3.62	190.01										

Purple: Exceeds 3 Limits
Yellow: Exceeds 2 Limits
Blue: Exceeds 1 Limit
*Pink: Occupancy Limitation

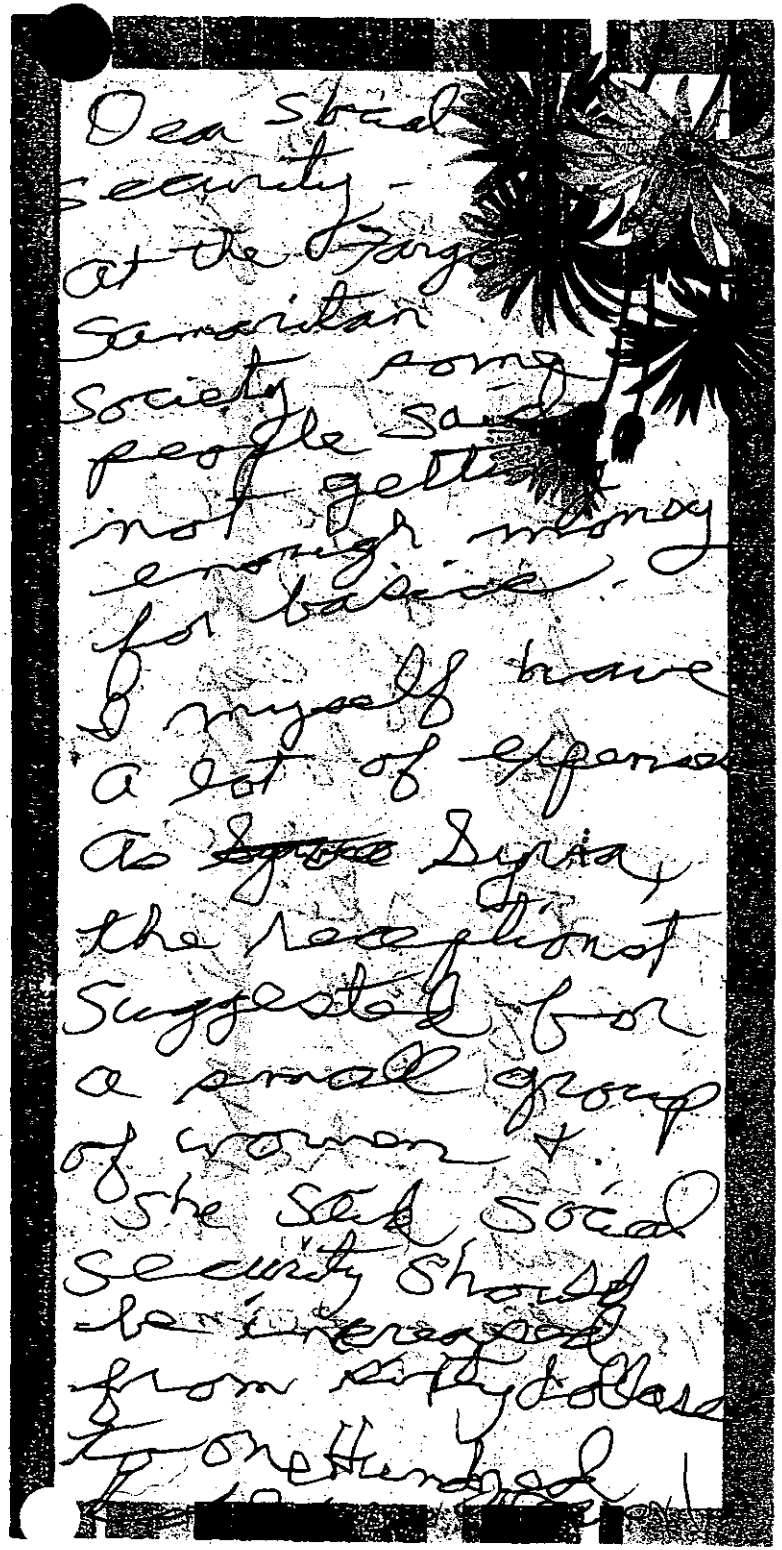
Provider Name	City	Case Mix Weight	Occupancy	Licensed Beds	Lost Reimbursement				
					Direct	Other Direct	Indirect	Occupancy Limitation	Over Limits
North Dakota Veterans Home	Lisbon	0.9187	98%	38	$370,358	$32,365	$305,532		$708,256
Tri County Health Center	Hatton	0.9948	95%	42		$7,262	$323,629		$330,892
Hi-Acres Manor Nursing Center	Jamestown	1.0082	92%	142	$212,031				$212,031
Kenmare Community Hospital	Kenmare	0.9830	96%	12	$24,480	$25,468	$149,172		$199,121
Presentation Medical Center	Rolette	1.1467	67%	46				$194,991	$194,991
Southwest Healthcare Services	Bowman	0.9567	97%	61	$81,589		$108,470		$190,060
Wedgewood Manor	Cavalier	1.0264	86%	60		$1,869	$108,970	$61,397	$172,237
Heartland Care Center	Devils Lake	1.0849	92%	88	$150,692				$150,692
Ashley Medical Center	Ashley	0.8884	85%	44		$33,817	$51,020	$48,042	$132,880
Rock View Good Samaritan Center	Parshall	1.0103	89%	38			$116,215	$10,203	$126,418
Westhope Home for the Aged	Westhope	0.9470	94%	25		$1,284	$103,323		$104,608
Jacobson Memorial Hospital Care Center	Elgin	1.0363	94%	25			$103,828		$103,828
Towner County Medical Center	Cando	1.1158	95%	45			$88,928		$88,928
Hillsboro Medical Center	Hillsboro	0.8718	91%	36	$41,787		$42,801		$84,589
Missouri Slope Lutheran Care Center, Inc.	Bismarck	1.0121	100%	250	$77,182				$77,182
Northwood Deaconess Health Center	Northwood	0.9886	96%	61		$1,709	$81,166		$82,876
Crosby Good Samaritan Center	Crosby	0.9933	98%	42			$74,444		$74,444
Baptist Home	Bismarck	0.9977	98%	141	$64,502				$64,502
Parkside Lutheran Home	Lisbon	0.9527	98%	40			$64,458		$64,458
Dunseith Community Nursing Home	Dunseith	0.9696	91%	35			$64,161		$64,161
St. Rose Care Center	LaMoure	1.0977	84%	44				$62,067	$62,067
Hill Top Home of Comfort, Inc.	Killdeer	1.0968	87%	50			$23,232	$30,953	$54,185
Bethel Lutheran Home	Williston	0.9480	88%	174				$53,420	$53,420
Osnabrock Good Samaritan Center	Osnabrock	1.0939	85%	24			$23,293	$27,686	$50,979
Mountrail Bethel Home	Stanley	0.9453	95%	57			$34,893		$34,893
Arthur Good Samaritan Center	Arthur	1.0312	94%	47			$33,124		$33,124
Four Seasons Health Care Center, Inc.	Forman	1.0672	85%	32				$32,116	$32,116
McKenzie County Healthcare System	Watford City	0.9335	99%	47			$31,044		$31,044
Heart of America Medical Center	Rugby	1.0291	97%	80			$28,803		$28,803
Aneta Parkview Health Center	Aneta	0.9211	90%	39			$23,432		$23,432
Prince of Peace Care Center	Ellendale	1.0969	88%	55				$21,834	$21,834
Pembilier Nursing Center	Walhalla	0.9307	87%	37				$17,555	$17,555
Garrison Memorial Hospital Nursing Home	Garrison	0.9034	99%	28			$16,551		$16,551
Knife River Care Center	Beulah	1.0178	98%	86			$16,143		$16,143
Souris Valley Care Center	Velva	1.0361	89%	50				$13,593	$13,593
Manorcare of Fargo ND, LLC	Fargo	1.2577	94%	109			$4,827		$4,827
Mott Good Samaritan Nursing Center	Mott	0.9704	90%	51				$955	$955
Maple Manor Care Center	Langdon	0.9754	90%	63				$250	$250
Total				2,344	$1,022,621	$103,774	$2,021,459	$575,062	$3,722,926

I am writing to request a greater allowance for personal cares for Basic Care residents in the state of North Dakota. I currently reside at Good Samaritan Society- Fargo and this is how my monthly $60 is used:

$60
- 10.62 Insurance Policy
- 3.79 AARP Medicare Rx
- 16.05 Phone
- 20.60 Pharmacy

This leaves me with approximately $4/month and I am unable to make a contribution to the church. Please consider increasing our personal allowance as I feel I have earned the right as I am almost 92 years and have paid for everything with cash my entire life. Thank you for your time and consideration.

Sincerely,
Norma Kortz



Dear Social
Security -
at the Good
Samaritan
Society home
people say
not getting
enough money
for basics.
I myself have
a lot of expenses
as ~~Syria~~ Syria,
the receptionist
suggested for
a small group
of women +.
She said Social
Security should
be increased
from sixty dollars
to one Hundred

we ask for
little. Major
expenses fall
upon me.
I was at Mayo
Clinic & got there
drs. paid I had
to be off aspirin
ten days for kidney
Repair. We are
just asking
for forty more
In closing,
after hearing
about this matter
~~$~~45 dollars perm.

July 29th, 2008

I moved into the Good Samaritan Society Feb. 1st, 2008, and am very thankful for a nice warm, friendly place to live. But with the cost of everything going up, $60.00 a mo is just not enough.

$60.00		$60.00
- 13.76 Phone	to	13.81 a month
46.24		46.19
16.00 - 4 Sunday Rides to Mass	→	20.00 5 Sunday Rides
30.24		26.19
10.00 A Mo. offering		10.00 offering
20.24		16.19
9.82 for visa { RCards, laundry supplies, stamps pop + misc	to	12.00 Visa supplies
10.42		4.19
4.00 coffee after Church	→	4.00 coffee after Church
6.42		.19

Then I need a perm every 3-4 mo; so then can not give at all to church. So that leaves nothing for personal items, such as shoes, undergarments or clothes. (even if I could find clothes at 2nd hand stores)

So I hope you could see to a raise of a $100.00 a month.

Sincerely Violet Wzuck

P.S. Have not ever been able to go for a Hamberg since moved here.

4502-37th ave So.
Fargo, No. Dak 58104

I was able to move into 17 Basic care facility facilaty the 1st of Feb 2008
I enjoy this facility very much but have found out even though it is furnished we feel
The $700.00 we are to keep just not reach out for a person.
I am hoping you can see fit to pass a law that would give us $100. a mo.
Below is my expenses for a Month
Medication.
Med. Pharmaceutical ins.
Church Giving
Clothes
Cleaners
hair care
$3.00 each way to take a bus to the store
some groceries
stamps
This would be a great help to us. We would be able than to go out to eat once a month

Thank You
Pearl Moen
4502-37th ave So.
Fargo - No. Dak 58104

August 26, 2008

NDLTCA
1900 11th Street North
Bismarck ND 58501

I am writing to request additional funds to supplement the current allotment allowed me of $60.00 a month.

I have the current monthly bills:

Canada Life (policy for Buriel)	$49.74
Qwest (phone bill)	$13.77
Linson Pharmacy (RX average)	$35.89
Union Bank Loan	$25.00
Total:	$124.40

Thank you,

Sincerely,

Norman Swanson

Norman Swanson
4502 37th Ave S # 119
Fargo ND 58104

Good Samaritan Society℠
FARGO

4502 37th Ave S
Fargo ND 58106-77158

Phone: 701-282-2651
Fax: 701-282-1220
www.good-sam.com

PETITION for
MONTHLY MONEY ALLOTMENT INCREASE
North Dakota Long Term Care Association
Bismarck, North Dakota

October 27, 2008

To the NDLTCA, Bismarck, North Dakota

We, the undersigned residents of the **Good Samaritan Society - Fargo**, do hereby petition the state of North Dakota to increase the monthly money allotment of $60.00 to $100.00 for **basic care residents**. We as seniors would like to maintain our independence for as long as possible and be cared for in an environment that is more homelike. As the cost of living increases, our expenses are increasing as well. On average we spend $15.00 per month on our telephone bills, $20-$25.00 per month on prescription costs. After these expenses, the amount of money for personal expenses, such as clothes, personal items and entertainment would only leave us with $20-$25.00 per month. We greatly appreciate all the help we receive, however, as costs continue to increase we are seeing a need for our personal monthly money allotment also increased.

Contact person Violet M. Wznick **Telephone** (701) 235-1156

Resident's Signature	Name (please print)	Address
Violet M. Wznick	Violet M. Wznick	4502 37th Avenue South, Fargo, ND 58104
Sandra Schimelpfenig	Sandra Schimelpfenig	4502 37th Avenue South, Fargo, ND 58104
Norman Swanson	Norman Swanson	4502 37th Avenue South, Fargo, ND 58104
M. T. Craig	M. T. CRAIG.	4502 37th Avenue South, Fargo, ND 58104
Caline Haugen	CALine Haugen	4502 37th Avenue South, Fargo, ND 58104
Norma Kerst	Norma Kerst	4502 37th Avenue South, Fargo, ND 58104
Gladys M. Podoll	Gladys M. Podoll	4502 37th Avenue South, Fargo, ND 58104
Sharon J. Sandness	Sharon J. Sandness	4502 37th Avenue South, Fargo, ND 58104

Good Samaritan Society℠
FARGO

4502 37th Ave S
Fargo ND 58106-77158

Phone: 701-282-2651
Fax: 701-282-1220
www.good-sam.com

Petition Continued

Resident's Signature	Name (please print)	Address
LARRY Hook	Larry Hook	4502 37th Avenue South, Fargo, ND 58104
Marian MacIver	MARIAN MACIVER	4502 37th Avenue South, Fargo, ND 58104
Loretta Loretta	LORETTA	4502 37th Avenue South, Fargo, ND 58104
Colvin Forbes	COLVIN FORBES	4502 37th Avenue South, Fargo, ND 58104
Pearl Moen	PEARL MOEN	4502 37th Avenue South, Fargo, ND 58104
Daniel maack	Daniel Maack	4502 37th Avenue South, Fargo, ND 58104
Dick Steffes	Dick Steffes	4502 37th Avenue South, Fargo, ND 58104
Eda Nogowski	EDA NOGOWSKI	4502 37th Avenue South, Fargo, ND 58104
Edith Sandvig	Edith Sandvig	4502 37th Avenue South, Fargo, ND 58104
John Thiessen	John Thiessen	4502 37th Avenue South, Fargo, ND 58104
Evelyn Hegvick	EVELYN Hegvick	4502 37th Avenue South, Fargo, ND 58104
[illegible]	[illegible]	4502 37th Avenue South, Fargo, ND 58104
Jean Pohl	Jean Pohl	4502 37th Avenue South, Fargo, ND 58104
Raymond Zeiszler	RAYMOND ZEISZLER	4502 37th Avenue South, Fargo, ND 58104
Jean Kappel	Jean Kappel	4502 37th Avenue South, Fargo, ND 58104
		4502 37th Avenue South, Fargo, ND 58104

cc Congressman Earl Pomeroy
Senator Byron Dorgan
Senator Kent Conrad

Testimony on HB 1012
Senate Appropriations
March 9, 2009

Good Afternoon Chairman Holmberg and members of Senate Appropriations. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. I am here to testify on behalf of long term care facilities in North Dakota and the residents and tenants under their care.

HB 1012 touches the lives of many individuals, one being frail elderly North Dakotans in need of significant care and services.

I want to briefly touch upon our funding priorities and hopefully in the end enlist your support of additional funding for long term care.

Annual Inflator

The Governor's budget provided for an annual inflator of 7&7 for all providers. We deeply appreciate the Governors support to assure all providers have sufficient funds to operate. Last year we experienced double digit inflation in our food costs, gas, fuel oil and health insurance. Recognition of these costs is necessary for all providers impacted by HB 1012.

Our greatest challenge today is staffing and the annual inflator you provide is not sufficient to get us out of our staffing crisis we are in today. The House added dollars to help with this crisis and I am asking you today to add additional dollars.

Salary Adjustment for Basic Care and Nursing Facility Staff

We are in the worst staffing crisis anyone can recall. Consider these facts:

- Certified Nurse Assistant (CNA) turnover is 51%.
- 49% of nursing facilities contracted with agencies in 2008 to deliver daily resident care because they did not have enough staff. Spending over $3.5 million on contract staff in 2008.
- It takes 8 months (32 weeks) on average to fill an open nursing position in a rural nursing facility.
- Nursing facilities reported over 1,000 open positions in April 2008, 733 openings were for CNA's
- 17% of nursing facilities stopped admissions in 2008 because of insufficient staffing.

- Our oldest caregiver is a 94-year-old dietary aide.
- Long term care wages are at the bottom of the barrel when compared to other entities in North Dakota. (See Attachment A)

The House provided an additional $4.9 million in state general funds and $1.0 million from the health care trust fund to help improve caregiver salaries. With this $5.9 million and another $9.1 million provided by the Senate, this would give us the $15 million in state general funds necessary to match federal funds. This $15 million will bring in an additional $30 million in federal funds. What an opportunity to secure and grow our workforce.

North Dakota has an opportunity to attract people from other states where unemployment is high and caregivers including nurses are a surplus. Long term care facilities in Michigan have been reporting to us an over abundance of caregivers. Michigan has a similar climate to North Dakota and a surplus of applicants for long term care jobs. Since the start of the recession, Michigan has lost over 600,000 jobs, close to the entire population of North Dakota. Today, we are spending $18,000 to recruit a nurse from the Philippians. Why not spend that money recruiting a family to North Dakota. Attached please see Attachment B which is a handout on Compass Point, a company specifically aliened to help citizens of Michigan re-locate to North Dakota. One barrier to implement this model is competitive wages. We need to offer attractive salaries and benefits. Please see Attachment C which outlines RN average salaries from the United States, unadjusted and adjusted by cost of living. If we want to recruit from Michigan we need to at least come close to their salaries. Currently Michigan is 10th in the nation and North Dakota is 36th. North Dakota has a growing economy, jobs for many and a future for kids

You are probably worried about sustainability. Sustainability is fast becoming a concern to many budgets. We too are worried about sustainability. To us it means sustaining our workforce to care for our aging population. If we don't do something bold this legislative session, we will not have future caregivers. Today, 34% of our workforce is age 50 or older, with 14% already at retirement age. When they retire, we will not have people to replace them.

If we don't sustain and grow our workforce we will see further closing of our rural facilities. We can solve this problem.

Help us address our workforce crisis, grow our population and continue to care for our aging population that needs 24-hour care. A salary/benefit boost will help

secure that future caregiver workforce. (See Attachment D) Why not use some of the stimulus dollars provided through increased FMAP to support our caregiver workforce?

This salary/benefit enhancement would go into the pockets and purses of 13,000 current staff and help us do specific recruitment from Michigan. This money will be spent on our current workforce in communities throughout North Dakota to buy groceries, shoes, repair homes, and fill the family car with gas. By improving our salary range, we hope to be successful in a strong recruitment effort in Michigan. For every dollar you appropriate to this salary/benefit adjustment, the federal government through FMAP matching will provide an additional two dollars.

The House attached a limit on who is eligible to receive the salary/benefit enhancement. The limit will negatively impact our most seasoned caregiving staff, many RNs, LPNs, and CNAs, with the most extensive experience. We need to reward longevity not punish it. We recommend that you remove the 80th percentile limit and allow facilities, as you did in 2001, to administer the wage/benefit to the area's deemed most needy. We commit to assuring all administrators not be eligible for the enhancement.

Asset Limit in Nursing Facilities

The cost of construction and renovation of nursing facilities continues to escalate. In the last session, you increased this limit and we are grateful; however it is not sufficient to cover today's costs. For life safety concerns, the Centers for Medicare and Medicaid Services is requiring all nursing facilities be equipped with automatic sprinkler systems. Nursing facilities still have 3½ years to achieve compliance, with approximately one-quarter still needing to upgrade. Many physical plants are forty and fifty years old, not efficient and in need of upgrades. Many facilities are trying to go with more private rooms to better meet the needs of their frail resident population. If the limit is not adjusted, the vast majority of all current and future projects will have not sufficient "property funds" to pay their mortgage obligations. Please support the House Action of increasing the limit at a cost of $324,506 in state general funds. This limit is still conservative. For the 52 skilled nursing facility beds at the Veteran's Home, they would be limited to $8.8 million (if this limit applied to them). If all the beds were skilled (150) they would be limited to $25.4 million in total funds.

Personal Needs Allowance

HB 1012 contains the funding for all nursing facility residents to receive $50 per month. A small minority are only receiving $30 and this has not been sufficient for many years. The other population we are requesting you consider an increase is for basic care residents. Since July 1, 2001, they have been receiving $60 per month. In almost eight years, they have not had an increase, not even the CPI. See the letters and petition I received from residents in the new facility in Fargo that opened in February 2008. I encourage you to take the time to read all letters. (See Attachment E) The House increased the personal needs allows from $60 to $75 monthly. The residents in the petition are asking you to consider a personal needs allowance of $100.00 monthly.

Assisted Living Funding

Today it is very difficult for low income individuals to access assisted living housing and service options. Although individuals can access services through Medicaid Waiver, personal care options and SPED services, money is not available to help with rent assistance. Just as the state makes available room and board assistance for low income individuals in Basic Care, we request that you consider that same type of assistance for individuals to access the assisted living environment.

In summary, we need your help. We have an opportunity to be bold and grow our workforce and compensate our caregivers. As you consider and fund your priorities, please consider the care to the 14,000 people that will receive care in a long term care facility, as a priority as you have in past sessions. They need caregivers and we need your support to achieve a stable workforce.

Shelly Peterson, President
North Dakota Long Term Care Association
1900 North 11th Street • Bismarck, ND 58501
(701) 222-0660 • www.ndltca.org • E-mail: shelly@ndltca.org

See also attachments to testimony of 1-26-09

North Dakota
LEGENDARY

Michigan to North Dakota Employee Placements

Compass Point Labor Management Staffing Support Programs for North Dakota Based Companies

Services Coordinated Through Several State of Michigan and Federally Funded Agencies

STAFFING AND LABOR MANAGEMENT
COMPASS POINT

Why Compass Point Labor Management

Reasons for Relocation to North Dakota

Michigan's Economy and Jobs Forecast

- Michigan's economy has been in recession since 2000 and recovery is not projected until at least 2011.
- Since start of the recession, Michigan has lost over 600,000 jobs..... close to the entire population of North Dakota.
- Unemployment rate is expected to go over 11% (January numbers). "Underemployed" brings rate to over 17%. Highest rates in country.
- Michigan's GDP decreased by 3% from 2003-2007. National GDP increased by 12% in same period. Michigan is the only state to show loss.
- Projected state budget deficit this year is $1.5B. Releasing plans this week for cuts in funding for schools, public safety, etc.
- Forbes list of "Ten Most Miserable Cities in US to Live," #6 Flint, #7 Detroit.
- Manufacturing accounts for 30% of Michigan economy. Multiplier effect impacts majority of the economy.
- Only two states had a net loss in population last year: Michigan and Rhode Island (90,000+ moved from Michigan to other states.)
- Health care industry was identified as strong market for state but:
    1. Michigan hospitals on average posted a negative 2.9% margin in 2008
    2. Losses from providing free care, picking up unreimbursed costs for uninsured patients and bad debt reached $2 billion last year
    3. Layoffs began in 2008 with more planned for 2009

STAFFING AND LABOR MANAGEMENT
COMPASS POINT

Greg Tusch

T (616) 453-0360
F (616) 453-0370

3950 Lake Michigan Drive NW
Walker, MI 49534-7815

greg@compasspointstaffing.com
www.compasspointstaffing.com

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Why Compass Point Labor Management

Reasons for Relocation to North Dakota

1. 11 years of economic contraction. Employees under 40 years old will have spent around 50% of their working lives in restrictive employment environment.
2. Exodus of people under 40 years old has already begun.
3. Recent study indicated over 6,000 Michigan resume postings for positions in Wyoming.
4. North Dakota has a growing economy, providing long-term career opportunities.
5. Michigan employees have many similar skill sets needed by North Dakota employers.
6. North Dakota's environment is similar to Michigan:
   - Climate
   - Work ethic
   - Family values
   - Rural communities
   - Culture
7. North Dakota has cost of living 20% below national average.
8. North Dakota has an excellent schooling system. Michigan must further reduce education funding (very important to relocating families.)
9. North Dakota has a low crime rate..... compared to Detroit, Flint and even Grand Rapids (plus Michigan is further reducing public safety funding.)
10. North Dakota's economy is allowing for community development and good quality of life.
11. Compass Point will assist candidates with relocation options: pre-relocation support groups, housing options, community information, federally funded relocation assistance where qualified, etc.
12. Compass Point provides candidates with in-depth information on North Dakota companies and positions.

Proof of Success

- Overwhelming response to positions already posted by Compass Point.
- Feedback from North Dakota companies that have already hired Michigan candidates (great employees, fit in well, great work ethics, excellent skills, etc.)

STAFFING AND LABOR MANAGEMENT
COMPASS POINT

Why Compass Point Labor Management

1. Only agency in Michigan that has earned the authorization to represent the state for On-The-Job-Training contracts written on behalf of client employers.
2. Only agency in Michigan that is supported by Michigan Department of Labor/Federal training assistance programs.
3. Recommended to Job Service North Dakota by Michigan Works.
4. Family held company with offices in Grand Rapids and Detroit.
5. Only agency in Michigan to be offered office space in new State-funded economic development office in Northern Michigan.
6. Extensive support from Michigan Works, Michigan Economic Development Corporation, Veterans Administration, Michigan Technical Education Centers, Grand Rapids Community College and Michigan Human Resources Development Inc.
7. On-going, on-site presence in North Dakota to facilitate employee relocations and service to North Dakota companies
8. Highly experienced staff with background in all areas of business management.
9. Exceptionally loyal client base and highly recommended by employees utilizing our placement services.
10. Approach to daily operations***

****We pride ourselves on conducting our daily operations with "old fashioned" ideals. We do not subject any callers to voicemail • we provide follow-up on a timely basis • we take time to know our clients and our placements in great depth • we value face-to-face meetings at any cost • we are flexible because our clients are the most important element of our business • we do not promise anything that we cannot fulfill.*

STAFFING AND LABOR MANAGEMENT
COMPASS POINT

Compass Point Labor Management Market Niche

Out-Of-State Placement Program

- Compass Point serves as a bridge between employers and Michigan/Federal agencies committed to re-employment of the Michigan workforce
- Compass Point has access to a wide range of State funded services including coordination of job fairs, pre-employment training, state-wide offices for recruiting efforts and specialized skills testing
- Compass Point recognizes that recruiting for positions requiring relocation requires specialized support services for the employee and family. Compass Point has developed unique programs that lessen the strain of relocation. These programs are implemented prior to relocation and are the differentiator for increasing the program success.
- Compass Point assigns a specialist to out-of-state employers that meets on-site to gain an in-depth understanding of the employer and the position requirements. On-site follow-up continues and increases success of placements.
- Compass Point will promote employers, local communities and the State of North Dakota, allowing for better understanding and willingness of employees to relocate

Funding and Support Programs Available to Employers

- On-The-Job-Training funding contracts are established and reimbursed 100% to employers
- WOTC tax credit programs are completely administrated on behalf of employers
- Pre-employment training programs may be applicable for employers at no cost for specialized skills training

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Services For Out-Of-State Employers

- Establish and manage job fairs and targeted candidate searches across Michigan for employers
- Promote client companies, State of North Dakota, communities and life-style to candidate pool
- Coordinate and perform recruiting activities in Michigan
  - Preliminary interviews
  - Testing
  - Background checks
  - Drug screens
  - Coordinate web-cam interviews between employer and final candidates
  - Arrange and assist with on-site interviews as appropriate
- Set-up, administrate and follow-up for all On-The-Job-Training programs for employers including timely funding payments
- Administration of all eligibility and documentation requirements for WOTC tax credits available to employers
- Coordinate cost-free pre-employment training programs between employers and Michigan Technical Education Centers when appropriate
- Develop detailed knowledge of employer and position requirements by on-site meetings and position reviews by Compass Point human resources specialist

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Services For Out-Of-State Placements

- Lead employees through relocation support services including funding programs established for returning Michigan workers to employment (programs include cost off-sets for travel expenses, relocation expenses, etc)
- Develop welcome kit that provides relocation assistance including pre-qualified housing alternatives, schooling information, banking contacts, community information, etc.
- Assist with obtaining employment options for spouses if desired
- Arrange pre-employment activities that allow placements and their families to meet and form support groups prior to relocation
- Link single placements with each other if placements are interested in co-housing arrangements, etc.

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COMPASS POINT

Program Cost Details

- Compass Point has been able to structure this program with minimal costs to the out-of-state employer. When factoring in the assumption of internal recruiting costs, the net cost to the employer can be less than internal recruiting.

- The structure of this program has been made possible by utilizing the coordinated services of *Michigan Works, Michigan Economic Development Corporation,* the *Veterans Administration* and *Michigan Technical Education Centers.*

North Dakota Placements Program Administration Fees

Combined Placements	Program Fee Per Placement	Training Funding Reimbursed to Employer	Est. WOTC Tax Credit (Est 20% Eligible)	Net Direct Cost Per Placement
Per placement	$2,060	$600	$480	$980

Net Direct Cost Minus Recruiting Cost Allowance

Combined Placements*	Net Direct Cost Per Placement	Average Recruiting Cost	Fully Allocated Costs (Savings)
Per placement	$980	$600 - $1,500	$380 – ($520)

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Risk Free Structure

Risk Free Structure for Employers

- Employees are retained based entirely upon the discretion of the employer.
- The employer is not responsible for relocation costs.
- Fees are pro-rated based upon the length of time that an employee is actively employed.
- Compass Point does not require any contracts of exclusivity or minimum placement requirements

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Suggested Next Steps

Suggested Next Steps

- Compass Point provides additional information and follows up by answering any specific questions
- Compass Point representative meets on-site with employers interested in program and answers questions related to specific needs
- Compass Point provides sample of appropriate candidates for review
- Compass Point compiles recruiting plans specific to individual employer needs

Frequently Asked Questions

Compass Point Labor Management Employee Recruitment for North Dakota

Who is Compass Point Labor Management?

Compass Point Labor Management is a placement agency with offices in Michigan that specializes in supporting the hiring functions of employers through State and Federal assistance programs.

Compass Point Labor Management has been approached by Michigan Works for the purpose of assisting with the placement and relocation of Michigan workers into positions based in North Dakota.

What is their experience with placements and government programs?

Compass Point has developed and managed an exclusive arrangement for placing employees and initiating on-the-job training programs supported by State and Federal funds. These arrangements include programs with Michigan Works, the Michigan Technology Education Centers and the Veterans Administration.

What are some of the benefits for North Dakota companies?

Compass Point functions as a bridge for out-of-state employers to access the Michigan labor pool. Various funding programs off-set Compass Point's fees. These fees cover extensive pre-employment screening processes, skills testing, face-to-face final interview opportunities (employer and candidates) and employee relocation assistance.

How do North Dakota companies insure that placements will be good fits?

Compass Point administers an extensive pre-screening process based upon a thorough understanding of the job requirements. Actual skills testing such as weld tests, construction skills testing, programming testing, aptitude testing and instructor references are utilized to the greatest extent possible. Compass Point spends time with the client employers to learn their culture, the work environment and the job requirements. Employers are able to conduct final interviews via web-casts, scheduled interviews in Michigan or on-site interviews in North Dakota.

How much does this program cost?

The majority of Compass Point's fees can be off-set by tax credits to the employer, on-the-job training (wage reimbursements) and coverage of internal recruiting costs. Depending upon the packages that can be compiled for specific placements, the employers may actually realize returns from the funding programs that exceed the placement fees.

How does Compass Point build their labor pool?

Compass Point works directly with Michigan Technology Education Centers, Michigan Works, the Veterans Administration and conducts its own recruiting. Many candidates are referred by employees, clients and business associates.

What is the relationship with the Michigan Technology Education Centers?

The Michigan Technology Education Centers (M-TEC) are skilled trades learning centers located throughout Michigan. Six hundred hour training programs provide specialized skills development in the following fields; welding, electrical, plumbing, construction/carpentry, cnc machining and information systems technology. Compass Point is a prime recruiter of graduates and has an agreement that allows for the training programs to be structured to specific employers' job requirements. Compass Point clients are also allowed to conduct actual skills testing of candidates at the training centers.

What is the relationship with ACT Work Keys?

Work Keys assessment tests have been developed by the ACT organization (known for college entrance exams). These tests measure real world skills that are used in nearly every job. Specific requirements have been compiled for thousands of jobs. Candidates are tested against these requirements for specific jobs, providing the employer with a quantified ranking of each candidate. Compass Point has agreements for administration of these tests at no cost for all of its candidates.

Why do candidates want to relocate?

The Michigan economy has displaced record numbers of employees. The downturn has resulted in permanent changes in the Michigan workforce needs. This realization has increased the pool of candidates that recognize that their long-term employment potential can be improved by considering relocation. Michigan workers have skill sets that are in demand in North Dakota. The environment and culture of North Dakota is also in alignment with backgrounds of many Michigan residents.

Are there any risks or commitments for North Dakota companies?

Employment of these candidates entails the same risks and commitments that a North Dakota employer would assume when hiring a local candidate, based on "at will" employment laws and policies within the State of North Dakota. Compass Point does not require a minimum commitment for placements.

What is the benefit for placements?

Compass Point provides in-depth information about the employer, the job and the long-term opportunities. Compass Point also provides relocation support systems such as assistance with relocation costs, relocation information packages and coordination of family support groups for relocating families. This extensive pre-relocation involvement greatly enhances the success of a long-term relocation.

What types of positions are being sought by the Compass Point labor pool?

Compass Point has the ability to recruit for any type of position. Candidates currently in our pool most willing to relocate, however, are skilled trade candidates. These include welders, pipefitters, electricians, construction trades, engineers and information technology personnel.

How can a company in Michigan represent my company in North Dakota?

Compass Point meets on-site with North Dakota client companies to learn first-hand about the company, its personnel, its culture, the job requirements and the work site. Compass Point promotes the company and North Dakota to the candidates. Compass Point also coordinates various types of interviewing options and meeting opportunities to insure a good pre-employment determination of employer/employee compatibility. Compass Point is also fully ingrained into the Michigan workforce network and can most effectively begin the recruiting process.

What are the next steps?

A Compass Point representative will be establishing meetings with North Dakota employers in Q1/09. Complete information about this program can be provided during such meetings or prior to a meeting. A simple risk-free, commitment-free trial of this program could be established after determining open position requirements.

North Carolina Center for Nursing - Quick Facts

Linda M. Lacey and Jennifer G. Nooney

www.NCcenterfornursing.org/research

2004 RN Average Salaries Across States: Unadjusted and Adjusted by Cost of Living

December, 2005

Studies of nursing salaries rarely consider the impact that the local cost of living makes on the purchasing power of a specific salary. Yet, the table below shows that once adjusted for the cost of living the rank ordering of states on average salary for RNs can change dramatically. California moves from 1st place to 44th, Hawaii from 3rd to 49th. North Carolina moves up in the rankings: from 30th to 20th. Texas moves into 1st place from 19th after adjusting for the cost of living. In fact, many of the states located near the top of the list for unadjusted RN salary levels move to the 3rd or 4th quartile after adjustment. Those states falling at the bottom of the list for unadjusted salary levels move up, although the change in ranking is not as dramatic.

State	Average Annual Salary	State Ranking Before Adjustment	Average Salary Adjusted for COLI	MERIC COLI value	State Ranking After Adjustment
California	$69,140	1	$45,849	150.8	44
Maryland	$65,750	2	$52,266	125.8	23
Hawaii	$64,320	3	$39,802	161.6	49
Massachusetts	$64,120	4	$50,970	125.8	34
New York	$62,140	5	$50,316	123.5	37
New Jersey	$61,790	6	$46,043	134.2	43
Connecticut	$61,450	7	$48,577	126.5	39
Alaska	$60,420	8	$46,946	128.7	41
Washington	$59,650	9	$57,633	103.5	3
Minnesota	$58,980	10	$58,745	100.4	2
Nevada	$58,630	11	$52,442	111.8	21
Oregon	$58,380	12	$54,765	106.6	11
District of Columbia	$58,330	13	$40,367	144.5	48
Delaware	$57,470	14	$55,850	102.9	6
Rhode Island	$56,910	15	$44,531	127.8	46
Michigan	$55,380	16	$54,832	101	10
Colorado	$55,010	17	$54,304	101.3	14
Arizona	$54,940	18	$53,600	102.5	16
Texas	$53,940	19	$60,539	89.1	1

The data used in this analysis comes from the employment and wage surveys conducted by the Occupational Employment Statistics (OES) program in association with the federal Bureau of Labor Statistics (BLS). The OES is a state-federal cooperative effort in which data is collected by the states and then aggregated by the BLS to produce national statistics. The average salary figures in each state in the table are from the November, 2004, tables released by the BLS.

State	Average Annual Salary	State Ranking Before Adjustment	Average Salary Adjusted for COLI	MERIC COLI value	State Ranking After Adjustment
Wisconsin	$53,700	20	$56,646	94.8	4
Pennsylvania	$53,670	21	$53,403	100.5	18
Virginia	$53,330	22	$51,676	103.2	31
New Mexico	$52,620	23	$51,945	101.3	30
Florida	$52,150	24	$51,994	100.3	29
Ohio	$51,840	25	$54,340	95.4	13
Illinois	$51,600	26	$52,069	99.1	26
Utah	$51,590	27	$55,954	92.2	5
South Carolina	$50,950	28	$53,407	95.4	17
Louisiana	$50,560	29	$52,178	96.9	25
North Carolina	$50,450	30	$52,827	95.5	20
Georgia	$50,330	31	$55,126	91.3	9
Tennessee	$49,890	32	$55,619	89.7	7
Missouri	$49,690	33	$54,544	91.1	12
Nebraska	$49,350	34	$52,894	93.3	19
Indiana	$49,100	35	$52,013	94.4	27
Kentucky	$48,980	36	$53,706	91.2	15
Vermont	$48,770	37	$42,706	114.2	47
Idaho	$48,000	38	$51,118	93.9	33
Arkansas	$47,990	39	$55,224	86.9	8
West Virginia	$47,780	40	$52,219	91.5	24
Mississippi	$47,220	41	$52,004	90.8	28
Alabama	$47,170	42	$50,830	92.8	35
Montana	$47,040	43	$47,805	98.4	40
Kansas	$46,910	44	$51,268	91.5	32
South Dakota	$46,830	45	$49,243	95.1	38
Oklahoma	$46,660	46	$52,368	89.1	22
North Dakota	$46,480	47	$50,742	91.6	36
Wyoming	$46,200	48	$45,517	101.5	45
Iowa	$44,000	49	$46,908	93.8	42

The cost of living index used to adjust the state-level average salary figures is a composite index developed by the Missouri Economic Research and Information Center (MERIC). They created a state-level index value by aggregating the city-level cost of living index values published by the American Chamber of Commerce Researchers Association (ACCRA) for the 4th quarter of 2004.

The point of time at which the cost of living was being measured in various cities around the country is consistent with the point of time for the RN salary information.

A more thorough discussion of the data elements used in this analysis and the mechanics of the adjustment procedure can be found in the May/June, 2006, issue of *Nursing Economic$* at www.nursingeconomics.net. See the article by Lacey and Nooney, "Which pasture is really greener? A research note on salary studies" which appears in that issue.

Readers interested in pursuing their own cost of living adjustments should visit the web site of the American Chamber of Commerce Researchers Association or other sites such as http://www.infoplease.com/ which also report cost of living information for selected U.S. cities.

BASED ON RATES SET BEGINNING JANUARY 1, 2009

						ACTUAL										$109.23	$20.70	$52.28	DIFFERENCE							
Provider Name	Provider No.	City	Census	90%	Licensed Beds	Direct	Other Direct	Indirect	Case-Mix Direct Rate	Other Direct Rate	Indirect Rate	Property Rate	Incentive	Operating Margin	Total Rate	DIRECT	OTHER DIRECT	IN-DIRECT	# of LIMITS	ONE LIMIT	TWO LIMITS	THREE LIMITS	Direct	Other Direct	Indirect
Villa Maria Healthcare	30086	Fargo	45,501	45,457	138	$92.11	$18.57	$52.20	92.11	18.57	52.20	28.74	-	3.28	194.90										
Benedictine Living Center of Garrison	30247	Garrison	21,434	20,752	63	$82.37	$20.44	$49.04	82.37	20.44	49.04	10.59	1.11	2.90	166.45										
Lutheran Sunset Home	30016	Grafton	34,693	34,258	104	$99.60	$18.13	$50.73	99.60	18.13	50.73	5.67	-	3.30	177.43										
Central Dakota Village	30020	Jamestown	35,676	32,940	100	$107.41	$16.28	$45.63	107.41	16.28	45.63	22.51	2.60	3.50	197.93										
Lakota Good Samaritan Nursing Home	30097	Lakota	16,641	16,141	49	$83.06	$15.92	$42.70	83.06	15.92	42.70	13.47	2.60	2.70	160.45										
Larimore Good Samaritan Center	30113	Larimore	16,155	14,823	45	$76.14	$14.62	$49.39	76.14	14.62	49.39	11.08	0.88	2.49	154.60										
Medcenter One Care Center	30288	Mandan	43,449	39,528	120	$97.95	$16.21	$40.86	97.95	16.21	40.86	38.62	2.60	3.47	199.71										
Luther Memorial Home	30024	Mayville	33,781	32,611	99	$100.56	$16.37	$51.89	100.56	16.37	51.89	7.81	-	3.22	179.85										
North Central Good Samaritan Center	30173	Mohall	20,190	19,435	59	$89.84	$16.99	$50.20	89.84	16.99	50.20	8.38	0.34	3.05	168.80										
Napoleon Care Center	30114	Napoleon	14,888	14,494	44	$87.05	$15.00	$51.55	87.05	15.00	51.55	9.17	-	2.68	165.45										
Lutheran Home of the Good Shepherd	30029	New Rockford	27,917	26,352	80	$97.29	$17.08	$45.36	97.29	17.08	45.36	6.51	2.60	3.28	172.12										
Elm Crest Manor	30116	New Salem	22,350	20,423	62	$91.83	$16.78	$45.00	91.83	16.78	45.00	7.60	2.60	3.03	166.84										
Oakes Manor Good Samaritan Center	30124	Oakes	35,511	33,599	102	$78.38	$14.05	$40.66	78.38	14.05	40.66	7.51	2.60	2.59	145.79										
Park River Good Samaritan Center	30154	Park River	26,855	25,034	76	$80.71	$16.93	$44.09	80.71	16.93	44.09	7.53	2.60	2.68	154.54										
Sheyenne Care Center	30073	Valley City	61,409	50,728	154	$95.15	$16.12	$39.65	95.15	16.12	39.65	13.58	2.60	2.90	170.00										
St. Catherine's Living Center	30034	Wahpeton	35,746	34,258	104	$74.36	$15.29	$48.80	74.36	15.29	48.80	14.08	1.27	2.60	156.40										
Manor Care of Minot ND, LLC	30479	Minot	36,760	34,916	106	$75.98	$16.03	$50.18	75.98	16.03	50.18	6.11	0.35	3.03	151.68										
St. Aloisius Medical Center	30129	Harvey	37,019	34,916	106	$91.49	$16.27	$48.10	91.49	16.27	48.10	6.24	1.74	2.92	166.76										
Valley Eldercare Center	30017	Grand Forks	61,437	57,974	176	$96.80	$17.67	$45.30	96.80	17.67	45.30	22.52	2.60	3.55	188.44										
Woodside Village	30201	Grand Forks	42,603	38,869	118	$101.89	$18.08	$43.53	101.89	18.08	43.53	27.58	2.60	3.54	197.22										
Dacotah Alpha	30225	Mandan	4,360		20	$172.63	$25.81	$78.47							-								$172.63	$25.81	$78.47
Sheyenne Care Center - Geropsych	30423	Valley City	5,852		16	$144.31	$16.12	$39.65							-								$144.31	$16.12	$39.65
Total																8	7	25	40	20	7	2			

Who will care for me?

North Dakota long term care facilities are in a staffing crisis.

- Long term care facilities spend over **$475 million** each year, with **86%**, or **$409 million**, of those expenditures **remaining in North Dakota.**
- North Dakota **leads the nation** in age **85+** population. North Dakota's **60+** population will reach nearly **200,000** by 2020.
- Over **1,700 additional caregivers** will be **needed** over the next seven years to provide care for North Dakota's aging population.
- The **202 long term care facilities** in North Dakota **employ over 14,000** caregivers at an **annual payroll** of nearly **$341 million.**

You can help.

Learn more at

Who will care for me?

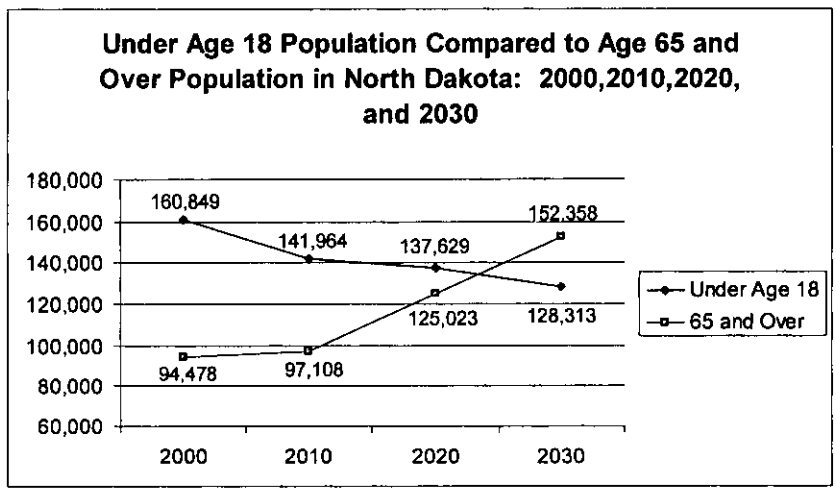
- **Long term care facilities** provide care for over **14,000** North Dakotans **annually.**
- **Lack of caregivers** was the main factor in the **closing** of one basic care facility and the announcement of a nursing **facility closure** in 2008.
- **34%** of caregivers in long term care are age **50 or older.**
- **14%** of the long term care workforce is **at or over retirement age.**
- The **oldest caregiver** in long term care is a **94-year-old** dietary aide.
- **17%** of nursing facilities **stopped admissions** in 2008 because of **insufficient staffing.**
- Nursing facilities reported over **1,000 open positions** in April 2008—**733** openings were for **Certified Nurse Assistants** (CNAs).
- **49%** of nursing facilities **contracted with agencies** in 2008 to deliver daily resident care—at **double or triple the cost.**
- **CNA turnover** is **51%.**
- **32 weeks** is the average time it takes to **fill** an open **nursing position** in a rural nursing facility.
- Entry level **CNA wages** in rural North Dakota are **$9.54** per hour, or **$19,843** annually.
- Following the **2001** long term care **wage/benefit pass-through**, CNA **turnover decreased** over **30%.**

Your support of the equity pool will help build North Dakota's caregiver workforce for the 21st century.

North Dakota Long Term Care ASSOCIATION

Aging in North Dakota

- North Dakota leads the nation with the highest proportion of individuals aged 85 and older comprising 2.3% of the total population.
- North Dakota is ranked fourth in the nation in citizens aged 65 and older
- From 2000 to 2030, North Dakota's age 65 and older population will grow by 61%, and our under age 18 population will decrease by 20%.
- Long term care facilities provide care for over 14,000 North Dakotans annually.



Who will care for North Dakota's Aging Population?

- Over 1,700 additional caregivers will be needed over the next seven years to provide care for North Dakota's aging population.
- Over one-third (34.2%) of nursing facility employees are 50 years or older.
- Over one-half (53.4%) of nursing facility employees are 40 years and older.
- Almost 14% of nursing facility employees are at retirement age.

North Dakota Long Term Care ASSOCIATION
1900 N 11th St 701.222.0660
Bismarck, ND 58501 www.ndltca.org

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Testimony on House Bill 1012
House Appropriations Committee – Human Resources Division
January 26, 2009

Presented by Carole Watrel
AARP North Dakota Volunteer

Chairman Pollert, members of the House Appropriations Human Resources Committee, I am Carole Watrel, a volunteer with AARP North Dakota. I am a licensed social worker, a volunteer adult legal guardian, and I work with the Alzheimers Support Group at St. Alexius Medical Center. I am here today on behalf of AARP's 88,000 North Dakota members to speak in support of three provisions in HB 1012:

1. Increasing the medically needy income levels; and
2. Revising the Service Payments for the Elderly and Disabled (SPED) fee schedule.
3. A 7% increase in reimbursement for providers for each year of the biennium.

Increased income levels for medically needy

The medically needy income levels allow Medicaid eligible individuals to keep part of the money they earn to meet expenses for basic needs like shelter, food, utilities, and clothing.

An estimated 3,200 North Dakotans would benefit from the executive budget proposal to increase medically needy income levels to 83 percent of poverty. The income levels would increase to $720 for a one-person household and $969 for a two-person household. The current levels have been frozen since 2003 at $500 per month and $516 per month, respectively. Imagine an elderly husband and wife trying to live from month-to-month on just $516. Since 2003, the costs of groceries, rent and utilities have gone up considerably. If we truly want to allow North Dakotans to remain in their homes and communities as they age, we need to allow them the means to do so.

A new survey of AARP members in North Dakota shows 75 percent are concerned about being able to stay in their homes as they get older. 68 percent are concerned about having enough money to meet daily living expenses. The proposed change to medically needy income levels would mean people could keep enough of the money they earn to maintain their own homes.

Revising the SPED Fee Schedule

As presented in the executive budget, revising the Service Payments for the Elderly and Disabled (SPED) fee schedule would reduce the cost sharing payment for the SPED program to allow individuals to keep more of their income before contributing to the cost of their care. According to the Department of Human

Services, the number of people in the SPED program will average almost 1,600 each month in the next biennium.

Social Security is the major source of income for most older North Dakotans. While the allowed income levels for SPED have remained stagnant since 2003, COLA increases in Social Security force a recipient to slide up the fee scale, paying a greater and greater percentage for their care. Medicare premiums and other costs of living go up...also taking away what little increase they received. SPED services sometimes become unaffordable for those who depend solely on Social Security to live. The updated SPED fee schedule was based on Social Security cost of living adjustments between 2003 and 2008 and an estimated cost of living adjustment for 2009.

The SPED sliding fee scales should be revisited every year. AARP would strongly support adding an automatic cost of living increase to the income levels, so that adjustments would be automatic from year-to-year based on inflation.

Provider Reimbursements

I want to also mention that AARP supports the executive budget recommendation for 7 percent increases in reimbursement to providers each year of the biennium. These providers are small businesses and workers in your communities who contribute directly to the community's financial base, and they deserve to be paid fairly for the services they provide. The 2007 Legislature increased the reimbursement levels for QSPs (Qualified Service Providers) to bring them up to a level of income equal to workers in similar jobs. If the current legislature were to address the reimbursement issue, we would suggest it be with particular focus on the direct care workers, those individuals who do the hands on work that help people live with dignity. While QSPs working independently benefited immediately from the equalization of reimbursements in 2007, we are not certain that the direct care workers employed by QSPs registered as agencies were as fortunate.

Members of the committee, thank you for your time and attention.

AARP[SM]

House Bill 1012
Senate Appropriations Committee
March 4, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, I am Carole Watrel, an advocacy volunteer for AARP North Dakota. I am a licensed social worker, a volunteer adult legal guardian, and I work with the Alzheimer's Support Group at St. Alexius Medical Center. I am here today on behalf of AARP's 88,000 North Dakota members to speak in support of four specific provisions in HB 1012:

1. Increasing the medically needy income levels.
2. Support for the Service Payments for the Elderly and Disabled (SPED) fee schedule.
3. A 7% increase in reimbursement for providers for each year of the biennium.
4. Establishment of an Aging and Disability Resource pilot.

Increased income levels for medically needy
The medically needy income levels allow Medicaid eligible individuals to keep part of the money they earn to meet expenses for basic needs like shelter, food, utilities, and clothing.

A new survey of AARP members in North Dakota shows 75 percent are concerned about being able to stay in their homes as they get older. 68 percent are concerned about having enough money to meet daily living expenses. House Appropriations has adjusted the increase to 75% of poverty...and we would encourage you to restore that figure to 83%...as it was in the executive budget proposal.

By increasing the Medically Needy income level to 83% of poverty...allowing someone to keep just $200 more a month... we could allow someone the dignity of choosing where they would like to live...and perhaps extending the time before they are in need of the more expensive care of a nursing home.

Revising the SPED Fee Schedule
As presented in the executive budget, revising the Service Payments for the Elderly and Disabled (SPED) fee schedule would reduce the cost sharing payment for the SPED program to allow individuals to keep more of their income before contributing to the cost of their care.

Social Security makes up at least half of the income for over half of North Dakotans 65 and older. A third of older North Dakotans rely on Social Security as their only source of income. While the allowed income levels for SPED have remained stagnant since 2003, COLA increases in Social Security force a recipient to slide up the fee scale, paying a greater and greater percentage for their care. Medicare premiums and other costs of living go up...also taking away

what little increase they received. SPED services sometimes become unaffordable for those who depend solely on Social Security to live.

Provider Reimbursements
I want to also mention that AARP supports the executive budget recommendation for 7 percent increases in reimbursement to providers each year of the biennium. These providers are small businesses and workers in your communities who contribute directly to the community's financial base, and they deserve to be paid fairly for the services they provide.

Aging and Disability Resource LINK
Finally, we are asking this committee to include funding for an Aging and Disabilities Resource pilot project as proposed in the executive budget. Carol Olson made this request of the committee yesterday during her testimony.

This is an important consumer issue, regardless of a person's socioeconomic status.

Establishment of such a service has been discussed and debated for more than 20 years. It's something an overwhelming number of our members tell us they want. I also want to remind you of Senate Concurrent Resolution 4018 passed by the 2007 legislature, supporting individual choice for long-term care. A copy is attached to my testimony.

You've seen the statistics. North Dakota's population is aging rapidly. Per capita, we already have the greatest percentage of people age 85 and older of any state. By 2020, 27% of the state's residents will be 60 and older. You also know that the vast majority of people want to remain in their own homes and in their communities as they age. That's why we can no longer delay.

The goal of an Aging and Disability Resource process is to minimize confusion, enhance individual choice, and support informed decision-making when individuals and families find they need long-term care services. An ADRC would provide a neutral place where people can obtain consistent and comprehensive information, objective advice, and access to a wide range of community supports. Those needing services and their family members could talk to someone face-to-face as well as access information by phone or online 24/7.

AARP has worked closely with the Department of Human Services and other advocacy organizations to build awareness and a foundation of support for this resource. We are committed to the successful implementation of the pilot to help ensure that those needing long-term care services would receive comprehensive, consistent information on all of the choices that are available, including services to allow them to remain in their own homes.

We encourage North Dakota policymakers in the strongest possible terms to embrace a philosophy of delivering services in a way that allows older people the greatest independence and greatest quality of life.

Members of the committee, thank you for your time and attention.

Filed April 20, 2007

CHAPTER 641

SENATE CONCURRENT RESOLUTION NO. 4018

(Senator J. Lee)
(Representative Boucher)

LONG-TERM CARE CHOICE SUPPORTED

A concurrent resolution expressing support for long-term care choices, including home and community-based services, for North Dakotans with disabilities and older adults.

WHEREAS, the public interest would best be served by a broad array of long-term care services that promote individual autonomy, dignity, and choice for older adults and those with disabilities, including more home and community-based services to give all North Dakotans who are older adults or who have a disability, free choice in planning and managing their lives; and

WHEREAS, the Legislative Assembly recognizes that nursing home care is also a critical part of the state's long-term care continuum and that such services should continue to promote individual dignity, autonomy, and a homelike environment to the greatest extent possible;

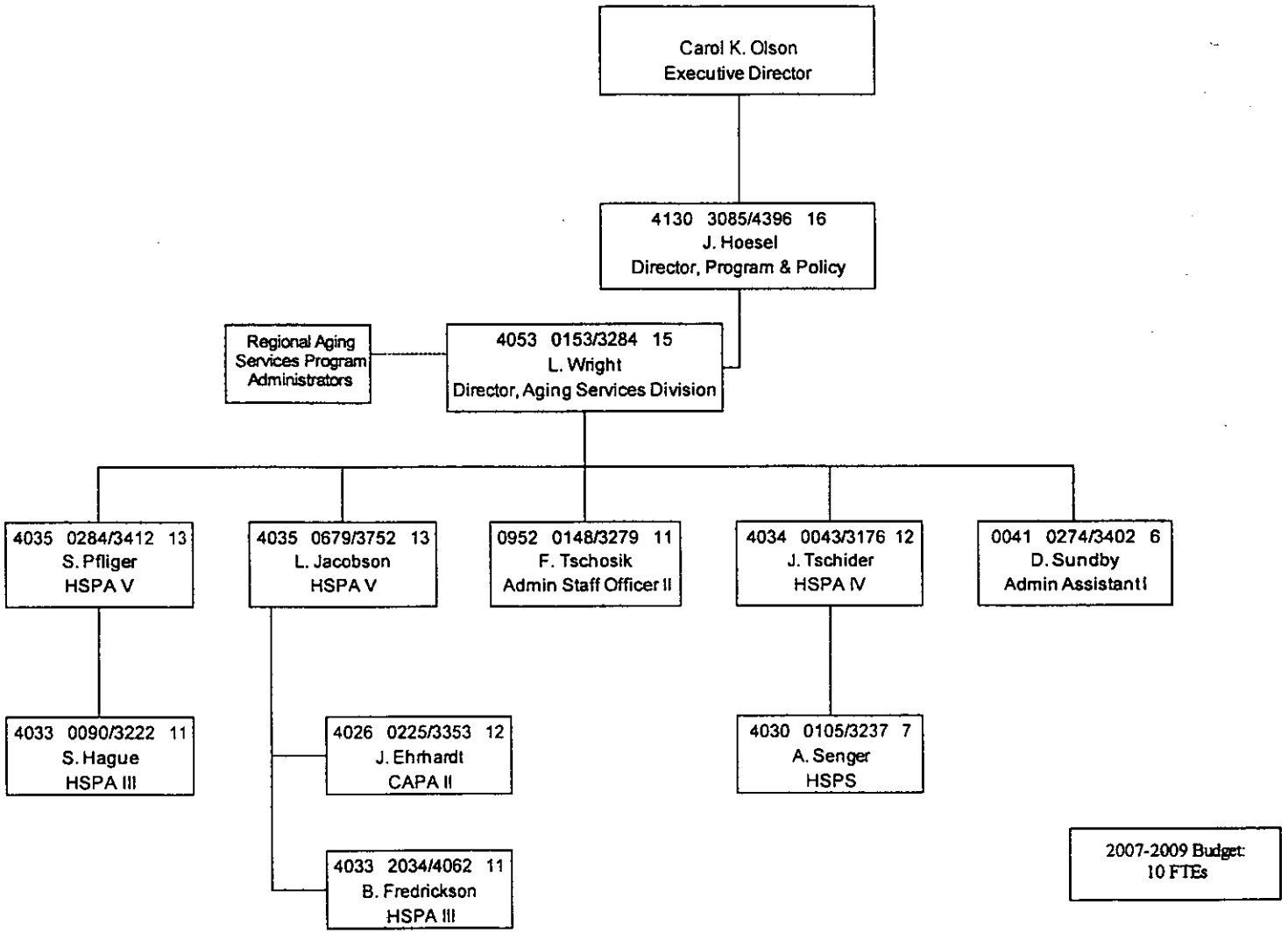
NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF NORTH DAKOTA, THE HOUSE OF REPRESENTATIVES CONCURRING THEREIN:

That the Sixtieth Legislative Assembly supports long-term care choices, including home and community-based services, for North Dakotans with disabilities and older adults to:

1. Plan and manage their own lives to the greatest extent possible;
2. Participate in the planning and operation of community-based services;
3. Receive information that will allow them to make informed care decisions;
4. Choose to remain in their communities and in their homes when appropriate to their needs and when it can be reasonably accommodated taking into account the resources available to the state and the needs of others with disabilities;
5. Meet their needs through a care system in a culturally sensitive way;
6. Support family members and other persons providing voluntary care; and
7. Make care choices from a long-term care continuum that is visible, trusted, and easily accessed.

Filed March 28, 2007

North Dakota Department of Human Services
Aging Services Division



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Revised 10/2/08

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Testimony
House Bill 1012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
January 13, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, I am Linda Wright, Director of the Aging Services Division of the Department of Human Services. I am here today to provide you an overview of the Division's budget for the Department of Human Services.

Programs

The Aging Services Division provides home and community based service options to maintain individuals in their homes and communities and assists in protecting the health, safety, welfare and rights of residents of long-term care settings and vulnerable adults in the community. This includes administration of Older Americans Act federal funds, the Telecommunications Equipment Distribution Program, State Funds to Providers, the Long-Term Care Ombudsman Program, the Guardianship Program for Vulnerable Adults, the Senior Community Service Employment Program, Qualified Service Provider Training, support for the Governor's Committee on Aging, Model Legal Systems Grant, and Aging and Disability Resource Center.

The Aging Services Division is a federally designated single planning and services area, which requires the Division to carryout the responsibilities of the State Unit on Aging and the Area Agency on Aging as set forth in the Older Americans Act (OAA). Among the requirements in the 2006 reauthorization of the OAA is the following:

"require state agencies to promote the development and implementation of a state system of long-term care that enables older individuals to receive long-term care in home and community based settings in accordance with the individual's needs and preferences."

Caseload / Customer Base

- In 2000, 118,985 (18.5 percent) of the population in North Dakota was 60 years of age or older.
- In 2020, it is projected that 170,117 (27 percent) of the population in North Dakota will be 60 years of age or older.
- In 2000, only one county (McIntosh) had more than 40 percent of its population age 60 or older.
- In 2020, 22 counties will have more that 40 percent of their population aged 60 or older.
- In 2020, three counties (Divide, Hettinger and McIntosh) will have more than 50 percent of their population age 60 or older.
- In 2000, 14,726 (2.3 percent) of North Dakota residents were age 85 or older.
- In 2020, it is projected that 20,106 (3.2 percent) of North Dakota residents will be age 85 and older.
- McIntosh County ranks number one in the nation among 3,142 counties for the highest percent of the population age 65 and older.

Please refer to the attached updated Graying of North Dakota brochure for additional information.

- In Federal Fiscal Year (FFY) 2007, 30,557 older persons received Older Americans Act funded services which includes home-delivered meals, congregate meals, outreach, health maintenance services, national family caregiver program services, legal services, in-home safety, senior companion services, vulnerable adult protective services, and long-term care ombudsman services.

Older American Act – Title III Programs	
SERVICE	UNITS OF SERVICE
Congregate Meals	752,072 meals
Home-Delivered Meals	535,646 meals
Health Maintenance	148,238 units
Information & Assistance	1,858 units
Legal Assistance	4,795 units
Outreach	118,025 units
Senior Companion	3,475 units

Vulnerable Adults Program	
New cases	444
Closed cases	404
Information/referral	392
Brief Services	223
Hours	7,008

Family Caregiver Support Program	
Unduplicated Caregivers Served	421
Unduplicated Grandparents Served	13
Respite Care Provided	190,584 hours

Long-Term Care Ombudsman Program	
Number of Complaints	1,142
Number of Cases Opened	824

- The Qualified Service Provider (QSP) training program under contract with Lake Region State College has trained 227 QSPs from July 2006 through June 2008 for provision of in-home care. The training is provided by 64 nurses statewide and is not a mandatory requirement to become a QSP. Due to the fact that a health care professional must sign off on the documentation of competency when a QSP enrolls to provide services, many QSPs chose to participate in the training program. The documentation of competency is then signed by the nurse trainer. As of December 2008, there were 1718 QSPs statewide which includes 139 agencies. Family home care or family personal care is provided by 373 QSPs which basically means that each QSP provides services to only one client (a family member).
- The Senior Community Service Employment Program will provide on the job training to 71 low-income individuals over the age of 55. The Division is contracting with Experience Works (formerly Green Thumb) to provide direct service to the enrollees. Experience Works serves an additional 275 enrollees in North Dakota through a national contract with the Department of Labor.

Program Trends / Major Program Changes

- As the result of a cooperative agreement with the Department of Transportation (DOT), transit services are no longer funded by the

Older Americans Act and are funded by DOT. We continue to have on-going communication with DOT and receive statistical data from them regarding the number of rides provided to older persons.

- The increasing costs of providing services, including raw food costs, and meeting the new federal dietary requirements for congregate and home delivered meals; transportation costs and other inflationary increases, along with fairly flat federal funding, have increased the burden on contract providers to meet expenses in providing services to older persons.
- The information and referral services provided by the Division, formerly known as the Senior Info Line has expanded its database and changed its name to the Aging and Disability Resource-LINK. In addition to phone calls and e-mail inquiries, the Resource-LINK web site receives about 700 hits or "visits" per month. The attached brochure provides additional details about the Aging and Disability Resource-LINK.
- The development of Aging and Disability Resource Centers (ADRCs) continues as a goal for the Department. ADRCs serve as integrated points of entry into the long-term care system, commonly referred to as a "one stop shop," and are designed to address many of the frustrations consumers and their families experience when trying to access needed information, services and supports. The research findings from the Department's Real Choice Change Grant strongly indicated that establishing an ADRC will provide the opportunity to move another step forward in providing ease of access to information and services for consumers.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / Decrease
Salary and Wages	1,171,458	1,335,767	164,309
Operating	11,499,804	12,994,723	1,494,919
Capital Payments	194	-	(194)
Grants	1,598,290	1,592,380	(5,910)
Total	14,269,746	15,922,870	1,653,124
General Funds	1,480,994	3,182,707	1,701,713
Federal Funds	12,378,752	12,429,971	51,219
Other Funds	410,000	310,192	(99,808)
Total	14,269,746	15,922,870	1,653,124

FTE	10.00	10.00	

The salary and wages line item has a net increase of $164,309 due to the following:

- $121,143 of which $91,857 is general funds for the Governor's salary package
- $19,601 in general funds for the cost to continue the second year salary increase
- $23,565 to maintain current FTEs.

The operating line item increased by $1,494,919. The major increases are:

- $35,500 increase, of which $8,875 is from the general fund for office rent at Prairie Hills Plaza. The Division relocated from the Capitol to Prairie Hills Plaza in November 2007.
- $29,971 increase, of which $700 is from the general fund for increased travel costs for staff and Volunteer Community Ombudsmen

- $30,000 increase, of which $9,980 is from the general fund for the training of Qualified Service Providers to meet the actual cost of the training.
- $106,400 in general funds for the inflationary rate increase for direct service providers.
- $600,000 in general funds to establish Aging and Disability Resource Centers. This is offset by an $840,000 decrease, of which $40,000 is from the general fund, to remove appropriation authority from last session for a federal grant (that was not received) to establish Aging and Disability Resource Centers.
- $900,000 from the general fund to increase the reimbursement to Older Americans Act service providers to assist in meeting the actual costs of providing services.
- $627,445, of which $2,021 is from the general fund for increases in operating fees and services related to:
    - Ombudsman Activities - ($23,567)
    - Telecommunications Equipment Distribution – $14,100
    - Preventive Health – ($3,700)
    - Title III B Community Services - $57,458
    - Congregate Nutrition - $88,780
    - Home Delivered Nutrition - $118,340
    - Alzheimer's Demonstration Project – ($226,725)
    - Nutrition Services Incentive Program - $453,654
    - Single Point of Entry – ($30,000)
    - Family Caregiver Support - $172,994

Grants decreased by $5,910 due to the following:

- A decrease of $15,000 in other funds for the Telecommunications Equipments Distribution program

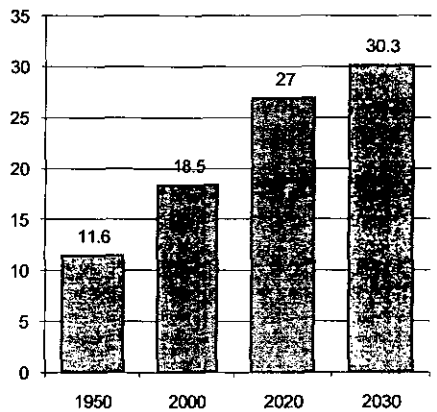
- An increase of $50,000 in federal funds for the Model Legal Systems for Seniors grant
- A decrease of $250,000 of federal and other funds for the closeout of the Alzheimer's Disease Demonstration grant
- An increase of $209,090 of federal funds for the Senior Employment grant

This concludes my testimony. I would be happy to answer any questions.

Percent of the North Dakota Population 60 Years of Age and Older and 85 Years of Age and Older

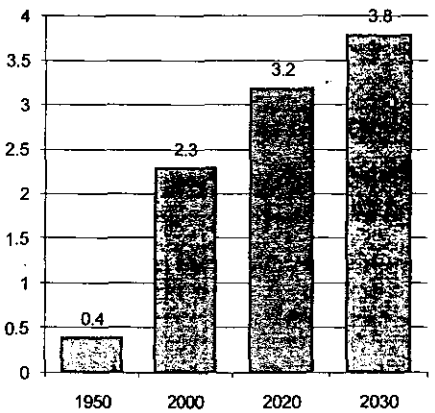
- **In 1950,** 72,050 (11.6%) of North Dakota residents were age 60 and older.
- **In 2000,** 118,985 (18.5%) of North Dakota residents were age 60 and older. The U.S. percent of residents age 60 and older was 16.3.
- **In 2020,** it is projected that 170,117 (27%) of North Dakota residents will be age 60 and older.
- **In 2030,** it is projected that 183,897 (30.3%) of North Dakota residents will be age 60 and older.

Percent ND Population Age 60 and Older



- **In 1950,** 2,262 (0.4%) of North Dakota residents were age 85 and older.
- **In 2000,** 14,726 (2.3%) of North Dakota residents were age 85 and older. The U.S. percent of residents age 85 and older was 1.5.
- **In 2020,** it is projected that 20,106 (3.2%) of North Dakota residents will be age 85 and older. The U.S. percent of residents age 85 and older is projected to be 1.9.
- **In 2030,** it is projected that 23,302 (3.8%) of North Dakota residents will be age 85 and older.

Percent ND Population Age 85 and Older



Challenges for the Future

- Addressing healthy aging through disease prevention and health promotion.
- Continuing to support the needs of family caregivers.
- Providing an array of quality long-term care options, especially home and community-based services which many people report they prefer.
- Addressing the mental health needs of older persons.
- Providing consumers and their families easier access to services through information and development of "one stop shop" programs.
- Addressing the issue of the direct care service workforce and the value of older workers.

For Additional Information Contact:
North Dakota Department of Human Services
Aging Services Division
1237 West Divide Avenue, Suite 6
Bismarck, ND 58501
www.nd.gov/dhs

To Locate Services:
ND Aging and Disability Resource-LINK:
1-800-451-8693
Searchable database:
www.carechoice.nd.gov
Email: carechoice@nd.gov

DN425

The Graying of North Dakota

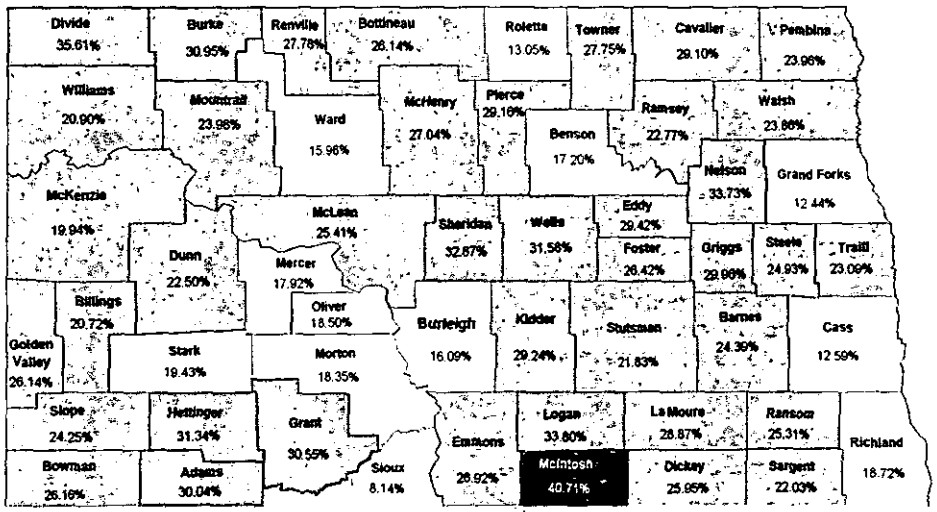
2000 - 2020

December 200

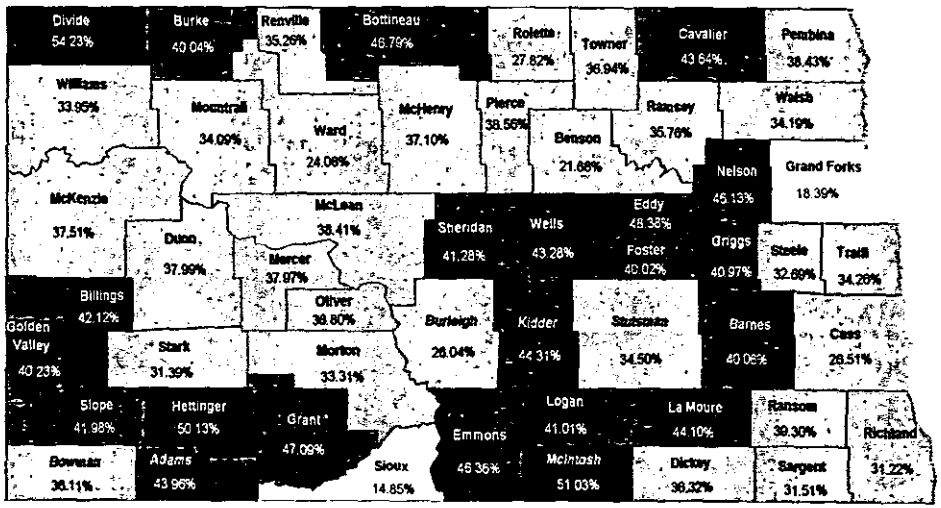
Percent Population Age 60 and Older in North Dakota Counties

White: < 20% | Light Blue: 20 - 29% | Medium Blue: 30 - 39% | Dark Blue: 40 - 49% | Navy Blue: 50+ %

2000



2020 (projected)



- **NORTH DAKOTA's** total population in 2000 was 642,200.
- **In 2000**, 118,985 (18.5%) persons in North Dakota were 60 years of age or older.
- **In 2000**, 16.3% of the U.S. population was 60 years of age or older.
- **In 2000**, fewer than 30% of persons in each of 43 counties in North Dakota were age 60 or older.
- **In 2000**, fewer than 20% of persons in each of 12 counties in North Dakota were age 60 or older.
- **In 2000**, only one county had more than 40% of its population age 60 or older.

SOURCE: File 2. Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex: July1, 2004 to 2030, U.S. Census Bureau, Population Division, Interim State Population Projections, 2005.

- **NORTH DAKOTA's** total population in 2020 is projected to be 630,112.
- **In 2020,** it is projected that 170,117 (27%) persons in North Dakota will be 60 years of age or older.
- **In 2020,** it is projected that 22.5% of the U.S. population will be 60 years of age or older.
- **In 2020,** only seven counties will have fewer than 30% of their population aged 60 or older. In two of those counties the percent of persons age 60 and older will be under 20%.
- **In 2020**, 22 counties will have more than 40% of their population aged 60 or older.
- **In 2020,** three counties will have more than 50% of their population age 60 or older.

Aging Services

Detail of Budget Account Code 621000 - Operating Fees & Services

Operating Fees & Services	General	Federal/Other	Total
State Funds to Providers	1,106,400		1,106,400
Community Supportive Services		2,386,244	2,386,244
Congregate Nutrition		2,947,008	2,947,008
Home Delivered Meals		1,919,196	1,919,196
National Family Caregiver		949,042	949,042
Nutrition Services		1,657,650	1,657,650
Preventive Health		208,158	208,158
Guardianship	40,000		40,000
QSP Training	39,980	20,020	60,000
Aged & Disabled Resources Center	600,000		600,000
Increase to OAA Service Providers	900,000		900,000
Other Miscellaneous Fees & Services	2,905	4,606	7,511
Total Operating Fees & Services Budget Account Code	$ 2,689,285	$ 10,091,924	$ 12,781,209

Aging Services

Detail of Budget Account Code 582000 - Rentals/Leases - Building Land

Rentals/Leases	Total	General	Federal/Other
Prairie Hills Plaza ($14.05 per sq foot)	$ 55,500	$ 13,875	$ 41,625
Miscellaneous (booth rentals)	850	475	375
Total Rentals/Leases - Building Land Budget Account Code	$ 56,350	$ 14,350	$ 42,000

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code		Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-43 AGING SERVICES									
		S101 FULL-TIME EQUIVALENTS (FTEs)		10.000	10.000	0.000	0.000	0.000	10.000
32510	B	511000 Salaries - Permanent		863,288	862,800	427,564	37,632	0	900,432
32510	B	516000 Fringe Benefits		287,442	308,658	144,475	5,534	40,872	355,064
32510	B	599110 Salary Increase		0	0	0	0	68,659	68,659
32510	B	599160 Benefit Increase		0	0	0	0	11,612	11,612
			Subtotal:	1,150,730	1,171,458	572,039	43,166	121,143	1,335,767
32510	F	F_1991 Salary - General Fund		392,550	329,427	242,167	15,047	91,857	436,331
32510	F	F_1992 Salary - Federal Funds		757,720	842,031	329,872	28,119	29,286	899,436
32510	F	F_1993 Salary - Other Funds		460	0	0	0	0	0
			Subtotal:	1,150,730	1,171,458	572,039	43,166	121,143	1,335,767
32530	B	521000 Travel		73,103	56,976	31,191	29,971	0	86,947
32530	B	531000 Supplies - IT Software		6,990	5,000	2,568	0	0	5,000
32530	B	532000 Supply/Material-Professional		4,237	4,000	1,937	(661)	0	3,339
32530	B	534000 Bldg, Grounds, Vehicle Supply		13	20	16	10	0	30
32530	B	535000 Miscellaneous Supplies		6,717	5,354	2,444	1,746	0	7,100
32530	B	536000 Office Supplies		4,512	5,300	2,777	(2,000)	0	3,300
32530	B	541000 Postage		5,210	1,350	97	(440)	0	910
32530	B	542000 Printing		11,187	13,300	6,560	0	0	13,300
32530	B	561000 Utilities		494	450	246	150	0	600
32530	B	571000 Insurance		1,295	0	0	1,500	0	1,500
32530	B	582000 Rentals/Leases - Bldg/Land		926	20,850	20,519	35,500	0	56,350
32530	B	591000 Repairs		973	1,000	932	1,328	0	2,328
32530	B	601000 IT - Data Processing		378	500	145	(300)	0	200
32530	B	602000 IT-Communications		4,593	4,500	2,349	300	0	4,800
32530	B	603000 IT Contractual Services and Re		5,608	0	0	0	0	0
32530	B	611000 Professional Development		27,036	23,840	11,110	3,970	0	27,810
32530	B	621000 Operating Fees and Services		10,458,131	11,357,364	6,051,864	1,423,845	0	12,781,209
32530	B	712000 Grants, Benefits & Claims		11,300	0	0	0	0	0

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code		Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-43 AGING SERVICES									
			Subtotal:	10,622,703	11,499,804	6,134,755	1,494,919	0	12,994,723
32530	F	F_3991 Operating - General Fund		812,489	1,151,519	575,108	1,594,857	0	2,746,376
32530	F	F_3992 Operating - Federal Funds		9,757,945	10,307,860	5,559,015	(59,705)	0	10,248,155
32530	F	F_3993 Operating - Other Funds		52,269	40,425	632	(40,233)	0	192
			Subtotal:	10,622,703	11,499,804	6,134,755	1,494,919	0	12,994,723
32550	B	683000 Other Capital Payments		1,883	194	187	(194)	0	0
			Subtotal:	1,883	194	187	(194)	0	0
32550	F	F_5991 Land & Cptl Imprv - Gen Fund		642	48	47	(48)	0	0
32550	F	F_5992 Land & Cptl Imprv - Fed Funds		1,240	146	140	(146)	0	0
32550	F	F_5993 Land & Cptl Imprv - Other Fnds		1	0	0	0	0	0
			Subtotal:	1,883	194	187	(194)	0	0
32560	B	712000 Grants, Benefits & Claims		1,104,462	1,598,290	1,167,054	(5,910)	0	1,592,380
32560	B	722000 Transfers Out		5,554	0	0	0	0	0
			Subtotal:	1,110,016	1,598,290	1,167,054	(5,910)	0	1,592,380
32560	F	F_6992 Grants - Federal Funds		872,010	1,228,715	962,265	53,665	0	1,282,380
32560	F	F_6993 Grants - Other Funds		238,006	369,575	204,789	(59,575)	0	310,000
			Subtotal:	1,110,016	1,598,290	1,167,054	(5,910)	0	1,592,380

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class FB	Budget Account Code		Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-43 AGING SERVICES								
		Subdivision Budget Total:	12,885,332	14,269,746	7,874,035	1,531,981	121,143	15,922,870
		General Funds:	1,205,681	1,480,994	817,322	1,609,856	91,857	3,182,707
		Federal Funds:	11,388,915	12,378,752	6,851,292	21,933	29,286	12,429,971
	300-43 AGING SERVICES	**Other Funds:**	290,736	410,000	205,421	(99,808)	0	310,192
		SWAP Funds:	0	0	0	0	0	0
		County Funds:	0	0	0	0	0	0
		IGT Funds:	0	0	0	0	0	0
		Subdivision Funding Total:	12,885,332	14,269,746	7,874,035	1,531,981	121,143	15,922,870

north dakota department of human services

Older Americans Act Services

Federal Fiscal Year 2007

Background

The Older Americans Act was signed into law July 14, 1965, for the purpose of improving the lives of older individuals in relation to income, housing, employment, long-term care, retirement, and community services. In addition to creating the Administration on Aging (AoA), the Act authorized grants to states for community planning, programs and services, and research, demonstration, and training projects in the field of aging.

The Department of Human Services' Aging Services Division serves as the single planning and service agency for older persons in North Dakota, as designated by the U.S. Department of Health and Human Services, AoA.

Eligibility

The Older Americans Act (OAA) provides funding for services for individuals age 60 and older. Services are not tied to income. Individuals must have an opportunity to contribute to the cost of the service, but no one can be denied service due to inability or unwillingness to contribute toward the cost.

Prioritizes Serving Older Individuals Who:

- Reside in rural areas
- Have low incomes/greatest economic and social needs
- Are considered to be of a minority
- Have limited English proficiency
- Have severe disabilities
- Are diagnosed with Alzheimer's disease and related disorders (*as well as, the caretakers of such individuals*)
- Are at risk of institutional placement

Individuals Served

- During Federal Fiscal Year 2007, a total of **30,557 older individuals** in North Dakota received services funded under the Older Americans Act.

OAA Requirements

Under this federal law, states are required to develop a comprehensive and coordinated system of home and community-based services that allows older individuals to lead independent, meaningful, and dignified lives in their own homes and communities.

To accomplish this, Older Americans Act funds, state funds, and local funds are coordinated to avoid duplication and maximize service. The Department of Human Services' Aging Services Division contracts with local providers for services.

OAA Services Provided

Assistive Safety Devices – A service that provides needed safety devices for older individuals.

Senior Center/Congregate Meals – A service that provides meals consisting of at least one-third of the daily dietary needs for an older individual eating in a group setting.

Home-Delivered Meals – A service that provides meals consisting of at least one-third of the daily dietary needs for an older individual who is homebound and unable to prepare an adequate meal.

Health Maintenance Services – Services provided to assess and maintain the health and well being of older individuals. Services include blood pressure/pulse/rapid inspection, foot care, home visits, and medication set-up.

Outreach Services – Efforts to seek out older individuals and identify their needs and to then make appropriate referral and linkage to available services.

Senior Companion Services – A service provided by volunteers (who receive a stipend) that offers periodic companionship and non-medical support to older individuals with special needs.

Continued on other side →

OAA Services (*Continued*)

Legal Assistance Services - Legal advice and representation are provided by an attorney to older individuals with economic or social needs and includes (i) to the extent feasible, counseling or other appropriate assistance by a paralegal or law student under the direct supervision of an attorney; and (ii) counseling or representation by a non-lawyer where permitted by law.

Information and Assistance - A service provided by the Department's **Aging and Disability Resource-LINK**, a nationwide toll-free number (**1-800-451-8693**), that provides information on a wide range of home and community-based and long term care and support services, volunteer opportunities, and benefits. Information can also be accessed on-line at http://www.carechoice.nd.gov/.

Senior Community Service Employment Program - Provides part-time employment opportunities in community service activities for unemployed low-income persons who are 55 years or older and who have fewer employment prospects.

Older Americans Act funds are also used to provide services through the:

- North Dakota Family Caregiver Support Program
- Long-Term Care Ombudsman Program
- Vulnerable Adult Protective Services Program

Separate fact sheets are available for each of the programs.

The Division also administers a federally funded demonstration grant: the **Model Legal Systems for Seniors grant**.

Federal Fiscal Year 2007 Older Americans Act Services
Number of Individuals Served/Units of Service Provided

Service	Individuals Served	Units of Service	
Congregate Meals	15,462	752,072 meals	1 unit = 1 meal
Home-Delivered Meals	6,183	535,646 meals	1 unit = 1 meal
Health Maintenance	4,790	148,238 units	Set billing units per procedure
Information & Assistance	1,858	1,858 units	1 unit = 1 contact
Legal Assistance	1,127	4,795 units	1 unit = 15 minutes
Outreach	15,695	118,025 units	1 unit = 15 minutes
Senior Companion	256	3,475 units	1 unit = 1 contact

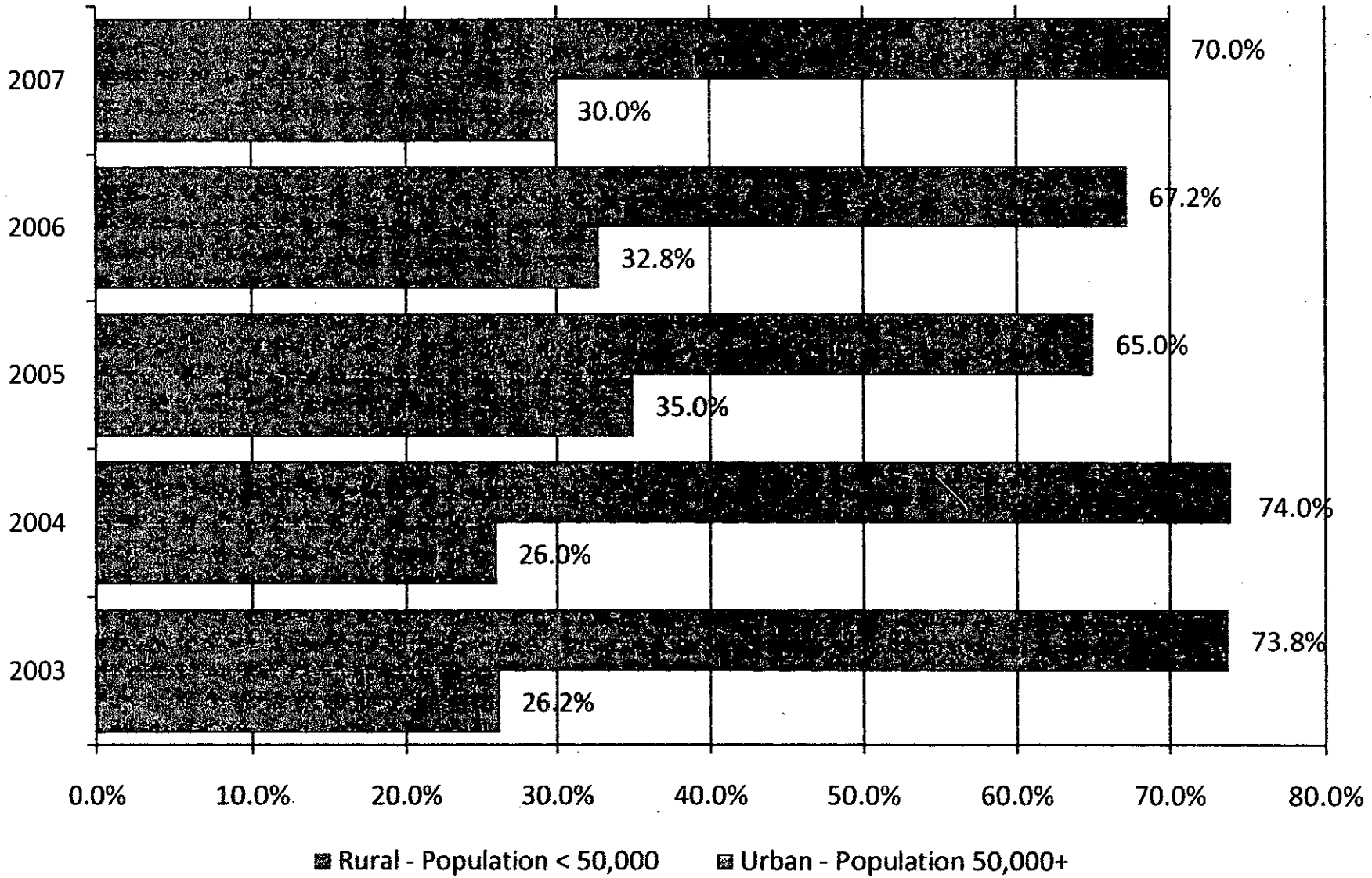
Funds Expended In Federal Fiscal Year 2007
for Services Listed in the Above Chart

Federal Funds – Older Americans Act	$ 3,974,950.18	37.1%
Federal Funds – NSIP (for Nutrition Programs)	796,730.00	7.4%
State Funds – Match for Older Americans Act Funds	360,000.00	3.4%
Required Match (from Providers)	731,605.68	6.8%
Additional Local Funds	1,746,206.51	16.3%
Program Income from Participants	3,103,605.44	29.0%
TOTAL AMOUNT EXPENDED	$ 10,713,097.81	100%

**Does not include expenditures for the Family Caregiver Support Program, Senior Community Service Employment Program, Long-Term Care Ombudsman Program, or the Vulnerable Adult Protective Services Program.*

Produced by: **N.D. Department of Human Services - Aging Services Division,** 1237 W Divide Ave, Suite 6, Bismarck N.D. 58501 Ph: 701-328-4601 TTY: 800-366-6888 www.nd.gov/dhs

Comparison of Rural /Urban OAA Clients



North Dakota Long Term Care: Issues and Recommendations, 1987
By: Interagency Task Force on Long Term Care
Targeted Population: Elderly and people with disabilities

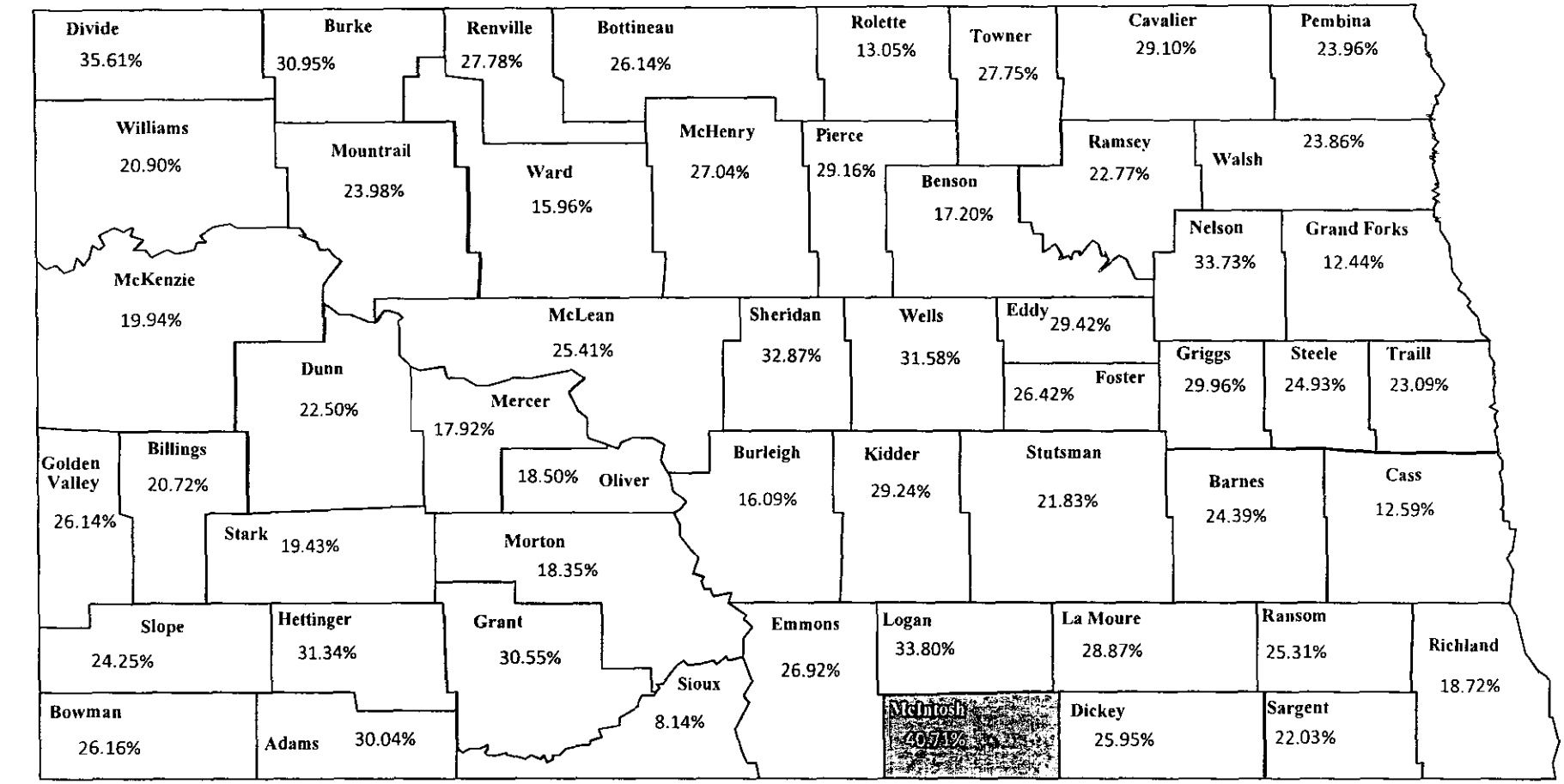
Summary of Information

The ND Interagency Task Force on Long Term Care, which includes the Governor's Office, Department of Human Services, and Department of Health, conducted a study in Drayton, ND in 1986. This study established the need to look at the structural, functional, financial and social concerns regarding the long term care delivery system in ND and how it affects the needs of the aging population in our state. The report is not directly about the Drayton Study, but about the issues that the nation and ND is facing in regards to long term care.

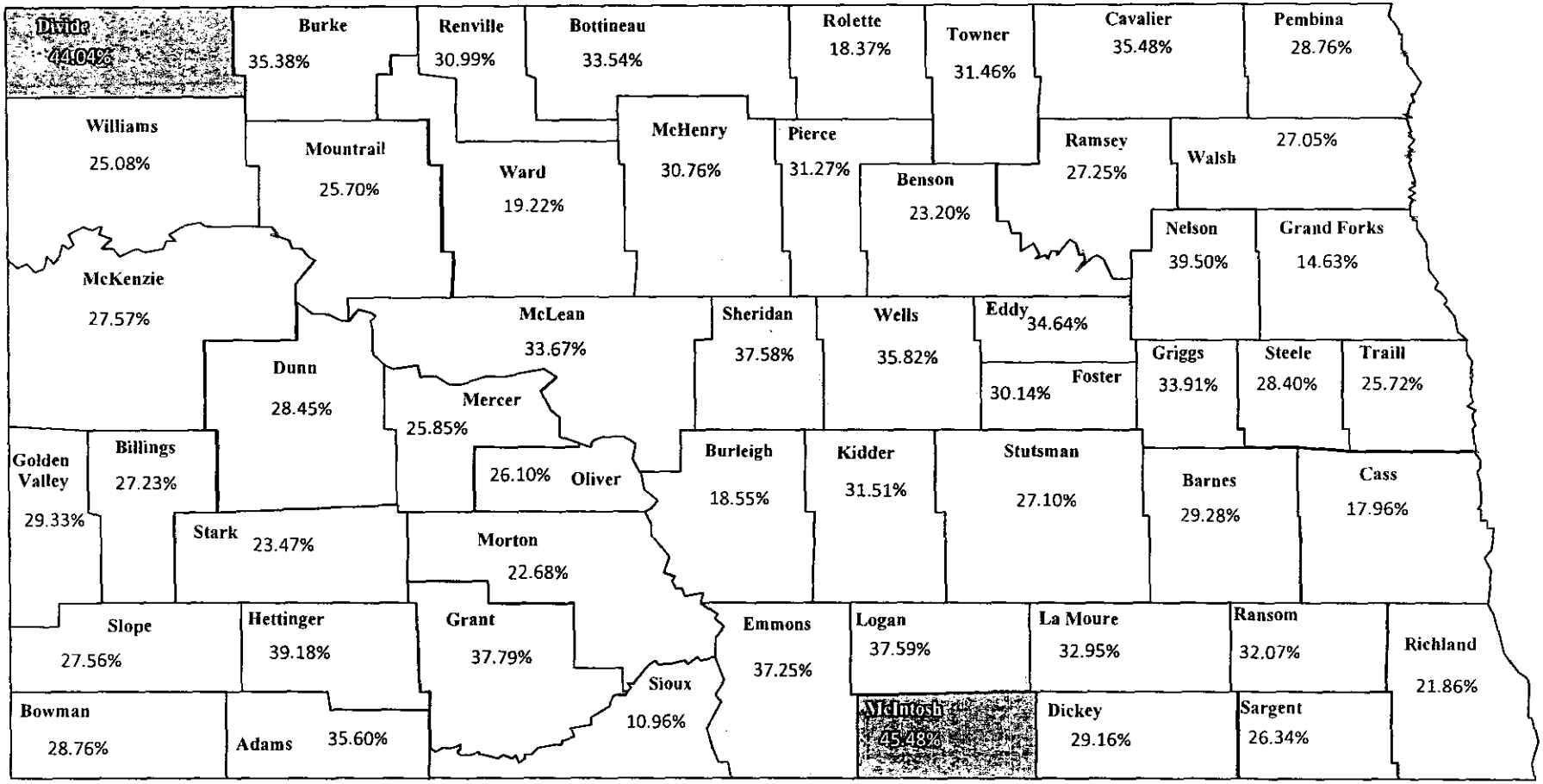
The following recommendations were given by the ND Interagency Task Force on Long Term Care:

- State policy be implemented to include: a) a balanced continuum of long term care services b) the functional limitations and needs of the elderly will serve as the principal criterion for the use of long term care services or the development of additional long term care services, c) the financial and organizational structure of the long term care delivery system will be designed to assist older adults in obtaining appropriate long term care services, d) access to appropriate long term care services for older adults will be improved through provided a central point of entry. e) institutional services will be considered "alternative" services with in the continuum of long term cares services f) families, as the principle caregivers to older adults, will be supported, g) ND's certificate of need law will continue as a function of the State Health Council and the Council will make necessary changes in it's review process that will further the development of a balanced continuum of long term cares services in ND.
- Single point of entry to the system of long term care be recognized and used, and that a system of case management be established and used.
- Federal and state dollars for long term care services be pooled in state government and dispersed on the basis of the functional needs of clients.
- The Department of Health and DHS continue the ongoing consolidation of the inspection of care function with the certification survey for ICF/MRs.
- Based upon the demonstrated efficiencies expected to be achieved under the ICF/MR consolidation pilot project, the task force recommends that the Department of Health and DHS consolidated the inspection of care, certification and licensure functions for all long term care facilities.
- Consolidation of inspection of care with the certifications survey process should accompany the consolidation of authority for imposing graduated economic sanctions on those facilities that fail to meet the quality compliance standards.
- The State Health Council, with the assistance of the Department of Health and DHS, should recommend to ND's Congressional delegation a series of changes in federal nursing requirements that would permit the state to reduce the burden of regulation for long term care facilities.
- Passage of legislation to improve access to HCBS by a) requiring all HCBS that are financed by the state be available in each county, b) apply economic assistance on a sliding fee scale, c) extend eligibility standards through assessments of functional impairment rather than the likelihood of institutionalization, d) a system of case management within the communities and pre-admission assessment of all applicants for nursing home care.
- Enact a bill that 1) Directs the DHS to develop a case-mix reimbursement system for nursing homes which will a) provide that the rates determined will be adequate to support the basic services, b) assures that payment system will provided incentives for service to "heavy care patients", c) require the payment system incorporate positive economic incentives for the efficient operation of nursing homes. 2) Provides that the rate of payment for the basic services required participation in the Medicaid program will apply to all residents equally.
- The Health Department, the DHS, the Governor's Office and the Office of Management and Budget recommend an appropriated level of state funding of the health planning/certificate of need programs for the 1987-1989 biennium.

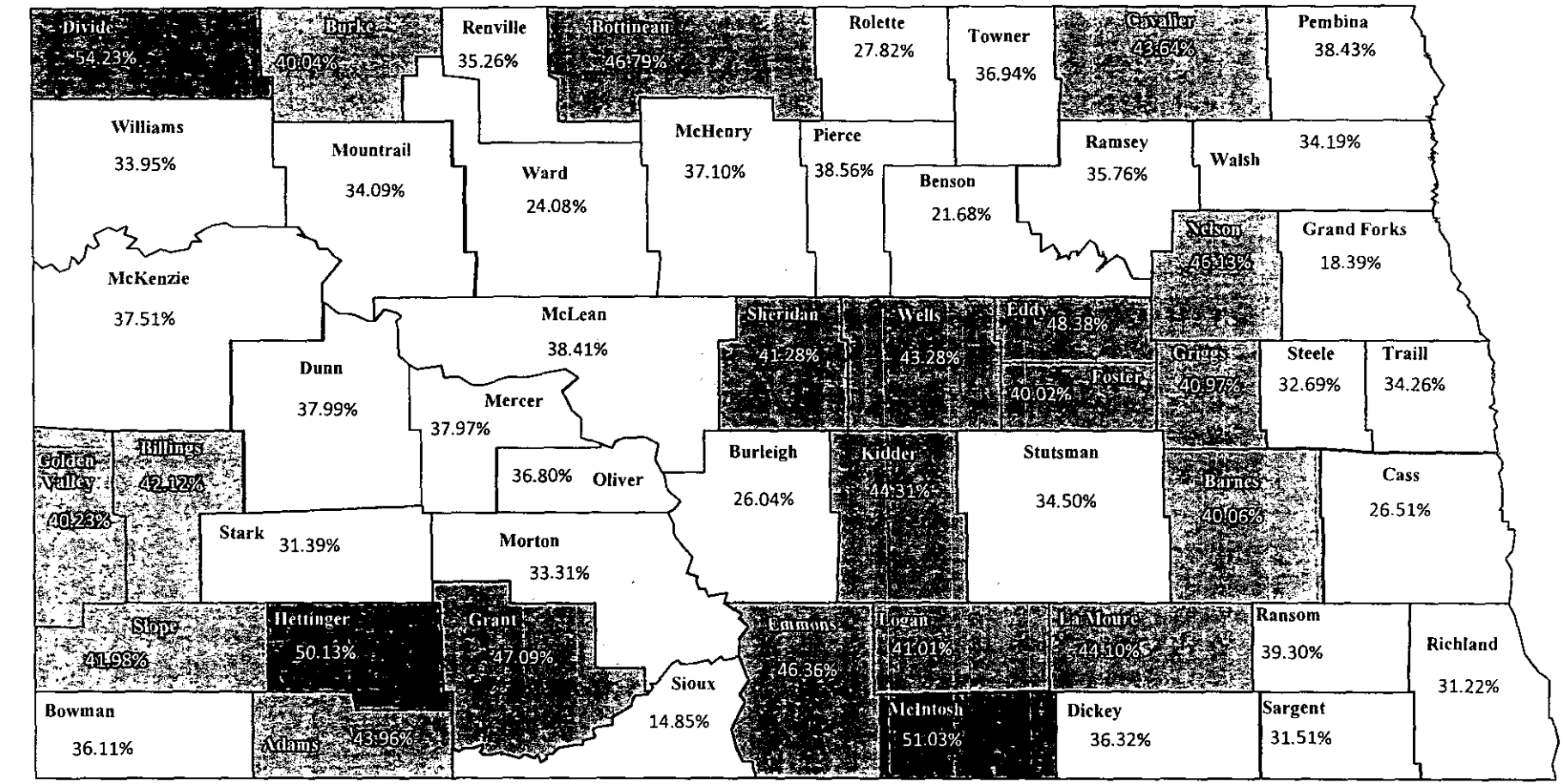
Percent of Population Age 60 and Over, 2000



Percent of Population Age 60 and Over, 2010



Percent of Population Age 60 and Over, 2020



Attachment A

Aging and Disability Resource LINK – No Wrong Door

Relevant information and advice when and where people need it

Is a process. Not one place.

Strengthens what we have.

Goal: Minimize confusion, enhance individual choice, and support informed decision-making regarding long-term care services

Pilot in 2 Regions

- **Region IV** (*Grand Forks, Nelson, Pembina, and Walsh counties*)
  Partners/Access Points
  - Northeast Human Service Center
  - County Social Service Offices
  - Options Interstate Resource Center for Independent Living
  - Senior Centers and Other Community Partners
- **Region VII** (*Burleigh, Emmons, Grant, Kidder, McLean, Mercer, Morton, Oliver, Sheridan, and Sioux counties*)
  Partners/Access Points
  - West Central Human Service Center
  - County Social Service Offices
  - Dakota Center for Independent Living
  - Northland PACE program
  - Senior Centers and Other Community Partners

Raise awareness of existing public and private community care and support services for seniors and people with disabilities through education and outreach.

Improve access to needed services.

Improve coordination between providers to better meet the needs of seniors, individuals with disabilities, and their families.

Trained Advisors at access points provide personalized solutions to individual needs.

- *Evaluate needs*
- *Explain options*
- *Explore benefits/programs they may qualify for and help apply*
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- *Be accountable for outcomes and conduct follow-up*

Available to all.

- Sliding fee scale (cost sharing) for private pay

Addresses Gaps/Issues while avoiding duplication.

- Awareness of available services
- Evening and weekend access to help
- Early coordination with hospital discharge planners
- Meet private pay individuals' needs too (If don't qualify for public services, referrals and help accessing private services is currently inconsistent)
- Stigma of contacting County Office or Human Service Centers

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
March 4, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, I am Linda Wright, Director of the Aging Services Division of the Department of Human Services. I am here today to provide you an overview of the Division's budget for the Department of Human Services.

Programs

The Aging Services Division provides home and community based service options to maintain individuals in their homes and communities and assists in protecting the health, safety, welfare and rights of residents of long-term care settings and vulnerable adults in the community. This includes administration of Older Americans Act federal funds, the Telecommunications Equipment Distribution Program, State Funds to Providers, the Long-Term Care Ombudsman Program, the Guardianship Program for Vulnerable Adults, the Senior Community Service Employment Program, Qualified Service Provider Training, support for the Governor's Committee on Aging, Model Legal Systems Grant, and Aging and Disability Resource-LINK.

The Aging Services Division is a federally designated single planning and services area, which requires the Division to carryout the responsibilities of the State Unit on Aging and the Area Agency on Aging as set forth in the Older Americans Act (OAA). Among the requirements in the 2006 reauthorization of the OAA is the following: "require state agencies to promote the development and

implementation of a state system of long-term care that enables older individuals to receive long-term care in home and community based settings in accordance with the individual's needs and preferences."

Caseload / Customer Base

- In 2000, 118,985 (18.5 percent) of the population in North Dakota was 60 years of age or older.
- In 2020, it is projected that 170,117 (27 percent) of the population in North Dakota will be 60 years of age or older.
- In 2000, only one county (McIntosh) had more than 40 percent of its population age 60 or older.
- In 2020, 22 counties will have more than 40 percent of their population aged 60 or older.
- In 2020, three counties (Divide, Hettinger and McIntosh) will have more than 50 percent of their population age 60 or older.
- In 2000, 14,726 (2.3 percent) of North Dakota residents were age 85 or older.
- In 2020, it is projected that 20,106 (3.2 percent) of North Dakota residents will be age 85 and older.
- McIntosh County ranks number one in the nation among 3,142 counties for the highest percent of the population age 65 and older.

Please refer to the attached updated Graying of North Dakota brochure for additional information.

- In Federal Fiscal Year (FFY) 2008, 31,979 older persons received Older Americans Act funded services, which

include home-delivered meals, congregate meals, outreach, health maintenance services, national family caregiver program services, legal services, in-home safety, senior companion services, vulnerable adult protective services, and long-term care ombudsman services. See Attachment 1 for additional information about Older Americans Act services.

FFY 2008 Program Utilization

Older American Act – Title III Programs	
SERVICE	UNITS OF SERVICE
Assistive Safety Devices	1,731 devices
Congregate Meals	732,015 meals
Home-Delivered Meals	540,319 meals
Health Maintenance	140,258 units
Information & Assistance	1,900 units
Legal Assistance	4,370 units
Outreach	94,339 units
Senior Companion	5,204 units

Vulnerable Adults Program	
New cases	486
Closed cases	468
Information/referral	360
Brief Services	257
Hours	6,839

Family Caregiver Support Program	
Unduplicated Caregivers Served	551
Unduplicated Grandparents Served	14
Respite Care Provided	47,230 hours

Long-Term Care Ombudsman Program	
Number of Complaints	1,091
Number of Cases Opened	732

- The Qualified Service Provider (QSP) training program under contract with Lake Region State College has trained 227 QSPs from July 2006 through June 2008 for provision of in-home care. The training is provided by 69 nurses statewide and is not a mandatory requirement to become a QSP. Due to the fact that a health care professional must sign off on the documentation of competency when a QSP enrolls to provide services, many QSPs choose to participate in the training program. The documentation of competency is then signed by the nurse trainer. As of February 2009, there were 1,713 QSPs statewide which includes 143 agencies. Family home care or family personal care is provided by 362 QSPs, which basically means that those QSPs provide services to only one client (a family member).
- The Senior Community Service Employment Program will provide on-the-job training to 71 low-income individuals over the age of 55. The Division is contracting with Experience Works (formerly Green Thumb) to provide direct service to the enrollees. Experience Works serves an additional 275 enrollees in North Dakota through a national contract with the Department of Labor.

Program Trends / Major Program Changes

- As the result of a cooperative agreement with the Department of Transportation (DOT), transit services are no longer funded by the Older Americans Act and are funded by DOT. We continue to have on-going communication with DOT and receive statistical data from them regarding the number of rides provided to older persons.
- The increasing costs of providing services, including raw food costs, and meeting the new federal dietary requirements for congregate and home delivered meals; transportation costs and other inflationary increases, along with fairly flat federal funding, have increased the burden on contract providers to meet expenses in providing services to older persons.
- The information and referral services provided by the Division, formerly known as the Senior Info Line has expanded its database and changed its name to the Aging and Disability Resource-LINK. In addition to phone calls and e-mail inquiries, the Resource-LINK web site receives about 700 hits or "visits" per month. The attached brochure provides additional details about the Aging and Disability Resource-LINK.
- The development of Aging and Disability Resource LINK "No Wrong Door" model continues as a goal for the Department, as included in the Executive budget. In addition to $600,000 in general funds, House Bill 1012 also contained revisions to N.D.C.C. 50-06-29. The House Appropriations Committee removed this statutory change from HB 1012 and included the establishment of an ADRC in HB 1476. That bill failed to pass the House. HB 1476 included language that would have allowed the Department not only to establish community-based Aging and Disability Resource Center

services, but also would have allowed the Department to secure funding from a variety of sources including federal grants, foundation funds, general funds and other funding sources. The Department has developed draft language that would revise the current state law allowing the Department to pursue other funding sources and implement the Aging and Disability Resource Link model. Without this change in statute, the Department cannot pursue future federal grants or other funding opportunities.

ADRCs have been developed in 45 states, as required by the Older Americans Act, and serve as integrated points of entry into the long-term care system, commonly referred to as "no wrong door" or "one stop shop", and are designed to address many of the frustrations consumers and their families experience when trying to access needed information, services and supports. Many long-term care studies that have been conducted in North Dakota, beginning with the "Drayton study" in 1987, have recommended establishment of a "one stop shop" or "no wrong door."
Please refer to attachments A through H for additional information about ADRCs.

The Aging and Disability Resource Link model is accountable for outcomes and follow-up with each consumer.

The service deliver model is a process. It does not replace the functions of agencies such as County Social Service Offices, Human Service Centers, Independent Living Centers, Older Americans Act Programs, etc., but instead brings the agencies together to build on existing services; to cross-train staff; to educate and inform the

public; to network and enter into collaborative agreements; to more effectively serve older persons, and persons with physical disabilities and their families by providing needed information, assessment, eligibility help, benefits counseling, and options for services.

The Aging and Disability Resource Link model does not create another layer of bureaucracy; but instead addresses gaps while avoiding duplication and improving consumer access to needed services.

The model establishes partners and access points in service areas.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase/ Decrease	2009 - 2011 Budget	House Changes	To Senate
Salary and Wages	1,171,458	164,309	1,335,767	(10,202)	1,325,565
Operating	11,499,804	1,494,919	12,994,723	(629,170)	12,365,553
Capital Payments	194	(194)	-	-	-
Grants	1,598,290	(5,910)	1,592,380	-	1,592,380
Total	14,269,746	1,653,124	15,922,870	(639,372)	15,283,498
General Funds	1,480,994	1,701,713	3,182,707	(622,056)	2,560,651
Federal Funds	12,378,752	51,219	12,429,971	(15,084)	12,414,887
Other Funds	410,000	(99,808)	310,192	(2,232)	307,960
Total	14,269,746	1,653,124	15,922,870	(639,372)	15,283,498
FTE	10.00	-	10.00	-	10.00

Budget Changes from Current Budget to Executive Budget:

The salary and wages line item has a net increase of $164,309 due to the following:

- $121,143 of which $91,857 is general funds for the Governor's salary package.
- $19,601 in general funds for the cost to continue the second year salary increase.
- $23,565 to maintain current FTEs.

The operating line item increased by $1,494,919. The major increases are:

- $35,500 increase, of which $8,875 is from the general fund for office rent at Prairie Hills Plaza. The Division relocated from the Capitol to Prairie Hills Plaza in November 2007.
- $29,971 increase, of which $700 is from the general fund for increased travel costs for staff and Volunteer Community Ombudsmen.
- $30,000 increase, of which $9,980 is from the general fund for the training of Qualified Service Providers to meet the actual cost of the training.
- $106,400 in general funds for the inflationary rate increase for direct service providers.
- $600,000 in general funds to establish Aging and Disability Resource Center services. This is offset by an $840,000 decrease, of which $40,000 is from the general fund, to remove appropriation authority from last session for a federal grant (that was not received) to establish Aging and Disability Resource Center services.

- $900,000 from the general fund to increase the reimbursement to Older Americans Act service providers to assist in meeting the actual costs of providing services.
- $627,445, of which $2,021 is from the general fund for increases in operating fees and services related to:
    - Ombudsman Activities - ($23,567)
    - Telecommunications Equipment Distribution – $14,100
    - Preventive Health – ($3,700)
    - Title III B Community Services - $57,458
    - Congregate Nutrition - $88,780
    - Home Delivered Nutrition - $118,340
    - Alzheimer's Demonstration Project – ($226,725)
    - Nutrition Services Incentive Program - $453,654
    - Single Point of Entry – ($30,000)
    - Family Caregiver Support - $172,994

Grants decreased by $5,910 due to the following:

- A decrease of $15,000 in other funds for the Telecommunications Equipments Distribution program
- An increase of $50,000 in federal funds for the Model Legal Systems for Seniors grant
- A decrease of $250,000 of federal and other funds for the closeout of the Alzheimer's Disease Demonstration grant
- An increase of $209,090 of federal funds for the Senior Employment grant

House Changes:

The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $3,350 – general fund and $6,852 – federal funds for a total of $10,202.

The House reduced 50 percent of the department-wide travel increase. Aging Services share of this decrease is $13,970 total funds; $3,506 – general fund; $8,232 - federal funds; and $2,232 - other funds.

The House reduced the inflationary increase for providers from 7% and 7% to 6% and 6% resulting in a decrease of $15,200 in general funds.

The House removed $600,000 general funds for the establishment of Aging and Disability Resource Center services.

This concludes my testimony. I would be happy to answer any questions.

Attachment A1

Aging and Disability Resource LINK – No Wrong Door

Relevant information and advice when and where people need it

Is a process. Not one place.

Strengthens what we have.

Goal: Minimize confusion, enhance individual choice, and support informed decision-making regarding long-term care services

Pilot in 2 Regions

- **Region IV** (*Grand Forks, Nelson, Pembina, and Walsh counties*)
  Partners/Access Points
  - Northeast Human Service Center
  - County Social Service Offices
  - Options Interstate Resource Center for Independent Living
  - Senior Centers and Other Community Partners
- **Region VII** (*Burleigh, Emmons, Grant, Kidder, McLean, Mercer, Morton, Oliver, Sheridan, and Sioux counties*)
  Partners/Access Points
  - West Central Human Service Center
  - County Social Service Offices
  - Dakota Center for Independent Living
  - Northland PACE program
  - Senior Centers and Other Community Partners

Raise awareness of existing public and private community care and support services for seniors and people with disabilities through education and outreach.

Improve access to needed services.

Improve coordination between providers to better meet the needs of seniors, individuals with disabilities, and their families.

Trained Advisors at access points provide personalized solutions to individual needs.

- *Evaluate needs*
- *Explain options*
- *Explore benefits/programs they may qualify for and help apply*
  - People leave with a plan, not a list of phone numbers
- *Be accountable for outcomes and conduct follow-up*

Available to all.

- Sliding fee scale (cost sharing) for private pay

Addresses Gaps/Issues while avoiding duplication.

- Awareness of available services
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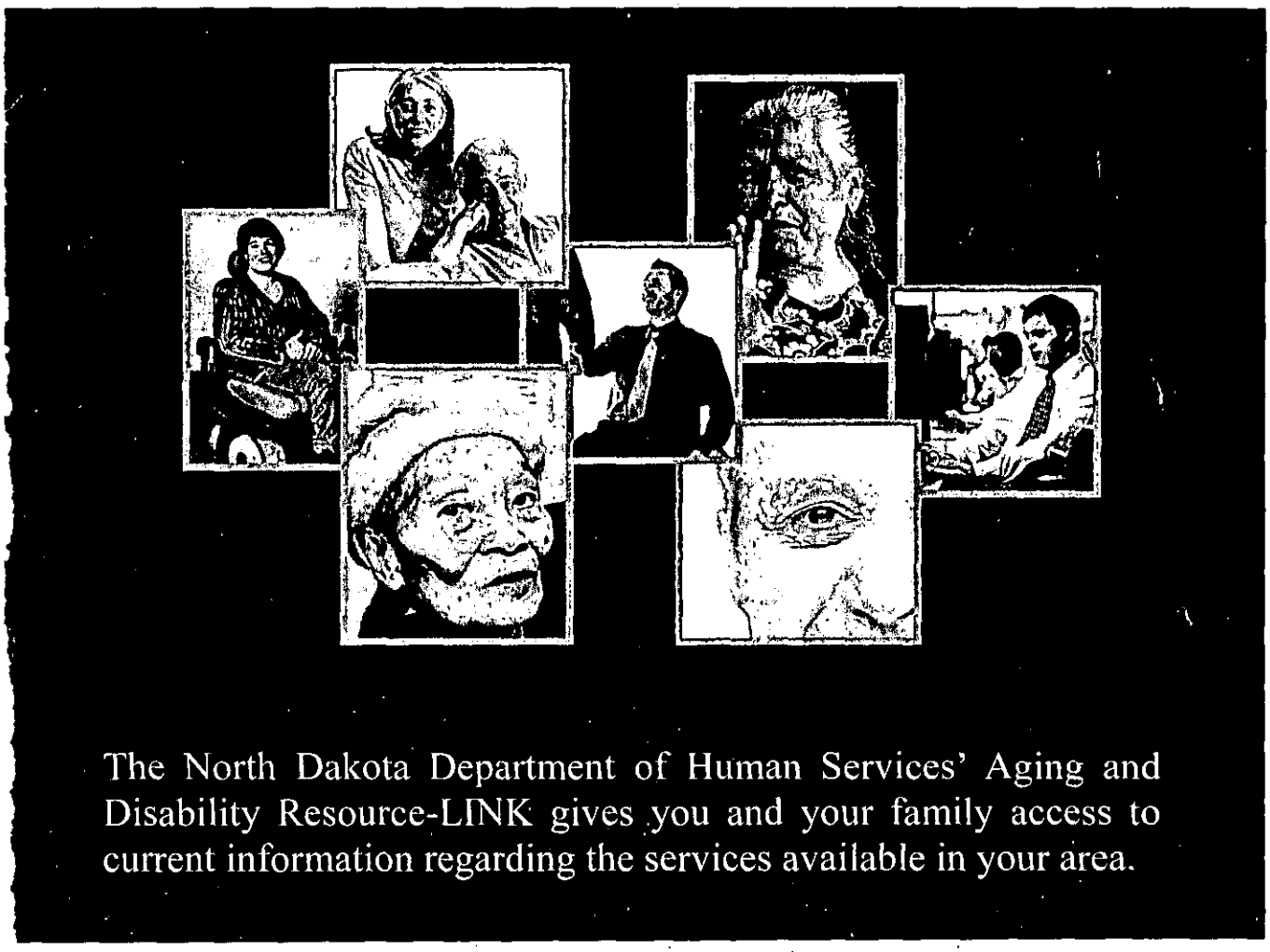
- Stigma of contacting County Office or Human Service Centers

NORTH DAKOTA AGING and DISABILITY

Resource-LINK

Your Care Choice Connection to Aging and Disability Resources

What Options and Choices are Available for Seniors and Adults with Disabilities?



The North Dakota Department of Human Services' Aging and Disability Resource-LINK gives you and your family access to current information regarding the services available in your area.

Independence. Choice. Self-Direction.

What is the Aging and Disability Resource-LINK?

The Aging and Disability Resource-LINK is a free service to help you make decisions regarding the type of care you or your loved one might need and it links you to available services in your community to help meet those needs.

This service is available by phone (nationwide toll-free) from 8:00 AM until 5:00 PM CST, Monday through Friday. The phone is answered by an individual who has met the requirements of a Certified Information Resource Specialist for Aging (CIRS-A) through the national Alliance for Information and Referral Systems.

The Aging and Disability Resource-LINK also maintains a website which is updated on a regular basis and provides the same information available through our toll-free phone service.

Contact the North Dakota Aging and Disability Resource-LINK

Finding Care and Support in your Home and Community

What options are available?

Not all services listed in this brochure are available in every community. Some programs may be paid for by county, state or federal funds, while others may not. Our specialist can help by reviewing options available in your community so you can make informed decisions.

In - Home Care:

- Medication Management/Administration
- Health Monitoring
- Home Health Care
- Parish Nurse Programs
- Physical, Occupational and Speech Therapy Training
- Transfers and Mobility
- Meal Planning and Preparation
- Help with Eating, Bathing, Dressing, Toileting and other Personal Care Tasks

Homemaking Services:

- Shopping Assistance
- Meal Preparation
- Housekeeping

1.800.451.8693 or www.carechoice.nd.gov

Nutrition Services:

- Senior Dining Programs
- Home Delivered Meal Services
- Food Pantries

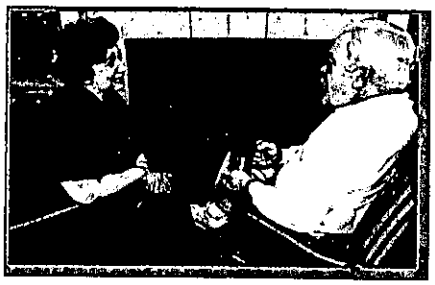
Delivery Services:

- Groceries
- Library Books
- Prescription Drugs

Federally Funded Program for Caregivers:

- ND Family Caregiver Support Program

Provides counseling, training, respite care services



Federal, State and County Funded Programs for Individuals and Caregivers:

- Home and Community Based Services Programs

Assistance with in-home services such as: personal care needs, housekeeping, money management, shopping, etc.

Resources for Coordinating Services:

- Information and Assistance
- Case Management
- Outreach
- Options Counseling

Contact the North Dakota Aging and Disability Resource-LINK

Adult Day Services:

- Adult Day Care Programs
- Respite Care Services
- Health Monitoring and Medication Administration
- Health, Nutritional and Social Services

Safety:

- Telephone Reassurance
- Home Injury Prevention
- Emergency Response Services
- Home Security Systems/Police or Fire Alert

Transportation:

- Public Transportation
- Non-Medical Transportation
- Senior Center Transportation Services
- Social Services Transportation Services
- Medical Transportation

1.800.451.8693 or www.carechoice.nd.gov

Social and Community Services:

- Senior Centers
- Services Sponsored by Religious Groups
- Special Interest Groups or Clubs
- Community Recreation Centers
- Counseling Centers and Support Groups
- Employment
- Volunteer Opportunities
    - ◊ Senior Companion Program
    - ◊ Foster Grandparent Program
    - ◊ Retired and Senior Volunteer Program (RSVP)

Home Maintenance and Modifications:

- Weatherization Program
- Chore Services
    - ◊ Lawn Care
    - ◊ Home Repairs
    - ◊ Snow Shoveling
- Home Accessibility
    - ◊ Ramps
    - ◊ Safety Bars
- Assistive Technology

Contact the North Dakota Aging and Disability Resource-LINK

Housing Options:

- Independent Living Options
  - ◊ Accessible Housing Resources
  - ◊ Retirement Complexes
  - ◊ Supported Housing
- Low Income Housing
- Assisted Living Options
- Adult Family Foster Care
- Basic Care
- Skilled Nursing Home Care

Other types of assistance:

- Ombudsman Services (*Advocate for people in alternative care settings*)
- Vulnerable Adult Protective Services
- Legal Assistance
- Protection and Advocacy
- Consumer Assistance and Protection
- Financial Assistance
- Energy Assistance Program
- Prescription Drug Programs

1.800.451.8693 or www.carechoice.nd.gov

Aging and Disability Resource Centers

A Joint Program of the Administration on Aging & Centers for Medicare & Medicaid Services

Working to Build the Future of Long-Term Care

Empowering adults as they age with reliable information and access to the care they need

Enabling individuals who are at high risk of nursing home placement to remain at home

Building disease prevention into community living through the use of low-cost, evidence-based programs

Administration on Aging

BACKGROUND

The Aging and Disability Resource Center Program (ADRC), a collaborative effort of the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS), is designed to streamline access to long-term care.

The ADRC initiative supports state efforts to develop "one-stop shop" programs at the community level that will help people make informed decisions about their service and support options and serve as the entry point to the long-term support system. States are using ADRC funds to better coordinate and/or redesign their existing systems of information, assistance and access and are doing so by forming strong state and local partnerships.

ADRC programs provide information and assistance to individuals needing either public or private resources, professionals seeking assistance on behalf of their clients, and individuals planning for their future long-term care needs. ADRC programs also serve as the entry point to publicly administered long-term supports including those funded under Medicaid, the Older Americans Act and state revenue programs.

In particular, ADRCs streamline access to long-term care services for individuals with disabilities, older adults, and their family caregivers, particularly those at highest risk of nursing home placement and spenddown to Medicaid.

AoA & CMS VISION FOR RESOURCE CENTERS

The goal of the ADRC Program is to empower individuals to make informed choices and to streamline access to long-term support. Long-term support refers to a wide range of in-home, community-based, and institutional services and programs designed to help individuals with disabilities.

The vision is to provide individuals across the United States access to ADRCs, which are highly visible and trusted places where people can turn for information on the full range of long-term support options. To help and support these efforts, in 2006, the Older Americans Act was reauthorized with the inclusion of language supporting the development of ADRC efforts in every state.

In many communities, long-term support services are administered by multiple agencies and have complex, fragmented, and often duplicative intake, assessment, and eligibility functions. Figuring out how to obtain services is difficult. A single, coordinated system of information and access for all persons seeking long-term support minimizes confusion, enhances individual choice and supports informed decision-making. It also improves the ability of state and local governments to manage resources and to monitor program quality through centralized data collection and evaluation.

ADRC GRANTEES

AoA and CMS launched the ADRC initiative in the fall of 2003. From 2003 to 2005 43 states were awarded grants to develop pilot programs. Additional funding was awarded in 2006 and 2007 to expand existing states efforts. In 2008, an additional two new states were funded bringing the total number of funded ADRC states to 45.

While grantees are only required to pilot their ADRC in at least one community, they are all striving to replicate the program

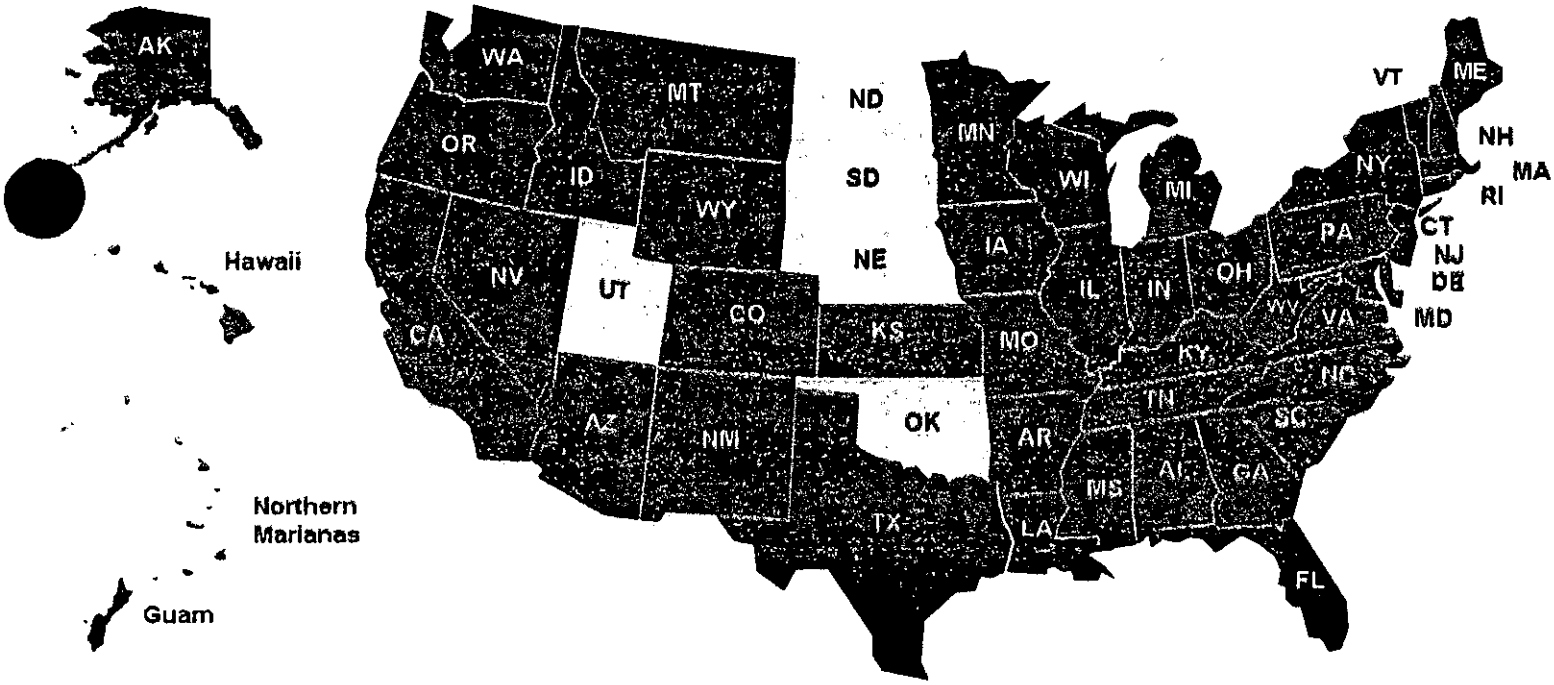
across the entire state. The map below indicates states that have been awarded ADRC grants and the year they received their award. In addition, the map below highlights states which are pursuing ADRC efforts even without receiving specific ADRC grant funds.

ADDITIONAL INFORMATION

For additional information on the ADRC initiative, please visit The ADRC Technical Assistance Exchange website at www.adrc-tae.org. The website includes contact information for AoA and CMS ADRC project officers, summary information on each of the grantees, and a variety of resources related to this initiative.

You can also find additional ADRC information on the AoA website at www.aoa.gov or the CMS web site at www.cms.hhs.gov/newfreedominitiative.

AGING AND DISABILITY RESOURCE CENTER AWARDEES



For More Information

AoA recognizes the importance of making information readily available to consumers, professionals, researchers, and students. Our website provides information for and about older persons, their families, and professionals involved in aging programs and services. For more information about AoA, please contact: US Dept of Health and Human Services, Administration on Aging, Washington, DC 20201; phone (202) 619-0724; fax (202) 357-3523; Email: aoainfo@aoa.gov or contact our website at www.aoa.gov

AGING AND DISABILTY RESOURCE CENTER (ADRC) COMPONENTS

This document was drafted by the North Dakota
Real Choice Rebalancing Grant Steering Committee

An Aging and Disability Resource Center (ADRC), also called a single point of entry, is designed to provide an identifiable place where people can get information, objective advice, and access to a wide range of community supports.

The ADRC must address the following criteria:

1. Ensure "one-stop access" for clients to services; eliminating duplicative assessments and numerous agency contacts.
2. Will serve all adults needing long term care services, targeting older persons and persons with disabilities (non DD). This includes both private pay and public funded individuals.
3. Will serve entire designated service area.
4. Will enter into collaborative agreements with other service providers in the service area.
5. Will coordinate with case management service providers.
6. Will advertise and conduct public education regarding the single point of entry.
7. Will conduct an initial brief assessment (screening) of each individual.
8. As appropriate, will conduct an in-depth assessment utilizing an electronic assessment document compatible within the state system.
9. Will coordinate with the Senior Info-Line, 211, First Link, and any other information and referral services.
10. Will recruit and train volunteers to act as referral sources and sources of basic information in each community.
11. Will provide face to face service to individuals in their own homes in the community, in medical care settings and in long term care facilities.
12. Will utilize a multi-disciplinary approach, to include medical, financial, and social expertise to develop an individual's option/service plan.
13. Will utilize both the formal and informal support networks in meeting the needs of the client.
14. Will determine eligibility for various services (both functional and financial).
15. Will be available 24/7, not to take the place of a crisis management system but to instead ensure timeliness of needed information and services and to streamline the process.
16. Provide follow-up services to include quality assurance.
17. Advocate on behalf of the consumer in securing services.
18. Assure that the service is consumer directed (person-centered approach) and all decisions are made by the consumer or their legal representative.
19. Ensure that consumers and their family members have access to all the information necessary to make decisions regarding continuum of care services.
20. Will provide disclosure of conflict of interest.
21. Create a community advisory committee.

Functions of an ADRC

Awareness & Information

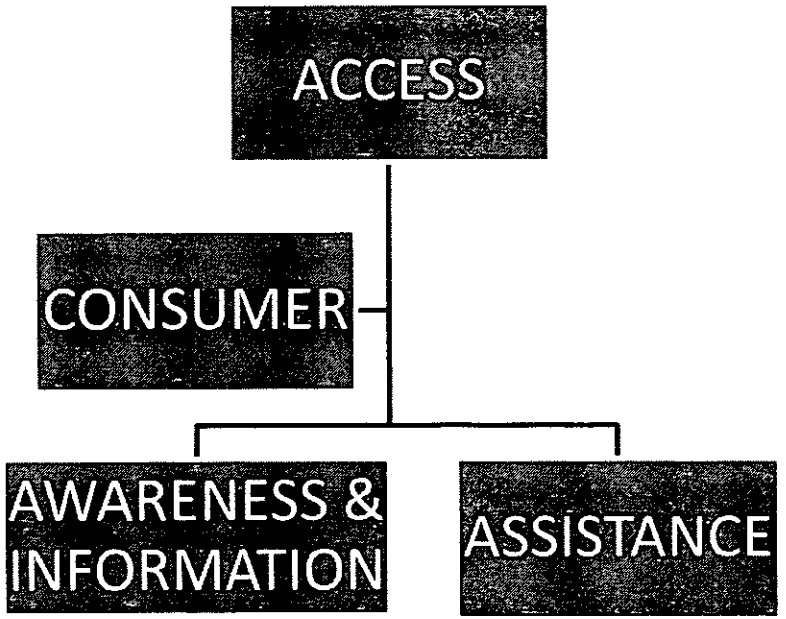
- **Public Education**
- **Information on Options**

Assistance

- **Options Counseling**
- **Benefits Counseling**
- **Employment Options Counseling**
- **Referral**
- **Crisis Intervention**
- **Planning for Future Needs**

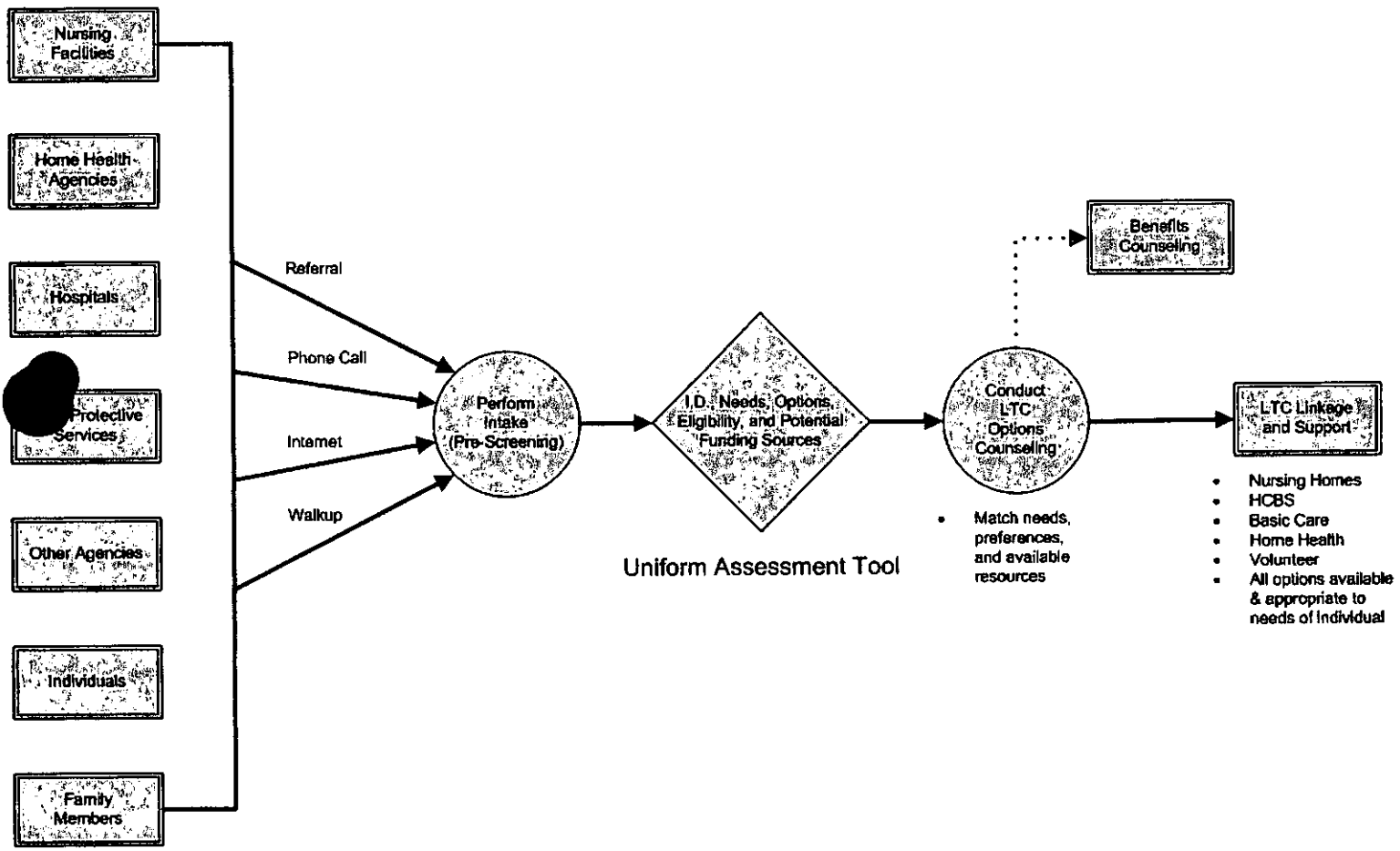
Access

- **Eligibility Screening**
- **Private Pay Services**
- **Comprehensive Assessment**
- **Programmatic Eligibility Determination**
- **Financial Eligibility Determination**
- **One-Stop Access to all public programs**

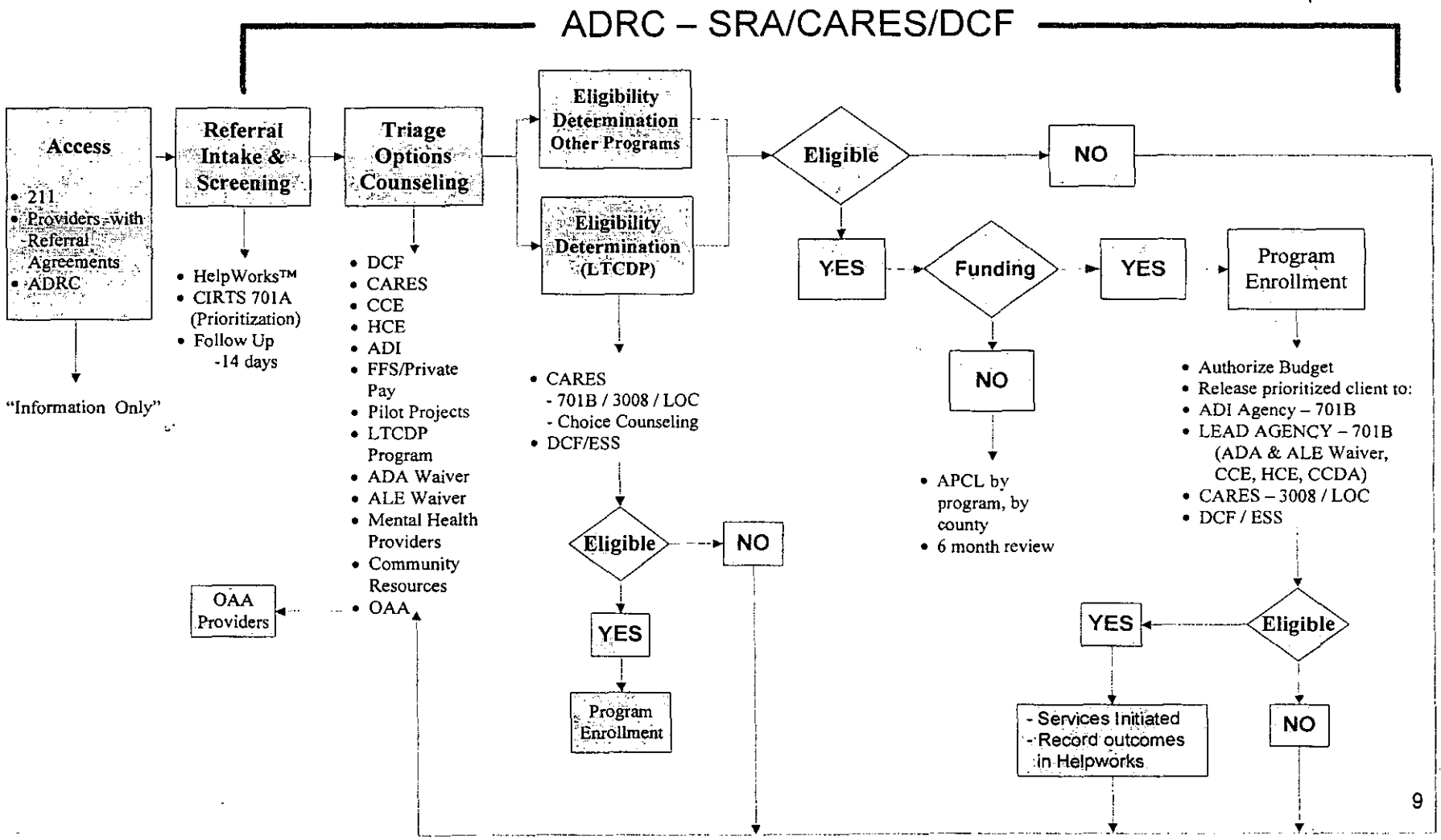


Draft 6.12.06

Example Single Point of Entry (SPE) Operational Flowchart



ADRC Centralized Model



Aging and Disability Resource Center Successes 2008

- ADRCs play an active role in **helping consumers access public benefits** for long term services and supports, making the application process less onerous and more seamless for consumers. **Among the 24 states** awarded grants in 2003 and 2004:
  - **all** assist consumers with **completing financial applications** for Medicaid,
  - **over half** have **functional** eligibility assessors **co-located** with the ADRC,
  - **one-third** have **financial** eligibility assessors **co-located** and
  - **three-quarters** can **track** the **eligibility status** of applicants as they move through the system.

- **Building on the strong existing networks** for Senior Information and Assistance, State Health Insurance Assistance Programs, and Independent Living Centers has resulted in **147 ADRCs serving 28 percent of the U.S. population** with only $39.8 million of federal seed money over a four year period.
  - States used this seed money to continue to **enhance the I&A infrastructure** to support cost-effective and efficient delivery of information.
    - **21 states** have statewide long term supports and services **resource directories** accessible to the public and professionals **via the internet** (twelve of them new since ADRC and another seven significantly enhanced through the ADRC project) and another **16** are **in the process** of developing similar statewide capability.
    - **34** of the 43 ADRC states have **Medicaid applications available on the internet** with **seven** of these (and another four in process) allowing consumers to complete the application online and **submit it electronically.**
    - **Five** ADRCs have **online consumer decision tools** and another **six** are in the process of **developing** such capability
    - ADRC pilot sites developed **information exchange protocols across partners** so consumers only have to tell their story once.
    - Several ADRCs use **portable technology** for data entry and scanning documents; eight states use laptops in the field and three employ portable scanning or photography.
  - ADRCs have furthered states' ongoing efforts to **improve access to long term supports** and services by strengthening **partnerships**, establishing **minimum standards** of service, fostering **consistency**, enhancing **professionalism**, and emphasizing the **consumers' perspective** in all activities.

- By **serving all income groups and across disabilities**, ADRCs **overcome the stigma associated with Medicaid** and can assist a wide range of individuals, including family

caregivers, in obtaining long term supports and services in the most desirable and appropriate setting.

- By intervening in **critical pathways** to long term services and supports, such as hospital discharge planners, physicians or other health professionals, or long term supports providers, through options counseling, ADRCs convey the range of alternative services and settings available, as well as methods to pay so individuals can both plan ahead and make informed decisions about current needs.
    - Nearly **one-half** of the individuals contacting ADRCs to date were **referred by critical pathway entities.**
    - While measuring **diversions from nursing facilities** is difficult, among the 13 states with a 25 percent decline in Medicaid nursing facility users per 1,000 elderly over the 1995-2005 period, **six** of them conducted **pre-admission screening through a single entry point** as of 2002 (Mollica and Gillespie, 2003). The **top three states** (Maine, Washington and Oregon, **all with declines greater than 35 percent** compared to a national average of 15.2 percent) all **have pre-admission screening through a single entry point.** In contrast, only six of the 23 states below the national average of 15.2 percent used pre-admission screening through a single entry point. [A total of 19 states used pre-admission screening through a single entry point for Medicaid entrants into nursing facilities in 2002].
    - ADRCs will play a **critical role in nursing facility transitions** under the Money Follows the Person Demonstration (MFP). Of the 31 **MFP states, 24 have ADRCs** and **18** of these ADRC have indicated that they **will play a role** in the grant implementation.

- States recognize the value ADRCs provide and:
    - **Over half** of the 43 ADRC grantees have passed **legislation,** developed **executive guidance,** and/or contributed **state funds** to enhance and expand ADRCs.
    - **State funding** contributions to date, not including the required match for the grants, **exceed $36 million.**
    - **Eleven ADRC grantees** have achieved **statewide coverage** with their ADRCs and
    - **Kentucky,** similar to **Wisconsin,** plans to use **the ADRC as the entry point to managed long term care** in the state.

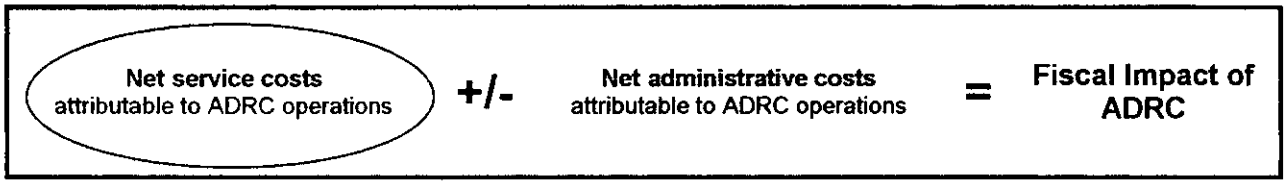
Options for Assessing the Impact of ADRCs on Long Term Care Costs

Measuring the effect of ADRCs and other initiatives that promote home and community-based services (HCBS) presents a major challenge. ADRCs comprise one component of complicated and constantly evolving state long term care (LTC) systems. States often simultaneously pursue multiple initiatives to promote HCBS, and the private market adapts to consumer preferences and financial opportunities, resulting in many intervening variables that make it difficult to determine the direct impact of specific initiatives. Nonetheless, there are multiple strategies for collecting evidence about the way ADRCs impact the broader LTC system.

This paper focuses on assessing the fiscal impact of ADRCs. While ADRCs might result in cost savings for Medicaid programs, many would argue that reducing unnecessary utilization and supporting community integration are important goals regardless of fiscal considerations. Nonetheless, policymakers in state and federal government have a major stake in better understanding the overall fiscal impact of implementing ADRCs.

As depicted in ***Exhibit 1***, the fiscal impact of ADRC operations includes two components: net service costs attributable to ADRC operations (new service costs minus offsets for shifting utilization to more cost-effective services) and net administrative costs attributable to running the ADRC (new administrative costs minus new administrative efficiencies). This paper focuses on the net service cost component of this equation. Whether these costs are positive or negative will determine what effect the ADRC has on overall costs.

Exhibit 1: Fiscal Impact Equation



Methodologically, a randomized control trial that assigns one group of people to receive ADRC assistance and others to a control group that does not would be considered the best and most robust way to study the impact of ADRCs. In practice, however, such a trial is impractical and unethical, and as such, has not been implemented by any ADRC grantees. Other methods for assessing the fiscal effects of an ADRC, such as the pre/post analysis discussed below, have serious limitations. Therefore, we recommend that evaluators approach this issue from multiple perspectives. A body of suggestive evidence, drawn from multiple types of analysis, can be compelling to policymakers even if any single measure has methodological limitations.

In this brief, we discuss three basic strategies for assessing the service costs and cost savings attributable to ADRC operations due to reduced use of institutional LTC services. We focus on institutional service utilization most typical of older adults and people with physical disabilities (i.e., nursing facility services), although the same logic can generally apply for other populations.

The strategies presented here are intended to be broadly applicable, but each can be tailored to the circumstances of a particular state or ADRC site. We have made every effort to simplify the analyses, at the expense of some important methodological considerations. We encourage you to use these strategies as starting points for additional thoughts on methodological refinement.

STRATEGY #1: PRE / POST ANALYSIS

The pre/post analysis strategy focuses on changes in service utilization before and after ADRC implementation. There are several measures against which pre/post analysis can be applied to help assess the fiscal impact of an ADRC.

Overview: Comparing nursing facility and HCBS expenditures before and after ADRC implementation.

Theory: By helping clients connect with resources, assess their options, and plan for future needs, ADRC activities should result in a decrease in the use of nursing facilities and an increase in the use of HCBS services for people enrolled in public programs. Although public spending on LTC may continue to grow (due to demographic trends and rising costs of services), this shift in services may slow the rate of growth.

Limitations: There are many intervening variables that make it difficult to isolate the impact of ADRCs or to attribute any changes over time to the ADRC initiative specifically. The more changes in the LTC system that coincide with ADRC implementation, the more difficult it will be to interpret the results of the analysis and make any conclusions about the impact of the ADRC.

What would I need to make this strategy work?

- Information about Medicaid nursing facility costs before and after ADRC implementation – in the aggregate and per capita
- Information about costs for HCBS, including Medicaid waiver costs, before and after ADRC implementation
- An understanding of other changes in the LTC system and how they may be overlapping with or working against the effect of the ADRC
- Sufficient amount of time in operation as an ADRC

Exhibit 2 provides an example for an ADRC that began operations on the first day of 2003.

Exhibit 2: Total LTC Costs, Before and After ADRC Implementation

	Period before ADRC implementation			Period after ADRC implementation	
ADRC areas	2000	2001	2002	2003	2004
Medicaid nursing facility costs (state share only)	$190,000,000	$199,500,000	$209,475,000	$216,806,625	$221,500,000
Medicaid HCBS costs (state share only)	$25,000,000	$26,275,000	$27,500,000	$28,400,000	$32,000,000
State-funded LTC	$10,000,000	$10,500,000	$11,025,000	$11,410,875	$11,900,000
Total	$225,000,000	$236,275,000	$248,000,000	$256,617,500	$265,400,000
Percent Change in Total LTC Costs		5.0%	5.0%	3.5%	3.4%
Difference in Rate of Change ((average rate 2000-2002) - (average rate 2003-2004))					1.6%

In this example, the rate of change in LTC costs declined from 5.0 percent to 3.4 percent after ADRC implementation. Because the rate of increase declined, this may be seen as a cost-savings. This cost savings can be converted into a dollar value, as shown in ***Exhibit*** 3.

Exhibit 3: Savings from a Decline In the Rate of Cost Increases

Baseline costs before ADRC implementation	Costs if they continued to increase by 5%	Actual costs after ADRC implementation	Difference
$225,000,000	$273,488,906	$265,400,000	$8,088,906

When looking at aggregate numbers, it is important to control for changes in cost, which vary from year to year. Major fluctuations in reimbursement rates, especially for nursing facility services, and other new or changing factors in the reimbursement system (e.g., intergovernmental transfers, provider taxes, and upper payment limits) also warrant careful consideration.

Advantages: This approach is straightforward and intuitive. By focusing on aggregate LTC costs, it gives a high-level overview and factors out any cost-shifting between programs.

Disadvantages: Many variables affect the trajectory of LTC costs that are independent of ADRC implementation, including concurrent changes in the LTC system and changes in Medicaid payment rates and eligibility rules. For example, a large increase in Medicaid payment rates to

Senate Appropriations Committee Testimony on HB 1012 – Medicaid Funding – PACE
Rodger Wetzel, Director, Northland PACE Senior Care Services Program

Mr. Chair and members of the Committee:

My name is Rodger Wetzel. Currently I am the Director for the Northland PACE Senior Care Services Program. We have developed this program first in Bismarck-Mandan and Dickinson, and plan to expand to other communities in the near future, after our first federal review.

PACE stands for "Program of All-inclusive Care for the Elderly." The emphasis is on "All-inclusive." I have attached our PACE brochure and the NDDHS PACE fact sheet. The NDDHS has supported our program since the beginning. All participants must be screened eligible for nursing home level of care, but cared for at home for as long as possible. It is a capitated program, whereby we receive a monthly fee for all usual Medicare, Medicaid, and HCBS services provided.

I have worked in the field of aging in North Dakota since I was 26, and I will turn 65 this year...almost 40 years of "aging" experiences in ND. Previously I served as Director of Eldercare at St. Alexius for 23 years; and prior to that I was the Assistant Administrator of the Aging Services Division of the NDDHS. While there I helped develop the first HCBS services for N.D. And now, PACE is a great example of the coordinated, comprehensive, preventive care for senior adults that many of us have hoped for and envisioned for many years.

We all know the rising cost of LTC services in ND, and our aging population, especially those over age 85. We also know the advantages to seniors and payers of keeping elderly in their own homes as long as possible. My mother is slowly recovering in a nursing home from a hip fracture, but we hope to return her to an apartment in the near future, with in-home services.

The legislature has funded many successful and cost effective home and community based services, such as SPED, expanded SPED, Medicaid Waiver Programs, etc. It is my understanding that the House considers those HCBS programs a priority in the NDDHS budget. PACE is the most comprehensive of these types of programs, combining HCBS services with medical, healthcare, preventive, social, and other services needed by each participant, for as long as they live. PACE program services cost an average of ½ of the average cost of nursing home care to Medicaid, and private payers. So it is financially advantageous to senior adults, their family members, Medicaid, and LTC insurances. Our very first PACE participant in Dickinson was moved out of a nursing home back to her own home.

It is my understanding that the NDDHS budgeted dollars for Medicaid, which would include LTC funding, which includes funding for PACE, has been reduced by the House. We are requesting no reduction in Medicaid funds for PACE, as these funds are necessary for us to expand PACE services to include more low-income participants in North Dakota. (over)

We have seen some of our PACE participants exhibit significant improvements in their health in just a short time after enrolling in PACE.

PACE staff monitor the participant's health status on a regular basis, sometimes daily. If a health problem occurs, staff generally will notice it, or be informed of it as soon as possible. Staff may notice changes while providing in-home services, services at the PACE center, through regularly checking vital signs, or through lab tests, such as blood or urine. They can see a doctor or nurse practitioner most days, if necessary.

We make sure that necessary medications are taken at the proper times. In the past they may have taken the wrong medications, taken too many, or taken too few. We also want to make sure our participants are eating healthy meals every day. This may include their eating meals at the PACE Center, having 1-2 daily meals delivered, microwavable meals, assisting with preparing meals, assistance with shopping for foods, or supplements.

A final reason for their health improvements is that PACE participants are encouraged to come to the PACE center on a regular basis for clinic and health services, therapies, noon meals, and recreation. Just getting out of the house and into a positive health-oriented environment can make a difference in lives of homebound older persons. We pay for all needed transportation to the center and all other needed appointments.

I ask for your support for Medicaid funding for PACE services during the next biennium. We have heard strong support for the PACE alternative model from many public and private agencies serving senior adults, as well as payers.

Thank you. I would be happy to answer any questions.

north dakota department of human services

Fact Sheet

September 2008

Program of All-inclusive Care for the Elderly (PACE)

Background:

- The Balanced Budget Act of 1997 established the PACE model for both Medicaid and Medicare programs.
- PACE providers receive a set amount of money on a monthly basis for each eligible Medicare and Medicaid enrollee to provide patient-centered and coordinated care to frail elderly individuals living in the community.
- PACE has been approved by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidenced based model of care.

What is PACE?

PACE programs provide a comprehensive service delivery system which includes all needed preventive, primary, acute and long term care services so that individuals can continue living in the community. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees. For most participants, the comprehensive service package permits them to continue living at home while receiving services. Providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.

Who Can Participate?

Participants must:

- Be a Medicare or Medicaid enrollee who is age 55 or older,
- Be eligible for nursing home level of care, and
- Live in a PACE service area.

PACE Services:

The emphasis of the PACE program is on enabling participants to remain in their community and enhancing their quality of life. A team of health care professionals from different disciplines assesses each participant's needs, develops a care plan, and delivers all services (including acute care and nursing facility services if necessary). Minimum services that must be provided in the PACE center include primary care services, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals. The services are provided primarily in an adult health center, supplemented by in-home and referral services in accordance with a participant's needs. PACE is a voluntary program.

Location:

The Northland Healthcare Alliance has developed two PACE organizations in North Dakota. They are located in Bismarck and Dickinson. The Bismarck PACE program is able to serve 150 enrollees and Dickinson is able to serve 25 enrollees.

Contact Information:

For information about PACE and how to enroll into the program, contact Northland PACE:

- Bismarck 701-751-3051
- Dickinson 701-456-7387
- Toll Free 1-888-883-8959

National PACE Association

Responding to the Unique Needs of Seniors and their Families

Program of All-inclusive Care for the Elderly (PACE)

PACE programs coordinate and provide all needed preventive, primary, acute and long term care services so that older individuals can continue living in the community. PACE is an innovative model that enables individuals who are 55 years old or older and certified by their state to need nursing home care to live as independently as possible. Through PACE, today's fragmented health care financing and delivery system comes together to serve the unique needs of each individual in a way that makes sense to the frail elderly, their informal caregivers, health care providers and policy makers.

PACE Programs Offer High Quality Care and are Proven Cost Effective

- PACE utilizes interdisciplinary teams - including physicians, nurse practitioners, nurses, social workers, therapists, van drivers and aides - to exchange information and solve problems as the conditions and needs of each individual who decides to participate in PACE change - all with the objective of enabling participants to live longer in the community.
- PACE provides participants regular access to doctors and other primary care professions who know them and who specialize in caring for older people.
- PACE participants have improved health status and quality of life, lower mortality rates, increased choice in how time is spent, and greater confidence in dealing with life's problems, according to a recent Abt Associates study.
- The PACE financing model combines payments from Medicare and Medicaid or private pay sources into one flat-rate payment to provide the entire range of health care and services, including paying for hospital care, in response to individual needs.
- PACE utilizes transportation systems to enable participants to live as independently as possible in the community while having access to the supportive services, medical specialists, therapies and other medical care they need.

Characteristics of PACE Participants

- The average age of PACE participants is 80 years old. Seventy-five percent of participants are female.
- The average PACE participant has 7.9 medical conditions, many of which are chronic conditions includ ing diabetes, dementia, coronary artery disease, and cerebrovascular disease.
- While most PACE participants live alone in the community, approximately 7% live in nursing homes for which the PACE program pays.

For more information about the National PACE Association or NPA Membership, call 703-535-1565 or visit www.NPAOnline.org.

10/03

801 North Fairfax Street • Suite 309 • Alexandria, Virginia 22314
Phone: 703-535-1565 • Fax: 703-535-1566 • www.NPAonline.org

North Dakota Department of Human Services
HB 1012 - LTC Continuum
PACE Allocation
To the House

	Adjustments Made for PACE		
PACE Allocation	09-11	Monthly Average Beds/Recipients/ Units	Allocation
Nursing Facilities	7,098,828	63	96.01%
Personal Care	140,634	5	1.90%
HCBS Waiver	23,091	1	0.31%
Inpatient Hospital	48,407		0.65%
Drugs	82,751		1.12%
Totals	7,393,711	69	100.00%

*** Allocation is based upon an analysis of claims data used by the actuary in the preparation of the per member, per month payment.

Of the nine (9) current clients, three (3) came from nursing homes, one (1) was receiving SPED services, one (1) was receiving HCBS Waiver services, and one (1) was receiving both SPED and Waiver services. The other three (3) were not previously receiving services.

Northland PACE Description

The Northland PACE Program is designed specifically to maintain independence for seniors by offering comprehensive, coordinated healthcare services through a single organization.

Advantages to participating in Northland PACE include:

- Dedicated, qualified healthcare professionals
- Long-Term care services
- Coordinated care 24 hours a day, 365 days a year
- Support for family care givers
- Personalized individual care

mission

Northland Healthcare Alliance, dedicated to the healing mission of the elderly, is a combined effort of its members to collaborate through our Northland PACE Project to provide healthcare services especially for the frail elderly in our communities by fostering independence, optimizing function, preserving dignity and assisting them to live in their community for as long as they are able.

NORTHLAND PACE

Program of All-Inclusive Care for the Elderly

NORTHLAND PACE

Program of All-Inclusive Care for the Elderly

dedicated to providing the **highest level of care to seniors** in our community

What is Northland PACE?

Northland PACE serves the elderly in our community. PACE is designed to keep seniors who are at risk for nursing home care living independently at home by providing the highest level of healthcare. Northland PACE employs a team of professionals called a care team that coordinates all aspects of healthcare for PACE participants. Our team approach promotes personal attention while adding quality to your or a loved one's life.

What is the Northland PACE care team?

Your care is provided by a team of specialists. This team includes a physician, a nurse practitioner, registered nurse, social worker, rehabilitation and recreation therapists, health aides and several others who will assist in your healthcare.

Our goal is to help you increase your quality of life allowing you to continue living at home.

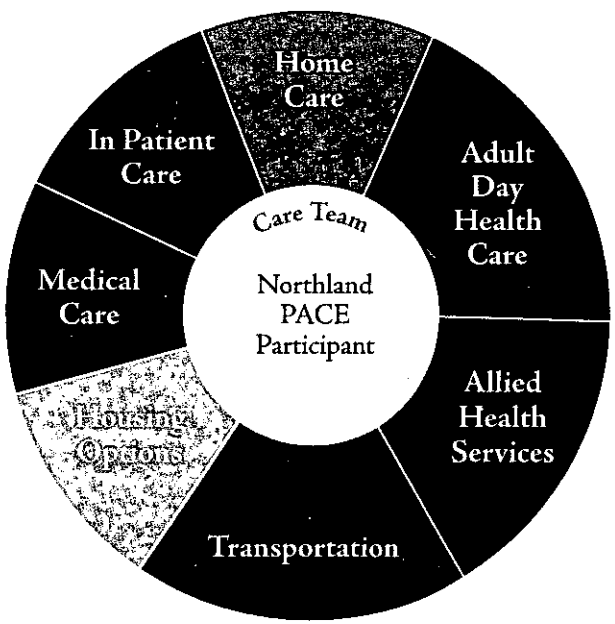
Who is eligible for Northland PACE?

To be eligible to enroll in the Northland PACE Program you must:

- Be at least 55 years old.
- Meet nursing home level of care.
- Be able to live safely in the community.
- Live within an area served by Northland PACE.

How much does PACE cost?

Northland PACE program accepts Medicare and Medicaid. Individuals eligible for Medicaid may have a monthly spend down amount calculated based on financial criteria. The spend down or private amounts are not impacted by a change in the PACE participant's health status. There are no hidden costs or deductibles.



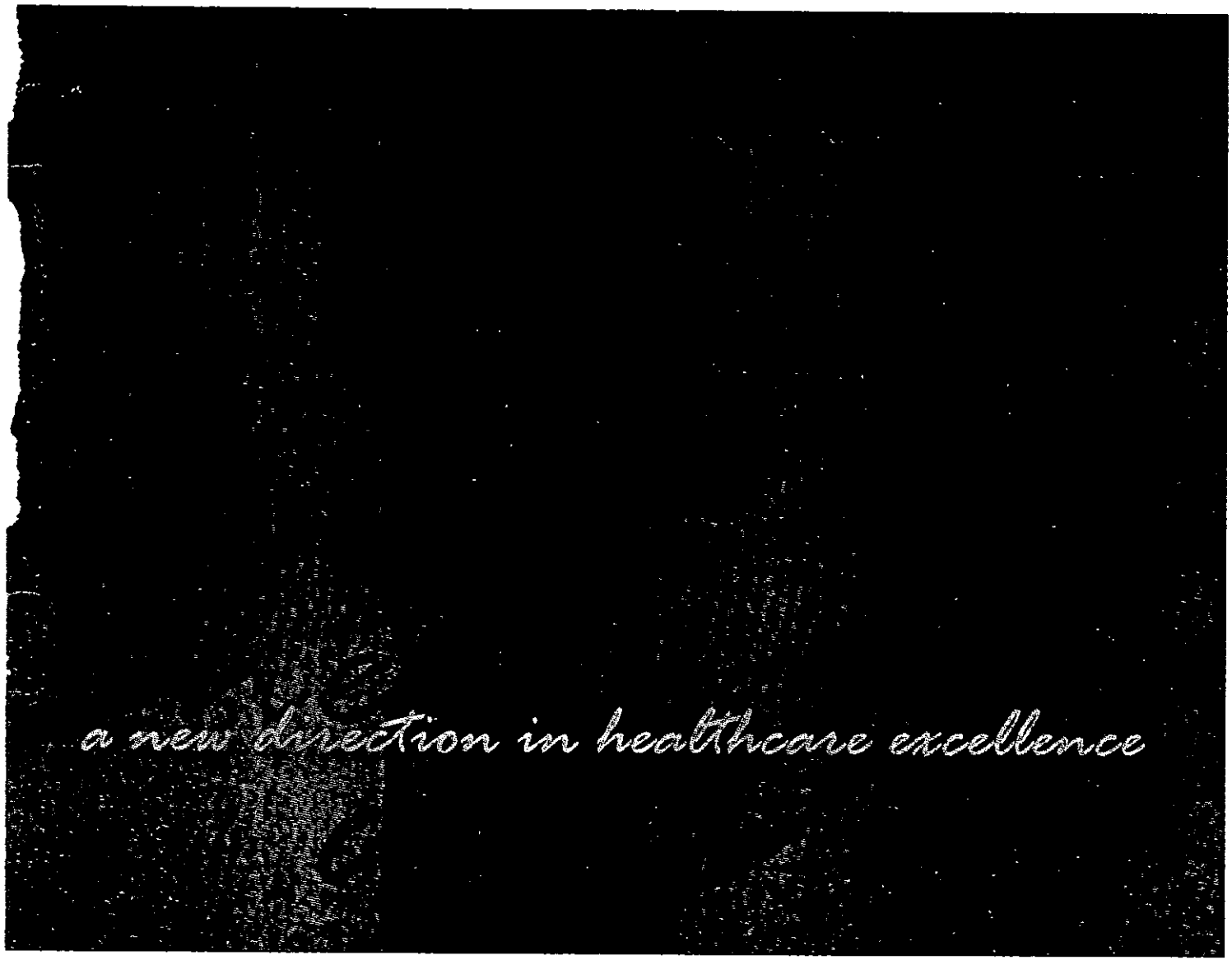
How is Northland PACE different from other healthcare providers?

Northland PACE has several different caregivers available to meet your healthcare needs every day to ensure you have the highest quality of care. With the Northland PACE care team, you won't fall through the cracks.

What services are available with Northland PACE?

- Comprehensive primary medical care provided by a Northland PACE physician
- Meals and nutritional counseling
- Services of medical specialists, including audiology, dentistry, optometry, podiatry, and speech therapy
- Home health care and personal care
- All necessary prescription drugs
- Social services
- Adult day center with therapists (physical, occupational, and recreational) and nursing care
- Hospital, emergency service and nursing-home care when necessary
- Transportation

NORTHLAND
HEALTHCARE ALLIANCE



MEMBER SERVICES

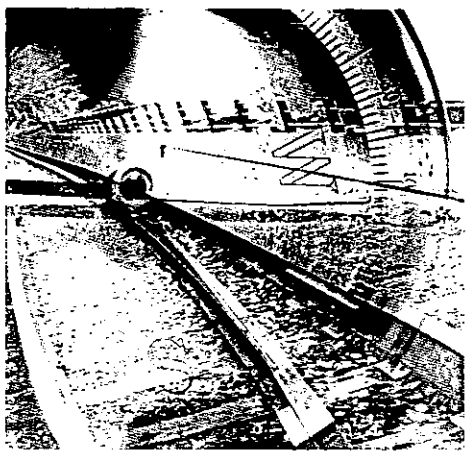
Sponsored by a partnership of Catholic Health Systems

The past 11 years have gone by faster than any in my life. I attribute that to the dynamic aspects of being involved in a network like Northland Healthcare Alliance. We have gone from a fledgling entity with two employees to a multi-faceted organization with more than 20 employees working on a full range of healthcare services. I never imagined that we would be running mobile MRI scanners down the road or that we would be buying huge amounts of natural gas in bulk for our members and other facilities. We have pursued programs that provide benefit to the members that participate and the formula of working together has paid off. Northland Healthcare Alliance is a unique entity in many ways. Many healthcare networks are founded and survive by aligning with a large Group Purchasing Organization (GPO). Northland has not done this and has relied on other programs to benefit its members.

I believe the key to our success has been and always will be the support and participation of our members in the idea-generating and development of the programs that are offered. We are unique because through these idea-generating sessions, we have created a slate of services for our members that are different from any network in the country.

This brochure provides a glimpse of the services and programs we offer. Take a few minutes to peruse this booklet and see if there are offerings that can benefit your organization. Better yet if you think of other ideas that would fit the network model, please feel free to call us. That is part of the power of the network model.

Timothy C. Cox, President



mission

Northland Healthcare Alliance, a Catholic-led integrated health care delivery network whose members include both Catholic and other partners, has as its purpose to enhance the healing mission of the Catholic health care ministry in the Dakotas.

The creation of Northland Healthcare Alliance was based on the desire to provide a working vehicle to insure the continuation of value-based healthcare in the Dakotas, and to have a far-reaching effect on the improvement of the health status of individuals in our communities, particularly in rural areas. Rural healthcare, since the organization of Northland Healthcare Alliance in 1996, has become a focus of law-makers in both state and federal levels to promote and support clinics, hospitals and long-term care facilities in rural communities.

Northland Healthcare Alliance is an integrated health care delivery network whose members include both Catholic and other partners. The creation of Northland Healthcare Alliance was based on the desire to provide a working vehicle to insure the continuation of value-based healthcare in the Dakotas. In addition, the Alliance strives to have a far-reaching effect on the improvement of the health status of individuals in our communities, particularly in rural areas. Since the organization of Northland Healthcare Alliance in 1996, lawmakers at both the state and federal levels have increasingly focused on promoting and supporting clinics, hospitals and long-term care facilities in rural communities.

Northland Healthcare Alliance is able to provide services directly to its members at a greatly reduced fee because of its ability to negotiate group pricing. Some services are provided at no charge as an added benefit to our members.

equipment services

Anesthesia Equipment Services: The Alliance has negotiated several joint services contracts that have reduced costs for anesthesia equipment service. Northland receives best pricing because of the large volume the group brings to the table.

Thermo Asset Management: Northland Healthcare Alliance uses Thermo Asset Management to manage maintenance and repairs of large capital equipment such as CT scanners, magnetic resonance imaging (MRI) equipment, and radiology and catheterization lab equipment. In addition to maintenance, Thermo Asset Management also offers analysis of new purchases to determine if the organization is receiving best pricing compared to similar organizations across the nation. Thermo Asset Management has an extensive database of information addressing repairs, equipment parts and service vendors to assist in maintaining these pieces of equipment. Members can still maintain their relationships and services with the original equipment manufacturers (OEM's) for their service work if they choose.

Sterilizer Maintenance Services: Member facilities rely on Northland for sterilizer maintenance services including inspections, preventive maintenance and repair of steam and gas sterilizers, decontamination washers, surgical tables and surgical lights. In addition, consultation to help determine needs, purchase and install equipment is also available. Our technicians have more than 30 years of experience working with sterilizer equipment in this area.

Biomedical Equipment Services: By taking advantage of biomedical services offered through Northland Healthcare Alliance, organizations can be assured of receiving the expertise necessary to ensure medical equipment meets manufacturers' standards in accordance to both safety and functionality. Our biomedical engineer will come on site to inspect, maintain and repair patient care monitors, defibrillators, fluoroscopes and ultrasound electrostimulization units. This accessibility translates into quick turnaround for repairs as well as eliminating the time and cost involved in sending equipment to the manufacturer for repair. Member facilities also receive site inspection reports necessary for accreditation and JCAHO requirements.

group contracting

Infectious Waste: Northland members benefit from discounted group contract rates for handling infectious waste. Northland also works with facilities to reduce the volume of infectious waste through staff training.

Natural Gas Purchasing: Northland Healthcare Alliance is one of the largest purchasers of natural gas in North Dakota. Northland Healthcare Alliance has created a large purchasing group of 23 entities that purchase natural gas in bulk. Extensive savings have been generated each year through the group purchase.

clinical services

Health Information Management Services: Northland Healthcare Alliance members benefit from expertise available through Northland Health Information Management (HIM) Services.

HIM Services include the following:

- Interim coding assistance for vacation/extended leave situations
- Coding audits (hospital and clinic)
- HIM consulting services (hospital, clinic and nursing home)
- General HIM department and record reviews
- Policy development
- HIPAA compliance reviews

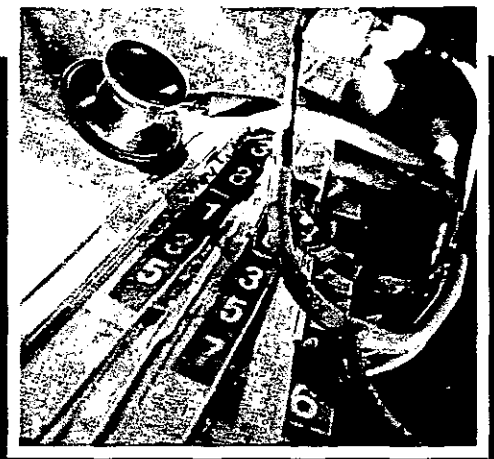
Staff and provider education is provided on a variety of subjects such as coding, documentation, compliance issues and HIPAA.

Mobile Imaging Services: Mondak Imaging Services LLC, a partnership between Northland Healthcare Alliance and Montana Health Network, provides magnetic resonance imaging (MRI) services to members in Montana, North Dakota and South Dakota. These mobile MRI units travel to member facilities to provide convenient, high-quality diagnostic imaging. Because services are provided on-site, patients and physicians receive results more quickly. In addition, facilities benefit by providing another revenue-generating service and offering state-of-the-art technology to patients without having to purchase the equipment. The mobile units are staffed by radiologic technologists who have attained national MRI certification.

Clinic Services: Clinic services focuses on improving health care delivery through the primary care clinics. In addition to disease management and quality improvement, clinic redesign workshops are available to our members. Billing support is also available to members.

Clinics are an integral partner for the future of hospitals and long term care facilities. Northland is developing approaches to help connect clinics and hospitals digitally so patient information can flow between each entity.

Telemedicine Services: Northland provides members the opportunity to participate in teleconference call capabilities for one-on-one clinical consults or group meetings of up to 50 locations. Members can take advantage of these services for educational purposes as well as administrative meetings. Telemedicine is the first step of a multi-step approach of bringing connective information technology to all member sites. Individuals in your community will appreciate being able to stay in their home town to receive many specialty services.



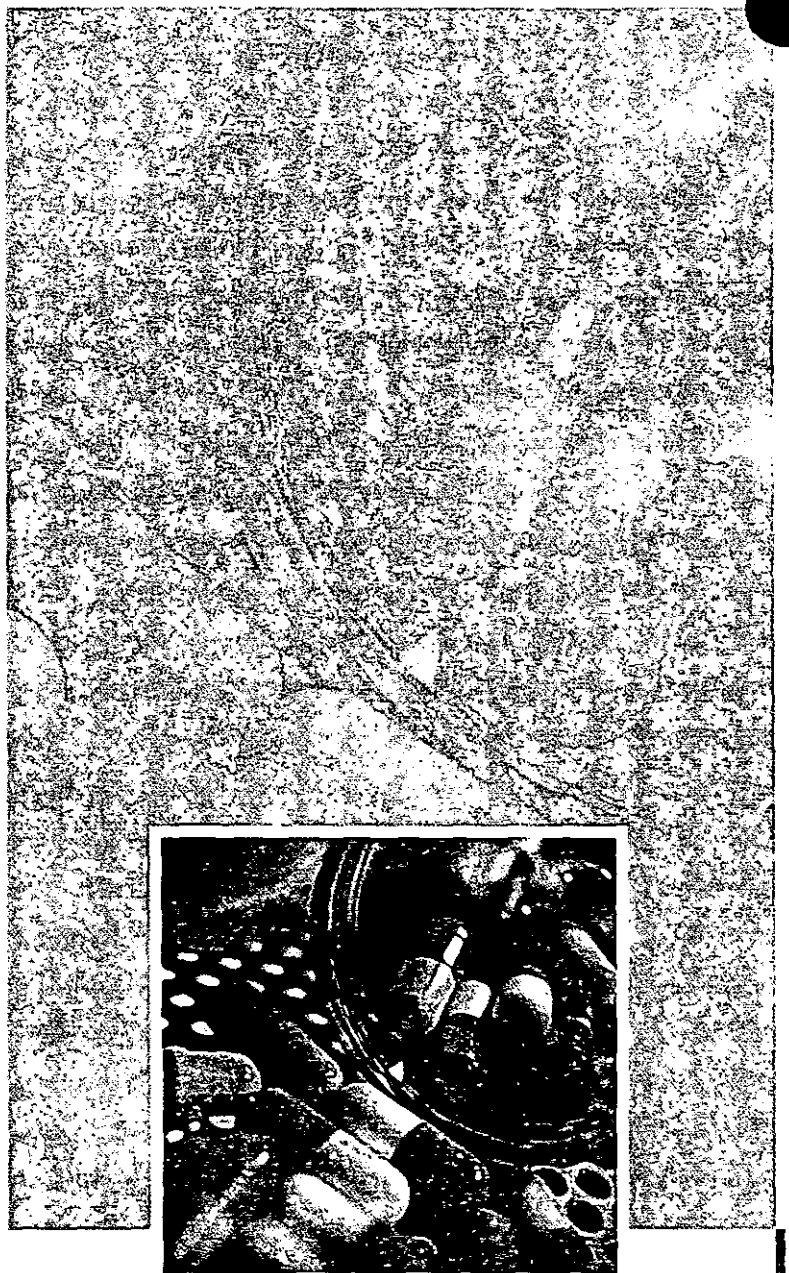
employee benefits

Cafeteria 125 Flexible Benefits: Northland Healthcare Alliance partners with Total Administrative Services Corporation to administer flexible spending accounts.

This service helps employees to pay for certain qualified services on a pre-tax basis. Paying for approved benefits with per-tax dollars reduces the amount employees pay in taxes and increases take-home pay.

Expenses including dental care, prescriptions, eyeglasses and out-of-pocket medical expenses are eligible. The program also includes savings for dependent care services and some transportation expenses.

Life Insurance: Members benefit from Northland's ability to negotiate preferred pricing based on its group size and buying power. This preferred pricing also applies to employee life insurance programs. Northland offers an excellent life insurance product at a reduced cost for its members. Members have saved thousands of dollars on a benefit that is relatively inexpensive and gives employees some peace of mind.



collection services

Recovery Resources, LLC: Recovery Resources, LLC, a full-service collection agency specializing in the healthcare industry, is owned by Northland Healthcare Alliance, Medi-Sota and Montana Health Network. As experts in the medical collection industry, Recovery Resources' staff members offer users exceptional customer service and reasonable commission rates with no up-front costs. Recovery Resources offers collections services on medical accounts. If payment in full is not an option, Recovery Resources' staff will work with the debtor to develop a reasonable payment schedule. If necessary, legal action, including garnishments and/or executions, may be considered if payment is not collected.

Recovery Resources also offers a program called LoanTrak Account Management. LoanTrak is an account management service provided by Alliance Financial Services, a subsidiary of Recovery Resources. This program amortizes loans, prints disclosure statements, generates coupon booklets, collects and tracks interest and principal payments, and identifies slow pay accounts for action or review.

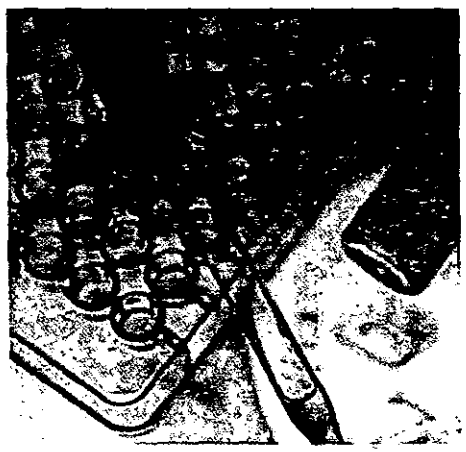
In addition, Recovery Resources offers the following services:

- Up-to-the-minute online account information
- Credit reporting
- Monthly, quarterly and annual reports
- Custom reports upon request
- Skiptracing
- Collection training and education
- Access to Recovery Resources' knowledge and resources
- Site visits

other services

Benchmarking Services: Hospital benchmarking software is available to members from Northland through membership in the National Cooperative of Health Networks Association. This software was developed by the Pioneer Health Network to assist smaller hospitals in collecting data to track and benchmark best practices. For a modest annual fee, the information allows a member to evaluate how its facility compares with like hospitals in North Dakota and throughout the country.

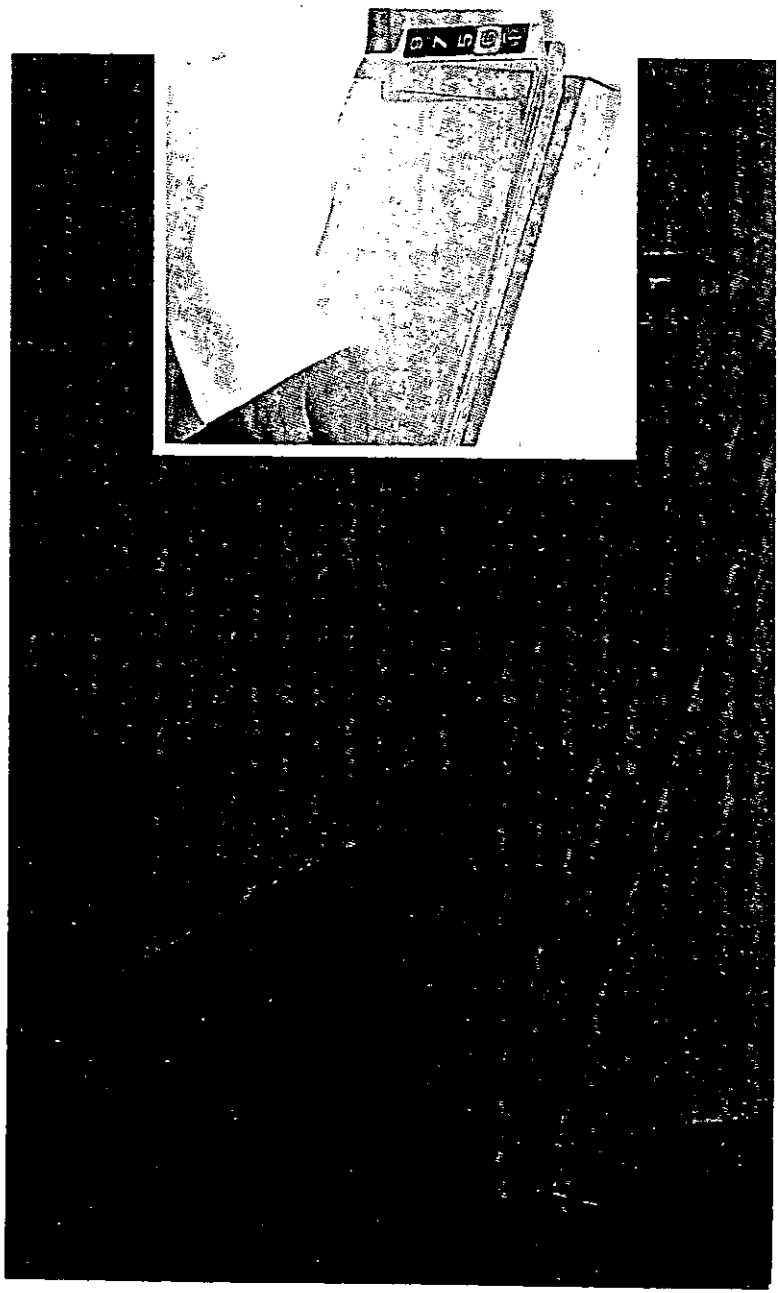
Education and Roundtables: The ability to work with other facilities and individuals to expand available resources for is just one benefit of network membership. Northland capitalizes on this and brings together task forces to share information and, in many cases, to develop programs or products relating to their respective interests. The 15 task forces include the following groups: behavioral health; capital equipment; community health needs assessment; critical access hospital; education; financial services; information technology, HIPAA, human resources, marketing, medical records, membership-new member recruitment, physician services; plant services and quality improvement. Northland sponsors an ongoing leadership development course for middle managers. This course covers a comprehensive set of training modules addressing strategic planning, problem solving, communication, budgeting, conducting meetings and conflict resolution.



Grant Development: Northland Healthcare Alliance has assembled a group of individuals with expertise to assist facilities in grant writing endeavors. In addition, the Alliance has vigorously pursued relevant grant programs to augment the resources of the network and expand programs that will assist each entity in fulfilling its mission. Funding organizations respond more favorably to applications that offer impact in more than 15 communities.

Critical Access Hospital Services: Assistance is also available for critical access hospital issues such as quality/compliance issues, financial aspects and general regulation compliance. Our staff has received extensive training to assist and facilitate issues that affect critical access hospital facilities. This resources is available to members to support them on an on-going basis.

Marketing Services: Northland offers services and support to develop and enhance marketing activities of member organizations. Expertise is provided for assisting with marketing and public relations functions including print material production, event coordination and marketing campaign planning and implementation.



NORTHLAND
HEALTHCARE ALLIANCE

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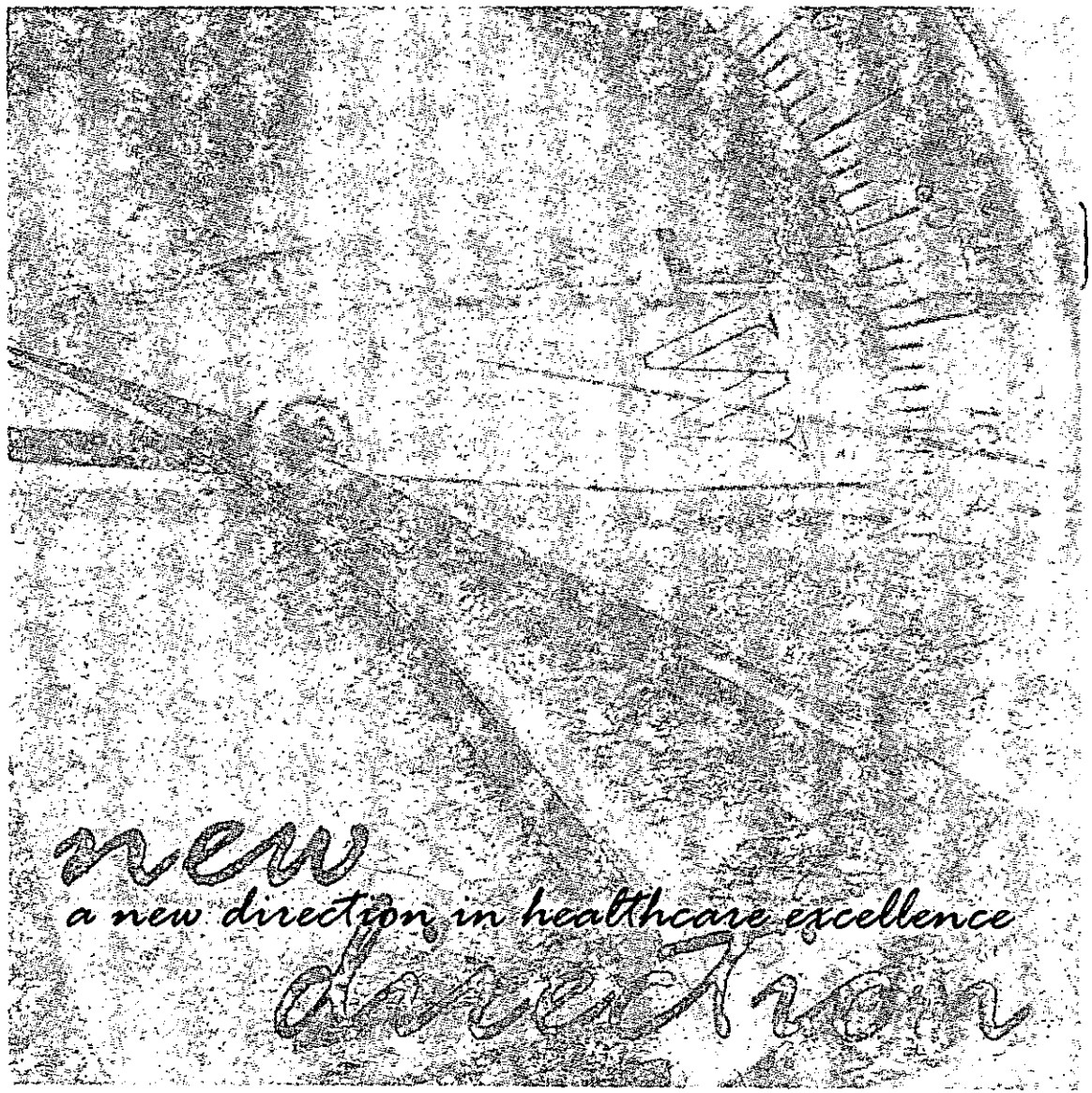


Testimony
House Bill 1012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
January 27, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, for the record, I am Edie Armey , Director of TrainND Northeast, formerly known as Workforce Training, a division of Lake Region State College. I am writing to provide testimony regarding the budget of the Aging Services Division.

Since 2001, we have worked under contract with the Division of Aging Services to deliver a training program for Qualified Service Providers. TrainND Northeast is honored to continue this valuable service. This program is delivered statewide with the aid of 69 Registered Nurses as trainers (this is 5 more than Linda shared with you due to filling a long-time need in Cass County). To date, the program has provided training to 732 care givers across the state. Based on Linda Wright's information of 1,718 QSPs involving 139 agencies, TrainND Northeast trained over 42% of the QSPs in North Dakota. Enlisting Registered Nurses across the state ensures that interested, caring individuals do not have to leave their area to receive this training. This program is vitally important for people who wish to stay in their homes but need additional care or assistance to do so.

The intent of Qualified Service Provider Program is to:

1. Provide training at the location where training is needed;
2. Ensure that care givers have demonstrated the mastery of the particular skills necessary;
3. Provide a standard of quality of care based on the needs of the client; and
4. Deliver the training on a one-on-one, face-to-face basis to ensure the highest level of learning.

As rural areas struggle with ***declining*** health care services and ***increasing*** health care costs, it is vital that quality in home care be available. Our program, utilizing experienced, skilled, Registered Nurses who have completed the *Train the Trainer* course are considered LRSC faculty in regards to liability. This protects the RN and also enforces our ability to train care providers who have demonstrated the necessary skills before being listed as a Qualified Service Provider with the Division of Aging Services.

Without Qualified Service Providers, many more elderly or disabled North Dakotans would be forced out of independence and into resident care. So often, resident care is not available in their home community, where they have loved ones and civic ties. The Qualified Service Provider training program offers them the chance to receive quality care and remain in their homes and community.

The current budget for the Qualified Service Provider Program of $30,000 coupled with the additional requested $30,000 will allow the training program to continue to provide in-home care services for many of our elderly. I urge you to continue the funding for this program at the level of $60,000 per biennium. Clearly the need and the positive outcomes of this program have been witnessed in its successes since 2001.

I would like to add one fact. Frequently, while at meetings of the Olmstead Commission's Sub-committee on Direct Care Service Workers, I hear representatives from many different factions say there is so much more need. In addition, they are genuinely concerned about the pay QSPs and Nurse Trainers receive. We currently serve 29 out of 53 counties. It is my hope that one day soon; the Department of Human Services and this committee will consider another increase which would allow us to hire one FTE devoted to this program so that we can meet the true needs of our dear, elderly North Dakotans in every county in this state.

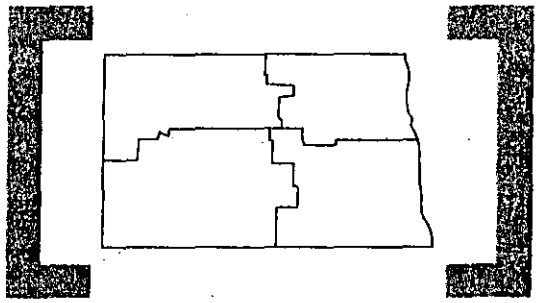
Respectfully Submitted,
Edith Armey
Director, TrainND Northeast
Lake Region State College, Devils Lake, ND

trainND

Powered by: Bismarck State College, Lake Region State College, Williston State College and North Dakota State College of Science

Why is TrainND important to North Dakota?

TrainND is the state's most comprehensive and inclusive training network. Our training services for business and industry help North Dakota businesses compete on a global level, and they are tailored to support their efforts to capitalizeon growth potential.



What business leaders are saying

When asked to describe TrainND in one or two words, business leaders, legislators and North Dakota employees at a Statewide Advisory Board Strategic Planning Retreat used words such as: Positive, Responsive, Effective, Affordable, Vital, Value-added, Customized and Flexible.

"Every service employee we hire receives training from TrainND before beginning duties in the field. This has helped create a safer environment for all of us as we move forward in the energy industry. Whenever we have needed specific training, they have been very helpful and accommodating."
Todd Beard
Nabors Well Service • Williston

"We saw the results of [coaching and communications] training through improved employee relations and greater consistency in the applications of rules and regulations at our Grand Forks plant."
Dan Gordon
LM Glasfiber • Grand Forks

"The southeast TrainND Region understands our need for flexible training in both specialized and general skills — small groups and company-wide. I congratulate any manager with the wisdom to make this connection."
Kim Lunde
Cherrington Enterprises, Inc.
Jamestown

"The southwest TrainND instructor works with our maintenance staff to develop a training outline, detailed test plans and coordinates the training schedule. Very positive feedback has been received with respect to the professional nature of training and the mobile facility."
Mark Thompson
Leland Olds Station • Bismarck

TrainND by the numbers

211,607 total training hours

1,345 businesses served

743 businesses returned for additional training

53% of our business is repeat business

17,380 total registrations

11,990 unduplicated registrations

99% client satisfaction

98% employee satisfaction

Fiscal Year 2008

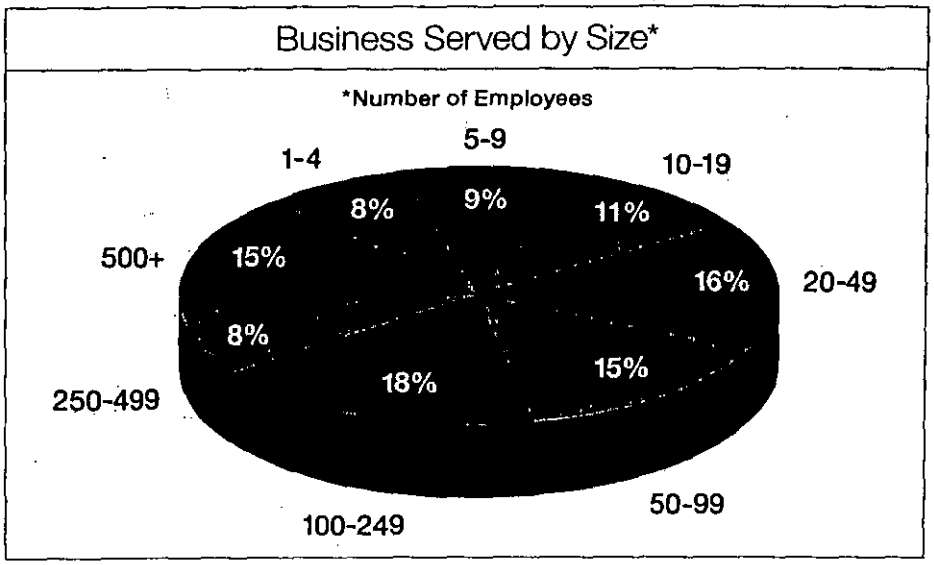
trainND

A good investment

The overall revenue generated from training this year is up 16% from last year. Training increases employee retention, productivity, competitiveness, quality and customer satisfaction.

Current efforts and goals of TrainND:

- Continue to inform policy makers
- Increase the consultative relationship with our clients
- Identify, clarify and communicate what workforce training is — and what it can do for North Dakota business
- Deliver training to clients anytime, anywhere
- Increase participation in events such as the Governor's Workforce Summit and HR Conference
- Collaborate and deliver programs across the state for welding, machining, manufacturing, oil and gas, commercial drivers license training and more



In 1999, after the legislative enactment of the workforce training system, the State Board of Higher Education charged Career and Technical Education plus regional training advisory boards with successful implementation of the new training system. In the 2007 Legislative Session, HB 1019 provided funding for new initiatives, salaries, operations and awareness. To address awareness-building goals, the regions collaborated to develop our brand, our new name (TrainND) and our new look. **www.TrainND.com**

Powered by: Bismarck State College, Lake Region State College, Williston State College and North Dakota State College of Science

trainND NORTHEAST

Training In-Home Care Providers

TrainND Northeast partners with the North Dakota Department of Human Services Aging Services Division to train in-home care providers. There is a critical need in North Dakota, especially in rural and tribal areas as our population ages. In-home care providers are trained by highly-qualified registered nurses who customize training to suit the provider and the client.

In-Home Care Providers make a difference

The goal of home care is to assist the client to be as independent as possible and remain in his or her home. Compassionate, competent care will help the client achieve this goal. A trained in-home care provider may make the difference between a client continuing to live at home or moving to a long-term care facility.

Who should be an In-Home Care Provider?

Delivering quality in-home care is an important job that requires a number of skills. The most valuable skill is professionalism, which encompasses dependability, empathy, trustworthiness, respectfulness, confidentiality, and communication.

"I'm grateful to TrainND for the training experience. I learned a lot about myself and the elder I help."

Julie Quallick
In-Home Care Provider

"The strongest part of this program was making sure the resident will be comfortable and reassured that you are there to assist them in whatever they need."

Pam Fehr
In-Home Care Provider

"I think you are doing a splendid job in training workers in this program. Keep up the good work!"

Helen Seigard
In-Home Care Provider

In-Home Care Provider Training *by the numbers - FY 08-09*

29	ND Counties Served	55%	ND Counties Served
170	Providers Trained	21	Providers Re-certified
69	Registered Nurse Trainers	98%	Participant Satisfaction

732 Total Providers Trained 2002-2008

About the program

- There is no cost to the In-Home Care Provider
- Instruction manuals for Nurse Trainers and In-Home Care Providers are provided by TrainND Northeast
- The goal of the program is to increase the number of capable In-Home Care Providers across the state

Testimony
House Bill 1012 – Department of Human Services
Aging Services Budget
Human Resources Division
House Appropriations Committee
January 27, 2009

Same testimony given to Senate

Chairman Pollert and members of the committee, my name is Brian Arett. I am the Executive Director of Fargo Senior Services and a representative of the 26 agencies that are members of the North Dakota Senior Service Providers (NDSSP) that provide Older American Act Services to the senior population of this state. I am here to testify in support of the budget for the Aging Services Division of the North Dakota Department of Human Services. In particular I am here to testify in support of the $900,000 increase in reimbursement to Older Americans Act Service Providers.

At the same time I am here to speak in support of this increase I am here to ask your committee to consider a request for an additional increase for Older Americans Act Service Providers. I make this request because of the significant challenges we face in providing for the growing numbers of seniors, particularly those age 85 and older, throughout the state, and because of the large number of services that we provide with no reimbursement.

Older Americans Act services such as Home Delivered and Congregate Meals, Outreach, Health and Senior Companion services are an important part of the continuum of care that helps our seniors to remain in their homes as late in life as possible. In testimony provided by Linda Wright on January 13th she highlighted the projected growth in the numbers of older people in the state over the next 11 years, particularly those people age 85 and older. This increase in the number of seniors in our state will certainly lead to further growth in the demand for the services we provide.

Linda's testimony also touched on some of the challenges Older Americans Act Service Providers are facing. She mentioned new federal dietary requirements for congregate and home delivered meals. These requirements were implemented in 2008 and require an additional half cup serving of fruit or vegetable, increased fiber requirements, an additional slice of bread and the use of 100% whole wheat bread for the meals we serve. These changes resulted in an increase of more than 40 cents per meal for our meals program in 2008. Linda also spoke about the increasing costs for inflation we are experiencing with respect to food, staff, transportation and supplies. Food costs alone are projected to increase 5-6% this year.

When we met with Governor Hoeven's office last fall to talk about our need for additional support for the services we provide for the elderly our request was for the state to fully fund the established reimbursement rate for the meals programs we operate and to increase the reimbursement rate to $3.50/meal. The reimbursement rate in 2008 was $3.00/meal but because of a shortage of federal/state funds the dollars available were only able to fund 944,444 of the 1,287,718 meals served in 2007 (the most recent numbers available) or 77.2%.

In 2009 the reimbursement rate was raised to $3.50/meal but funding was only increased by $64,506 so this year only 67.6% of the meals that will be provided will be funded at the new $3.50/meal rate. In essence, the reimbursement rate was raised but because the amount of dollars did not go up at the same proportion state/federal dollars will run out sooner leaving it to us to have to make up an even bigger share of the costs associated with this program.

The result in 2008 was that eight meal sites out of a total of 198 sites throughout the state were closed. Projections are for an additional four to close in 2009 and possibly as many as 14 more in 2010. Generally the meal sites that close are in the most rural parts of the state and in towns where we contract with restaurants for meal service. Thirty-four percent of our service sites (65 communities) are in towns

with populations of 200 people or less. In 46 of the communities served, the meals are provided through a contract with a local restaurant, nursing home or hospital. Many times these sites close because we are not able to reimburse these small restaurants a more reasonable rate due to the limited reimbursement we receive.

I have talked about services statewide. I would like to talk a little about the services provided by Fargo Senior Services. We serve 6 counties and 33 communities in Region 5. In 8 of these communities we contract with a local restaurant for meal services. Our agency has 24 full time and 60 part time employees with a total annual payroll of more than $1.5 million. We spend just over $1 million annually on food purchased from wholesale vendors and restaurants.

Our request of your committee is to increase funding for Older Americans Act Meal Service Providers by an additional $1.9 million so that we can be reimbursed at the established state rate for every meal we provide. We arrived at this amount by multiplying the number of meals served in 2007 by $3.50/meal and subtracting state/federal dollars already available as well as the increase already included in the department budget request as follows:

1,287,718 meals x $3.50/meal = $4,507,013
$4,507,013 - 3,047,839 (federal/state funds in 2009) = 1,459,174
$1,459,174 x 2 years = $2,918,348 (estimated shortfall for the biennium)
$2,918,348 - 900,000 – 106,400 = $1,911,948 shortfall
$1,911,948 is equal to 546,271 meals for the biennium

The member agencies of the NDSSP are the organizations providing services to older people in the most rural parts of our state. Meal services are provided in 190 communities of all sizes and in all corners of the state. Many of the older residents of small towns throughout the state rely on these meal services as one of the few alternatives to institutional care available in their community.

The increase being requested in the DHS budget will help us to keep up with the inflationary increases we are experiencing. In particular, it will help us to maintain an adequate reimbursement rate for the many rural restaurants we work with. I know I speak on behalf of my colleagues throughout the state in highlighting this area.

If we are going to keep up with the growing costs for providing services and the growing need for services brought on by the ever increasing senior population we need to raise revenues from somewhere. Local resources have been stretched as thin as they can be. In 2007 (the most recent year figures are available) funds spent on Older Americans Act Services came from the following sources; 44.5% Federal, 29% Program Income, 23.1% Local and 3.4% State.

We look to the state as a natural partner in helping us to meet this need. The major benefit for the state comes from assisting seniors to stay at home in a less restrictive and much less expensive setting, saving dollars that would have to be spent on nursing home care if our services are not available. A list of the agencies that are members of the North Dakota Senior Services Providers is attached.

Thank you for your time. I would be happy to answer any questions you might have.

Organizations that are members of North Dakota Senior Service Providers:

1. Williston/Region I Senior Services
2. Minot Commission on Aging
3. Kenmare Wheels and Meals
4. Tri County Meals and Services, Rugby
5. Souris Basin Transportation, Minot
6. Cavalier County Meals and Services, Langdon
7. Nutrition United, Rolla
8. Benson County Transportation, Maddock
9. Senior Meals and Services, Devils Lake
10. Walsh County Nutrition Program, Park River
11. Pembina County Meals and Services, Drayton
12. Greater Grand Forks Senior Citizens Association
13. Fargo Senior Services
14. Dickey County Senior Citizens, Ellendale
15. James River Senior Services, Jamestown
16. South Central Adult Services, Valley City
17. Central Valley Health Unit, Jamestown
18. West River Transportation, Bismarck
19. Mandan Golden Age Services
20. Burleigh County Senior Adults, Bismarck
21. Kidder/Emmons Senior Services, Steele
22. Mercer McLean Counties Commission on Aging, Hazen
23. Elder Care, Dickinson
24. Southwest District Health Unit, Dickinson
25. Southwest Transportation, Bowman
26. Legal Assistance of North Dakota, Bismarck

Testimony
House Bill 1012 – Department of Human Services
Aging Services Budget
Human Resources Division
House Appropriations Committee
January 27, 2009

Same testimony given to Senate

Chairman Pollert and members of the committee, my name is Pat Hansen. I am the Executive Director of South Central Adult Services and I am also a representative of the 26 agencies that are members of the North Dakota Senior Service Providers that provide Older Americans Act Services to the senior population of this state.

Brian Arett's testimony explained the statewide situation regarding meals for seniors. I would like to provide you with information concerning my project. South Central Adult Services provides congregate and home delivered meals, outreach, and transportation to Region VI which includes the counties of Barnes, LaMoure, Foster, Logan, McIntosh, Griggs, Dickey, Stutsman, Wells and Sheridan. South Central provided 116,087 congregate meals, 94,640 home delivered meals, 12,841 billable units of outreach and 53,623 rides in 2008. We provided 64,139 meals with no federal/state reimbursement. At the $3.00 meal reimbursement rate for 2008 this is a shortfall of $192,417. At the 2009 rate of $3.50 this amount increases to $224,486. South Central Adult Services did not receive any increase in federal/state meal dollars for 2009.

I have been employed by South Central Adult Services since 1980 in several positions, including secretary, outreach worker, administrative assistant, fiscal officer, and for the past two years, director. South Central employed a total of 111 people in full and part-time positions last year. We have gone from an administrative staff of 3 ½ people down to 2. We have no retirement benefits, and the agency only pays $100 per month of our health insurance benefits. Several years ago the Board of Directors voted to implement a retirement plan for the employees. I was the fiscal officer at the time, and after compiling the budgets for

each of our counties, I determined that we would have to close seven meals sites to pay for the minimum match required for a retirement plan. I recommended that we forego the retirement plan and maintain the meal sites. We have consistently opted to cut anything EXCEPT services. Sadly enough, this year when I presented budgets to my county councils, I had to ask them to try and maintain their services and sites for one more year, 2009. I informed them of our contact with the Governor's staff and my hope that during this legislative session funding would be appropriated to pay for ALL of the meals we are providing, allowing us to pay for the increasing cost of food and supplies and to keep staff to operate the sites and prepare the meals. All of my counties are spending more local dollars than they will receive this year. This cannot continue.

I have seen many changes in our programs, and in the population we serve over these many years. When I first began with Aging, much of the emphasis was on socialization and outreach. The people who participated in the programs were 60-70 years old, and most were very active and did a lot of volunteer work in the senior centers and their communities. Today, in our region, 24% of all services are provided to people age 85 and older, and 40% of all home delivered meal participants are age 85 and older. The meals are no longer just a social activity. They are a necessity. For those of you who are familiar with nursing home admission criteria, people who have deficits in two or more Activities of Daily Living (ADLs) are eligible for nursing home admission. In my region alone we are serving 222 people who meet or exceed that criteria. If in-home services were not available and these people required nursing home placement it would cost in excess of $13.3 million dollars each year for their care, just for Region VI.

Let me share a story with you about what happens when people do not receive Home Delivered Meals. In McVille (population 470) in Nelson County in 2007 meals were provided 5 days per week by a cafe. In May of that year, the city-owned cafe changed managers and was closed for one month. Prior to the sale of the cafe, 8 people received a home delivered meal every day. When the cafe

re-opened after the one month closure, there were only 4 people left on the home delivered list. What happened to the other 4 people, you might ask? The answer is - all 4 of them went to a Nursing Home during that one-month period when they did not receive Home Delivered Meals. The only thing that changed in these 4 people's lives is that they did not get a meal and for them it was the tipping point that led them to need nursing home care.

Statewide statistics on active participants in 2008 indicate that there are a total of 1,149 people who meet the ADL criteria. If 574 (1/2) were forced to enter facilities it would cost $34.4 million dollars. Of the 1,149 people, 297 are already below poverty level and would likely qualify for Medicaid on admission. The increase in Medicaid funding for those individuals would exceed $17.8 million dollars.

I have a difficult time putting dollar values on the quality of life we provide for our elderly. I love my job, and it is not because of the great salary and benefits. It is because of the benefit I receive from serving some of our most precious assets, our seniors. Most of them worked to provide the quality of life we all have in North Dakota, and I think they deserve the best we can provide for them in their "golden" years. I would ask that you consider what your desire, or the desire of your parents or grandparents, is for the future. Do you want to continue to live in your own home, surrounded by members of your community? Or do you want to live in an institutional setting when a few relatively inexpensive services could keep you at home? We all know that nursing homes and assisted living facilities are necessary when we are unable to care for ourselves, but let's not hurry the process.

Thank you for allowing me to present this information. I have included attachments for your individual review. The first is a listing of the number of clients in each county with 2 or more ADLs. The second is an explanation of what the ADLs consist of. I would be happy to answer any questions you may have.

County	Clients with 2 or more ADLs	Age 60-74	Age 75-84	Age 85+	Living Alone	Below Poverty	Male	Female
Adams	6	0	6	0	3	1	3	3
Barnes	89	16	34	39	44	17	58	31
Benson	10	1	2	7	5	4	3	7
Billings	1	0	1	0	1	0	0	1
Bottineau	10	0	6	4	2	4	4	6
Bowman	1	1	0	0	0	0	1	0
Burke	2	0	2	0	2	0	0	2
Burleigh	83	22	37	24	40	14	23	60
Cass	209	55	73	81	125	62	61	148
Cavalier	5	0	3	2	1	0	1	4
Dickey	12	4	3	5	4	4	4	8
Divide	5	1	1	3	3	1	1	4
Dunn	4	1	1	2	1	2	2	2
Eddy	6	2	0	4	1	2	3	3
Emmons	17	6	7	4	10	6	9	8
Foster	8	3	4	1	3	1	3	5
Golden Valley	4	2	1	1	2	1	3	1
Grand Forks	42	6	22	14	17	5	12	30
Grant	6	3	3	0	3	0	1	5
Griggs	6	0	4	2	2	2	2	4
Hettinger	3	1	1	1	0	0	1	2
Kidder	30	7	9	14	15	10	9	21
LaMoure	16	4	8	4	6	5	8	8
Logan	4	0	3	1	1	1	1	3
McHenry	10	2	6	2	2	5	3	7
McIntosh	13	3	6	4	2	3	5	8
McKenzie	4	2	0	2	3	1	1	3
McLean	25	8	4	13	14	7	8	17
Mercer	29	3	12	14	21	10	9	20
Morton	37	12	19	6	15	10	11	26
Mountrail	16	7	4	5	6	7	6	10
Nelson	6	2	2	2	3	2	2	4
Oliver	6	3	2	1	3	2	2	4
Pembina	45	16	16	13	22	5	14	31
Pierce	10	1	6	3	5	1	1	9
Ramsey	29	6	15	8	15	10	10	19
Ransom	5	2	1	2	5	1	2	3
Renville	4	3	0	1	2	2	0	4
Richland	16	3	8	5	8	1	6	10
Rolette	35	15	13	7	13	14	17	18
Sargent	14	4	5	5	2	6	4	10
Sioux	14	9	1	4	3	6	5	9
Slope	1	0	0	1	1	0	0	1
Stark	49	9	18	22	24	16	8	41
Steele	5	1	4	0	3	2	2	3
Stutsman	59	17	23	19	31	26	13	46
Towner	8	1	2	5	6	1	1	7
Traill	1	0	1	0	0	0	1	0
Walsh	55	9	32	14	34	6	23	32
Ward	48	10	20	18	21	8	16	32
Wells	15	1	10	4	3	1	9	6
Williams	11	3	5	3	1	2	5	6
	1149	287	466	396	559	297	397	752

V. ADL's/IADL's

V.A. Activities of Daily Living (ADL)

1. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform BATHING (include shower, full tub or sponge bath, exclude washing back or hair)?

- ☐ 1 - Independent
- ☐ 2 - Requires assistance
- ☐ 3 - Totally dependent

2. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform DRESSING?

- ☐ 1 - Independent
- ☐ 2 - Requires assistance
- ☐ 3 - Totallty dependence

3. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TOILET USE?

- ☐ 1 - Independent
- ☐ 2 - Requires assistance
- ☐ 3 - Totally dependent

4. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TRANSFER?

- ☐ 1 - Independent
- ☐ 2 - Requires assistance
- ☐ 3 - Totally dependent

5. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform EATING?

- ☐ 1 - Independent
- ☐ 2 - Requires assistance
- ☐ 3 - Totally dependent

6. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform WALKING IN HOME?

- ☐ 1 - Independent
- ☐ 2 - Requires assistance
- ☐ 3 - Totally Dependent

What is the client's ADL count?

V.B. Instrumental Activities of Daily Living (IADL)

1. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MEAL PREPARATION?

- ☐ 1 - Independent
- ☐ 2 - Requires assistance
- ☐ 3 - Totally dependent

2. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MANAGING MEDICATIONS?

- ☐ 1 - Independent
- ☐ 2 - Requires Assistance
- ☐ 3 - Totally dependent

3. Specify the client's ability to MANAGE MONEY.

- ☐ 1 - Independent
- ☐ 2 - Requires assistance
- ☐ 3 - Totally dependent

4. Specify the client's ability to perform HEAVY HOUSEWORK.

- ☐ 1 - Independent
- ☐ 2 - Requires assistance
- ☐ 3 - Totally dependent

5. Specify the client's ability to perform LIGHT HOUSEKEEPING.

- ☐ 1 - Independent
- ☐ 2 - Requires assistance
- ☐ 3 - Totally dependent

6. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform SHOPPING?

- ☐ 1 - Independent
- ☐ 2 - Requires assistance
- ☐ 3 - Totally dependent

7. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TRANSPORTATION?

- ☐ 1 - Independent
- ☐ 2 - Requires assistance
- ☐ 3 - Totally dependent

8. Rank the client's ability to use the TELEPHONE.

- ☐ 1 - Independent
- ☐ 2 - Requires assitance
- ☐ 3 - Totally dependent

What is the client's IADL count?

K

NDAHC **North Dakota** Association for **Home Care**

Testimony

House Bill 1012-Tammy Theurer, ND Association for Home Care

House Appropriations Committee-Human Resources Division

Representative Pollert, Chairman

January 27, 2009

Chairman Pollert and members of the House Appropriations Human Resources Committee, my name is Tammy Theurer, I am a registered nurse and the Director of Home Care & Hospice at St. Alexius Medical Center. I am here today as the Past President of the ND Association for Home Care (NDAHC) and representing the association.

The NDAHC represents Home Health Care Agencies (Hospital-based, County, nonprofit, and proprietary) and their branches, providing care throughout ND, allowing clients to remain in their homes.

Home Health Care provides: Skilled Nursing, Physical Therapy, Speech Therapy, Occupational Therapy, Certified Nurse Assistants (CNAs), Infusion Therapy, Medical Social Workers, Pediatric and Psychiatry Programs, as well as Home Health Aides and Homemaker services, or Personal Care Services assisting with activities of daily living and in certain circumstances, tele-health services. Today I will address the Skilled Nursing and Personal Care, or QSP (Quality Service Provider) services provided by Home Health agencies.

QSP services are provided by individuals, proprietary agencies, and Home Health Care Agencies. Home Health agency QSP services are provided within a medical model of care. These agencies are certified by Medicare and Licensed by the state of North Dakota. Agency QSP providers are generally CNAs, or minimally Nurse Assistants registered in the state, who are directly supervised by a registered nurse. These CNAs receive ongoing education and evaluation of their skills and abilities.

In 2006, NDAHC surveyed members to determine the number of agencies providing these services, the level at which they were reimbursed, as well as their cost to provide the services. At that time, there were 17 agencies providing this care, with varying levels of reimbursement. The average reimbursement in 2006-07 was $15.14 per hour with an average cost of $22.92 to provide this care. Data from the Department of Human Services for January 1994 through January 2006 showed an average annual increase in reimbursement for these services to be 3.21 %. If Home Health Care agencies

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were to continue to provide personal care services and allow individuals to remain in their homes, agencies needed to keep pace with the increasing cost to provide the services.

The 2007 Legislature addressed the reimbursement for personal care services, standardizing the reimbursement rate among agencies and providing a positive increase. Currently, these services are reimbursed at $19.64 per hour.

A recent survey of our members concluded that the average cost to provide Personal Care Services in the year 2008 was approximately $27.75/hour, compared to an average cost of $22.92/hour in 2006-2007(based on a prior survey of our members). This is an increase of $4.83 during this two year period, which translates to an increase in cost to provide services of approximately 10.5% per year of the biennium. The areas that appear to have the greatest effect on this increase in cost are due primarily to travel costs, wages and benefits, and staff recruitment and retention. Considering the reimbursement is $19.64 per hour and the average cost is $27.75 per hour, Personal Care services are currently reimbursed at 71% of agency costs. Although we are very appreciative of the 7/7% inflationary increase in the Governor's budget, in order to lessen this gap and bring agencies closer to a break even situation, we are requesting a 15% increase in Personal Care payments, in addition to the 7/7% inflationary increase.

Comparing QSP Home Health Care Claims from 2006 to 2008, all agencies providing these services are continuing to do so. The number of clients served for the 11 months of data in 2006 was 516. For the 12 months ended 6/30/08, the number of clients being served by Home Health Agencies only was 523. As you can see, the demand for these services has not decreased. In fact, based on the demographic trends throughout the state, particularly with regards to our aging population, we only expect the number of clients we serve to increase.

Skilled care services provided by Home Health Agencies include Skilled Nursing, Physical Therapy, Speech Therapy, and Occupational Therapy.

According to the Provider Fee Schedule from the Department of Human Services, the current average allowable charge for Home Health Providers is $81.60 per visit. The average cost for these skilled services was $126.28 per visit. Payments from ND Medicaid cover less than 65% of agency costs. We are requesting an increase in the provider fee schedule by 15%, in addition to the annual 7% increase recommended in the Governor's budget. This increase would be an important move toward minimizing the deficit between the amounts paid to agencies and the actual costs to provide services. As with the Personal Care services, the costs are primarily due to wages and benefits, travel time and mileage, and costs to recruit and retain staff.

Telehealth/Telemonitoring Services:

At this time only three agencies in ND are providing telehealth/telemonitoring services. These services are not reimbursed by ND Medicaid. These three agencies have been able to demonstrate significant

benefits with the addition of this technology, which enhances the care provided to patients in their homes. For example, with the use of telemonitoring equipment, agencies are able to identify changes in the patient's medical condition more quickly, resulting in timely interventions that in turn result in the avoidance of a hospital stay or an emergency room visit. NDAHC is requesting that ND Medicaid reimburse Home Health Agencies for telehealth/telemonitoring visits at the same rate as a skilled nursing visit. Minnesota Medicaid's reimbursement structure includes reimbursement of telehealth visits at the same rate as skilled nursing visits. NDAHC would advocate for similar reimbursement by ND Medicaid, but would recommend that the definition of telehealth or telemonitoring visits be broad enough to account for ever changing technology. Options range from very sophisticated, high cost units involving video cameras and complex computers, to monitors utilizing phone lines or web based technology. Industry information indicates that only a small percentage, between 3 and 4 %, of individuals benefiting from telemonitoring services require the more elaborate and expensive real time video equipment.

The reimbursement of telehealth/telemonitoring visits by certified Home Health Agencies would enable more agencies to provide this important technology to more efficiently manage patient conditions. This technology would be of particular importance in the rural areas of our state, resulting in closer patient oversight and management of their disease processes. By increasing the use of this technology, the savings resulting from fewer hospitalizations and emergency room visits would easily surpass the expenditures paid for telehealth/telemonitoring visits.

The increase in reimbursement for QSP services as a result of the 2007 Legislature has allowed our agencies to continue providing these much needed services. Payments to agencies for both Personal Care services and Skilled Services remain significantly below agency costs to provide this important care to the citizens of North Dakota. In order to lessen this gap, we are requesting additional increases beyond the proposed inflationary rates. In order to expand the use of telehealth/telemonitoring, we are asking for reimbursement for those services. However, if we do not receive an increase which would bring us closer to our cost to provide these services, we are afraid we will be forced to limit our service area and possibly even the number of clients we are able to serve. Home Health Agencies in North Dakota are committed to bringing needed care to individuals in their homes. Home Care continues to be a very cost effective option.

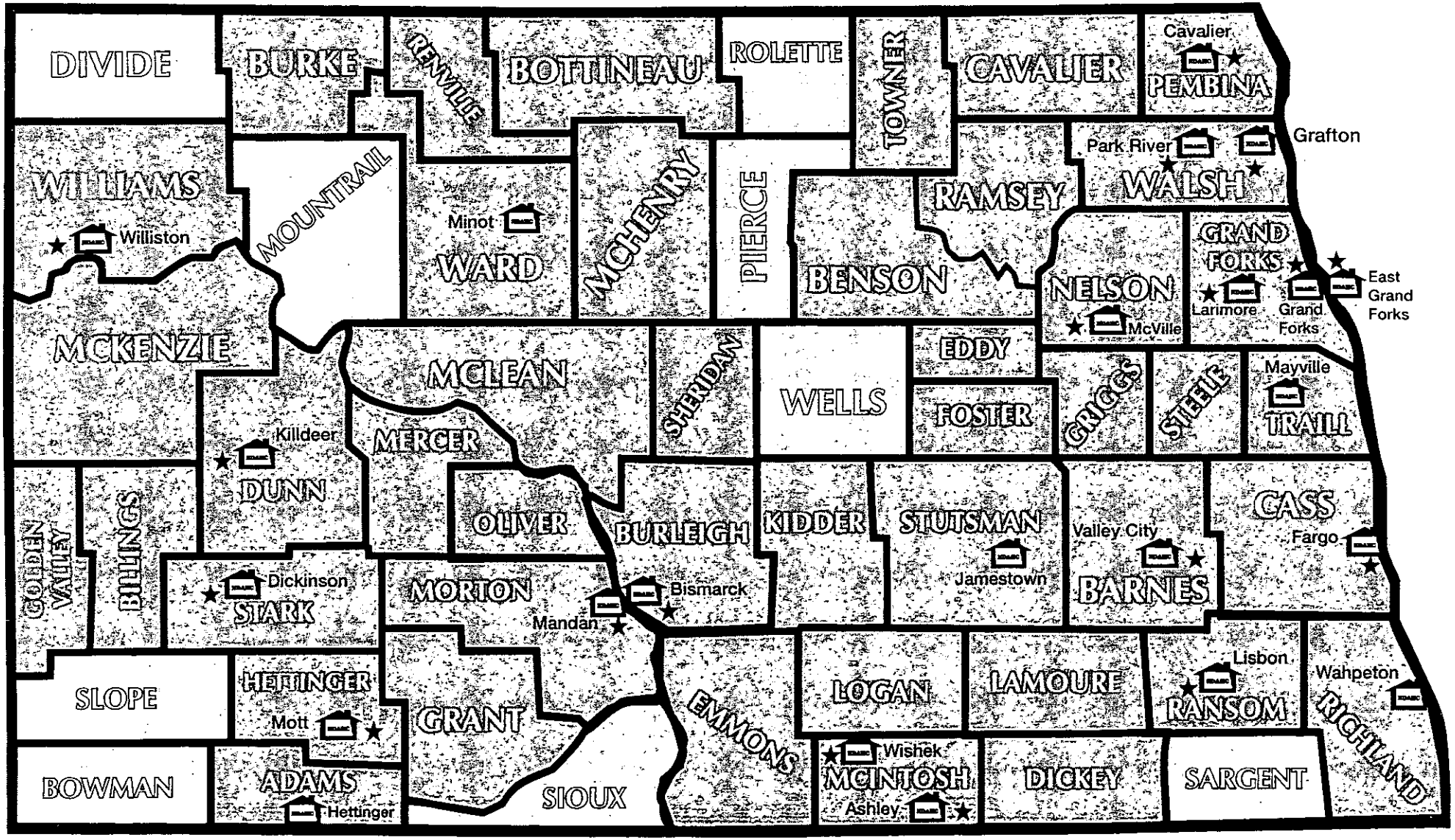
Thank you for the opportunity to testify before you today. We appreciate your consideration of our situation. I'd be happy to answer any questions you might have.

NDAHC

ND ASSOCIATION FOR HOME CARE

LEGEND/KEY

- NDAHC MEMBER AGENCY
- ★ PERSONAL CARE SERVICES PROVIDED BY NDAHC MEMBER AGENCY
- SKILLED NURSING SERVICES PROVIDED BY NDAHC MEMBER AGENCY
- RECEIVING PARTIAL SERVICE BY NDAHC MEMBER AGENCY



AGENCY	CITY	COUNTIES SERVED BY NDAHC MEMBERS
★ Altru Home Services	Grand Forks	45 mile radius from Grand Forks office
★ Altru Branches		
★-Cavalier	Cavalier	Pembina and fringes of Cavalier-32 mile radius from Cavalier office
★-Grafton	Grafton	Walsh, Fringes of Grand Forks, Pembina-30 mile radius of Grafton office
★-Mayville	Mayville	Steele, Traill, Fringe of Cass-40 mile radius of Mayville office
★-McVille	McVille	Nelson, Northern Griggs, Fringes of Ramsey, Foster, Eddy-45 mile radius of McVille office
★-Park River	Park River	Walsh, Fringes of Grand Forks, Nelson, Pembina-30 mile radius from Park River office
★ Ashley Home Health Agency	Ashley	Dickey, Emmons, LaMoure, Logan, McIntosh
★ City County Health & Home Care	Valley City	Barnes County 10 miles surrounding Barnes to include portions of Cass, Stutsman, Griggs, Steele, LaMoure, Ransom, & Foster
★ Good Samaritan Society Larimore	Larimore	Grand Forks, Steele, Traill, Nelson, Walsh, Cass, Barnes, Griggs, Ramsey, Cavalier, Pembina, Benson, Towner, Eddy, Foster, Ranson, Lamoure
★ Hill Top Home Health	Killdeer	50 mile radius of Killdeer & 50 mile radius of Dickinson
Jamestown Hospital Home Health	Jamestown	Stutsman, Part of Logan & LaMoure-20 mile radius of each Jamestown Medina, Edgeley, Judd
★ Medcenter One Home Health & Hospice	Mandan	Burleigh, Morton, Western Kidder, Eastern Oliver and McLean
★ Mercy Home Care & Hospice	Williston	Williams, McKenzie-45 mile radius from Williston (only to MT border)
★ Mercy Home Care Services	Valley City	60 mile radius of Valley City office
★ MeritCare Home Care	Fargo	Cass, Traill, Ransom, Steele, Stutsman, Griggs, Lamoure, Grand Forks, Nelson, and Walsh
★ MeritCare Branches	Lisbon	30 mile radius of Lisbon office
★ Prairieland Home Care	Fargo	Cass,Traill, Barnes - 50 miles from Office
★ Professional Home Care, Inc.	Bismarck	Currently providing service in Burleigh & Morton. Licensed but not currently providing service in Burke, Divide, Dunn, Emmons, Grant, Kidder, Logan, McClean, McIntosh, McKenzie, Mercer, Mountrail, Oliver, Sioux, Stark & Williams
Richland County Home Health Agency	Wahpeton	Richland
★ St Joseph's Home Health Services	Dickinson	Billings, Dunn, Golden Valley, Hettinger, Stark
★ St. Alexius Home Care & Hospice	Bismarck	Burleigh; Eastern Dunn; Northern Emmons; Grant; Eastern Hettinger; Kidder, Northern Logan; McLean; Mercer; Morton; Oliver; Northern Sioux; Sheridan; Eastern Stark; Western Stutsman; Southern Ward; Southwest Wells
Trinity Home Health	Minot	Burke, Bottineau, McHenry, McKenzie, McLean, Mountrail, Renville, Ward, Williams - 45 mile radius
★ West River Nurse Corps		
-Hettinger	Hettinger	Adams, Grant, Hettinger, Bowman-ND(40 Mile radius from office)
★-Mott Nurse Corps	Mott	Adams, Grant, Hettinger, Bowman - N.D.
★ Wishek Home Health Agency	Wishek	NW 1/4 Dickey, E. 1/2 Emmons, W. 1/2 LaMoure, Logan, McIntosh, SW 1/4 Stutsman, Kidder

★ PROVIDE PERSONAL CARE SERVICES

L

NDAHC North Dakota Association for Home Care

Testimony

House Bill 1012 - Jo Burdick, North Dakota Association for Home Care

House Appropriations Committee - Human Resources Division

Representative Pollert. Chairman

January 27, 2009

Same testimony given to Senate 3-4-09

Chairman Pollert and members of the House Appropriations Human Resources Committee, my name is Jo Burdick. I am a registered nurse and the Executive Director of MeritCare Home Care. I am here today as the Vice President of the ND Association for Home Care (NDAHC) and representing the association. I would like to discuss the use of technology in home health care utilizing home tele-monitoring units in patient homes.

Home Tele-monitoring is not a new concept but it isn't widely used in North Dakota. Currently, only three agencies in ND are providing home tele-monitoring services. Many of the counties served by home health agencies in North Dakota are designated as "Frontier Counties", counties with less than 6 persons per square mile. Tele-monitoring brings needed intervention to these sparsely populated areas where winter driving and distance often limit access. Home Tele-monitoring allows a patient to be monitored on a daily basis, and as needed, for signs and symptoms of exacerbations and have more immediate response to impending problems, averting more intensive treatment including use of emergent care and re-hospitalization.

Home tele-monitoring has helped nurses and home health agencies overcome the challenging position of compromising patient care for the sake of cost. It allows nurses to increase operational efficiencies by scheduling visits according to the patient's needs. The ability to visit when clinically appropriate, rather than being constrained by a pre-determined schedule further enhance these efficiencies. Clinicians can react quickly to actual or potential problems. Patient needs are identified more efficiently for improved outcomes.

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Testimony

House Bill 1012-JoAnn Ferrie, ND Association for Home Care

Senate Appropriations Committee-Human Resources Division

Senator Holmberg, Chairman

March 4, 2009

Chairman Holmberg and members of the Senate Appropriations Human Resources Committee: My name is JoAnn Ferrie. I am a registered nurse and the Director of Professional Home Care. I am here today as a member of the ND Association for Home Care (NDAHC) representing the association.

The NDAHC represents home health care agencies (hospital-based, county, nonprofit, and proprietary) and their branches, providing care throughout ND, allowing clients to remain in their homes.

Home health care provides: skilled nursing, physical therapy, speech therapy, occupational therapy, certified nurse assistants (CNAs), infusion therapy, medical social workers, pediatric and psychiatric programs, as well as home health aides, homemaker services, and personal care services, assisting with activities of daily living and, in certain circumstances, tele-health services. Today I will address the skilled nursing and personal care, or QSP (Quality Service Provider) services provided by home health agencies.

QSP services are provided by individuals, proprietary agencies, and home health care agencies. Home health agency QSP services are provided within a medical model of care. These agencies are certified by Medicare and licensed by the state of North Dakota. Agency QSP providers are generally CNAs or, minimally, nurse assistants registered in the state, who are directly supervised by a registered nurse. These CNAs receive ongoing education and evaluation of their skills and abilities.

In 2006, NDAHC surveyed its membership to determine the number of agencies providing these services, the level at which they were reimbursed, as well as their cost to provide the services. At that time, there were 17 agencies providing this care, with varying levels of reimbursement. The average reimbursement in 2006-2007 was $15.14 per hour with an average cost of $22.92 to provide this care.

The 2007 Legislature addressed the reimbursement for personal care services, standardizing the reimbursement rate among agencies and providing a positive increase. Currently, these services are reimbursed at a maximum of $19.64 per hour.

A recent survey of our members concluded that the average cost to provide personal care services in the year 2008 was approximately $27.75 per hour. Although we are very appreciative of the 7/7% inflationary increase in the Governor's budget, we are requesting a 15% increase in personal care payments, in addition to the 7/7% inflationary increase.

Comparing QSP home health care claims from 2006 to 2008, all agencies providing these services are continuing to do so. The number of clients served for the 11 months of data in 2006 was 516. For the 12 months ending 06/30/08, the number of clients being served only by home health agencies was 523. As you can see, the demand for these services has not decreased. In fact, based on the demographic trends throughout the state, particularly with regard to our aging population, we only expect the number of clients we serve to increase.

Skilled care services provided by home health agencies include skilled nursing, physical therapy, speech therapy, and occupational therapy.

According to the Provider Fee Schedule from the Department of Human Services, the current allowable charge for home health providers is $81.60 per visit. The average cost for these skilled services was $126.28 per visit. We are requesting an increase in the Provider Fee Schedule by 15%, in addition to the annual 7% increase recommended in the governor's budget. When home health and QSP services are provided, our citizens can remain at home. They buy groceries and pay taxes and utilities. Some may volunteer and may have jobs while utilizing these QSP or skilled services.

The caregivers providing these services are qualified and could work in any facility—hospital, SNF, or DDMR facility—and should be paid like wages, regardless of where they work. This increase would be an important move toward minimizing the deficit between the amounts paid to agencies and the actual costs to provide such services, and keep more North Dakotans at home.

Thank you for the opportunity to testify before you today. We appreciate your consideration of our situation. I would be happy to answer any questions you might have.

C

Testimony for HB 1012
House Appropriations
January 26, 2009

Good afternoon Chairman Pollert and members of the House Appropriations - Human Resource Division. My name is Cathy Schmidt, I am the Director of Valley View Heights Assisted Living here in Bismarck. I am here to testify on behalf of assisted living facilities throughout North Dakota and I am here to ask for your support of an OAR within the Department of Human Services budget. The OAR was not in HB 1012 and it would have provided $2.1 million to support low and moderate income individuals so they could access assisted living.

These are people who couldn't have planned for assisted living when they were in their 40's and 50's because assisted living didn't exist. They are finding now that they either can't afford to enter an assisted living community or once they're in one they may not be able to stay in their home because their funds have run out. Just last month one of my own tenant's daughters informed us that her mother only had a month left of resources to live at Valley View Heights. This is a lady who worked as a secretary most of her adult life and moved in because of dementia. Since last month, this lady was discharged to a nursing home that takes Medicaid and the move has made such a negative impact on her dementia that she was admitted within days to a secured memory care unit.

As a member of Money Follows the Person Housing subcommittee, and the Department of Human Services Assisted Living Workgroup, I hear of the need for a rent subsidy from other committee members such as the Housing Authority, Protection and Advocacy, the Option Resource Center for Independent Living, as well as AARP. These groups are finding that the "nearly poor" are falling through the cracks in North Dakota.

Why are they choosing assisted living? Assisted living usually offers an apartment setting as opposed to a single room. Because most tenants are leaving their own home to move to these communities it is important to know that these apartments do not have the feel of an institution but rather a social setting. Tenants are as independent as they can tolerate much like you and I. They are able to continue to live independently - with some help.

These tenants are an average age of 85 years old. They are leaving their homes primarily because of physical decline, cognitive decline or both. They can no longer do the things necessary to maintain their homes or health but they're not ready for a skilled nursing facility. Some simply need assistance with housekeeping, laundry, meals, transportation and other incidental activities of daily living. While others need those services as well as medication oversight, assistance with bathing, dressing and supervision.

Well over 90% of tenants who live in assisted living are self pay. They saved for a rainy day and are now spending down their savings as life starts to "sprinkle" on them a little. Unfortunately, some were not able to save enough to stay in assisted living while others were not able to get into assisted living at all because they just couldn't get the help.

It's heartbreaking to see the people who call or come into our facilities looking for a place to live that do not quite qualify for Medicaid but don't have enough resources to come into these apartments on their own. SPED programs are available to help these individuals with the service component but it does not help with the housing component keeping assisted living out of reach for many.

In conclusion, I ask that you support the $2.1 million OAR within the Department of Human Services budget. By doing so you will be giving a hand up to those elderly North Dakotans who fall through the cracks of available housing. Thank you for your time.

Testimony for HB 1012
O.A.R. 5
Senate Appropriations
March 9, 2009

Good afternoon Chairman Holmberg and members of the Senate Appropriations committee. My name is Cathy Schmidt, I am the Director of Valley View Heights Assisted Living here in Bismarck. I am here to testify on behalf of assisted living facilities throughout North Dakota and the North Dakota Long Term Care Association but most importantly, I am here on behalf of the elderly and disabled who need a little help to obtain housing options. I am here to ask for your support of OAR #5 within the Department of Human Services budget. The OAR was not in HB 1012 and it would have provided $2.1 million to support low and moderate income individuals so they could access assisted living.

These are people who couldn't have planned for assisted living when they were in their 40's and 50's because assisted living didn't exist. They are finding now that they either can't afford to enter an assisted living community or once they're in one they may not be able to stay in their home because their funds have run out. Just a couple months ago one of my own tenant's daughters informed us that her mother only had a month of resources left to live at Valley View Heights. This is a lady who worked as a secretary most of her adult life and moved in because of dementia. This lady was discharged to a nursing home that takes Medicaid and the move made such a negative impact on her dementia that she was admitted within days to a secured memory care unit.

As a member of Money Follows the Person Housing subcommittee, and the Department of Human Services Assisted Living Workgroup, I hear of the need for a rent subsidy from other committee members representing; the Housing Authority, Protection and Advocacy, the Option Resource Center for Independent Living, as well as AARP. These groups are finding that the "nearly poor" are falling through the cracks in North Dakota. As you heard in testimony last Wednesday, the Minot State University study on affordable housing for the elderly reinforces this.

Why are they choosing assisted living? Assisted living usually offers an apartment setting as opposed to a single room. Because most tenants are leaving their own home to move to these communities it is important to know that these apartments do not have the feel of an institution but rather a social setting. Tenants are as independent as they can tolerate much like you and I. They are able to continue to live independently - with some help.

These tenants are an average age of 85 years old. They are leaving their homes primarily because of physical decline, cognitive decline or both. They can no longer do the things necessary to maintain their homes or health but they're not ready for a skilled nursing facility. Some simply need assistance with housekeeping, laundry, meals, transportation and other incidental activities of daily living. While others need those services in addition to medication oversight, assistance with bathing, dressing and supervision.

Well over 90% of tenants who live in assisted living are self pay. They saved for a rainy day and are now spending down their savings as life starts to "sprinkle" on them a little. Unfortunately, some were not able to save enough to stay in assisted

living while others don't even make it in the door at all because they just couldn't get the help.

It's heartbreaking to see the people who call or come into our facilities looking for a place to live that do not quite qualify for housing assistance but don't have enough resources to come into these apartments on their own. SPED programs are available to help these individuals with the service component but it does not help with the housing component keeping assisted living out of reach for many.

In conclusion, I ask that you support the $2.1 million OAR within the Department of Human Services budget. By doing so you will be giving a hand up to those elderly North Dakotans who fall through the cracks of available housing. Thank you for your time.

Cathy Schmidt
Director
Valley View Heights Assisted Living
2500 Valley View Ave.
Bismarck ND 58501

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1/26/09

Representative Chet Pollert, Chairman Human Resources

Chairman Representative Pollert and committee members. My name is Allan Metzger, past administrator of Golden Acres Manor, a 60 bed skilled nursing facility in Carrington.

I am here to ask for your support on funding legislation for what is termed, "wage pass through" for long term care employees. I thank you in advance for allowing me the time to address this committee.

In my opening statement I used the term past administrator. I retired this past December 2008. I had been the administrator of Golden Acres for 32 years. My reference to longevity will hopefully become clearer by the end of my testimonial.

As you debate a wage pass through for long term care employees, I want to step back in time. The year was 2001. The funding mechanism was Intergovernmental Transfer Funds. The legislature at that time created the funding for a wage pass through to long term care employees. The benefits of that legislative sessions' actions were profound and long lasting to Golden Acres Manor.

Prior to 2001, Golden Acres like other nursing homes were struggling to maintain staffing at most levels. Our jobs were viewed by many as secondary market income jobs. People would come and go at levels that would not ensure quality of care. The wage pass through could not have been timelier for the following reasons:

- July 2001 every employee received $1.65 per hour wage increase by-passing any corporate intent.
- After July 2001 the jobs went from secondary market jobs to jobs of choice.
- A wave of commitment and professionalism was brought to a higher level as the staff's attitudes went from knowing they were good, but why where they here, to knowing they were good and pleased that they were recognized for their efforts.
- Unfilled positions were filled.
- Quality individuals showed up asking for applications.
- Employees that gave of their time and talent decided to stay and are with us today.
- Our corporation was then able to take the biennial operating increases in funding and strengthen our health insurance program and create a 401-K retirement plan.

Golden Acres went from having okay jobs to "Career Jobs" because of the actions of some of you and former colleagues in 2001.

Today Golden Acres has a wage and benefit expenditure of $3.2 million while employing 90 plus individuals. Entry level support staff starts around $11.00 per hour, mid level around $16.00, and licensed and or degreed around $23.00, all receiving paid health insurance and 401-K benefits.

What you created in 2001, to your credit, was a stimulus package for the individual worker and it worked. It will work again in 2009. A 'wage pass through" will enhance the present staff and bring new staff into the health care industry by enhancing wages.

My passion is for my former staff that say, "I have a career in health care, not a job in health care". Because of a stimulus package on behalf of North Dakota Long Term Care Employees through past actions added many great years to my career in health care.

I ask for your support on House Bill 1012.

Thank You!

Allan Metzger
Past Administrator
Golden Acres Manor
Carrington, ND
701-652-3117

My name is Kurt Stoner and I am the administrator of Bethel Lutheran Home in Williston, ND. Bethel Lutheran Home is a 168 bed skilled nursing home and a 19 bed basic care facility. Through our Foundation we also offer senior living through 47 senior independent living apartments. I also currently serve as chairman of our North Dakota Long Term Care Association Board of Directors. I am here today on behalf of the 13,000 North Dakota residents who are provided care in basic care and nursing facilities throughout our state. This past year at Bethel we have experienced a staffing crisis that has not been equaled in my 17 years of service to that organization. We have stopped or slowed admissions numerous times throughout 2008 in an effort to maintain quality care for those we serve. In May of 2008 we increased salaries by 50¢ per hour for all of our staff in an effort to become more competitive with the local labor market. This adjustment was above and beyond the annual performance adjustment our employees are eligible on their anniversary date of employment. Although the salary adjustment did make a difference in our ability to attract staff we found we are still unable to compete in our local economy due to the heightened oil activity. In October of 2008, our Board of Directors approved an additional 50¢ per hour increase to all staff. Today our CNA's starting salary at 10.85 an hour. I am pleased to report following the second salary adjustment that our staffing improved significantly. However, the combination of slowing admissions (up to 16 open beds) while at the same time increasing our salaries is probably not an option for most nursing homes. Because of our reimbursement system in North Dakota the vast majority of these costs will not be recognized until 2010, with 8 months of the second 50¢ raise not

recognized until 2011 rate year. Bethel at this time is experiencing significant losses from operation. After our second salary adjustment our losses total over $~~160~~ 130,000 in November and December alone. Because of funded depreciation monies that have been previously set aside we are able to pay for these salary increases until our costs are recognized in future rate years. This however is not the case for many nursing homes. Since October our staffing has improved and we currently have only 6 open beds with prospect for several more admission. My story may be unique only because my set of circumstances involves an oil boom economy. However, in Fargo or Bismarck it may not be oil, but a diverse economy with more options available for prospective employees. In smaller communities you are competing for a limited number of workers in your geographic region. The end result however is the same. If we cannot offer competitive wages we cannot attract quality, compassionate caregivers. A salary/benefit pass through, however, will provide the upfront monies to allow facilities who do not have the cash reserves to pay a living wage to their employees and get those costs recognized immediately. North Dakotans are blessed to have 83 Nursing Homes and 58 Basic Care Facilities throughout our State. The majority of these facilities are non-profit facilities whose original mission statement resonates through the quality care they provide. I want to thank you for your time and ask for your support for the Governor's proposed inflator and salary/benefit pass through that that will allow all of us the ability to maintain our history of providing quality, compassionate care. Thank you.

1/26/2009

Amanda Chase
Sheyenne Care Center
Valley City, ND

Good Afternoon Chairman Pollert and Committee Members.

My name is Amanda Chase; I'm a Certified Resident Assistant at the Sheyenne Care Center in Valley City. I have worked as a Certified Resident Assistant for the last 13 years and LOVE what I do. The Resident's mean everything to me and I enjoy the relationship that I have developed with them over the years. I'm here in support HB1012 which contains the 7% inflator and consider an amendment to increase all long term care salaries and benefits by $2.00.

I'm married and have 5 children whose ages are Lane 11, MaKell 8, John 4, Parker 3, and Kathryn 4 months. My husband and I live 10 miles from town and both work in Valley City. This last year we experienced financial stress with the cost of everything going up. Which meant we had to seriously evaluate everything we do from gasoline we use to drive to work, to food cost and daycare.

Over the last 13 years I have worked full-time at 32 hours per week and my salary currently is $13.70 per hour. I work a total of 64 hours in a period of 2 weeks. I do not work more than this, as the cost of daycare would take my entire paycheck.

My gross income in 2 weeks is $920.20. After deductions of $173.25 medical insurance, $2.50 vision insurance, and $25.00 dental insurance, $36.81 in a 401K retirement plan, $7.46 for life insurance and the state and federal taxes totaling $144.90, my net pay, in what I bring home to my family, is $530.28 every 2 weeks. This gives my husband and I $265.14 per week to pay bills and buy the necessities for our family of 7 such as food, gasoline, clothing, a home mortgage, and heating oil.

Our income disappears very quickly. Our medical bills, even with insurance exceed $2000 per year. Our daycare expense for our children is $288 per month. We get by with a lesser expense of day care because I work the 3:00-11: 30 pm shift and they are not in daycare that long. Imagine our expense if I were to work a normal 8-5 shift.

As you know, these are only a few of our expenses we have in raising a family of 7. I truly don't know how basic care and nursing facility employees who make less money than I do survive.

Even though I love what I do, it has lead me to evaluate my career and financial situation for future income growth. I decided due to "higher costs" of living in ND, gas and food prices, to go back to college in 2007. I figured with a college degree, I would be able to bring home a better income for my family. I am now faced with $20,000 in student loans when I graduate in May. It is very depressing. Like I said earlier, I love what I do and I

would look at making my position as a Certified Resident Assistant a career if the financial income is such that helps my family.

As a Certified Resident Assistant at Sheyenne Care Center, I have helped residents through some of there most difficult times. I have helped residents who look at me as their family member and I have also sat with residents and cried during their final hours of life. There is no monetary reward large enough for helping people in times like this. But as a mother, I will always try to do what is best for my family.

The $2.00 salary enhancement would not only help our family and our financial situation but would help every basic care and nursing facility employees doing the same work everyday. Helping people!

I ask you to support HB1012, which contains the 7% inflator and consider an amendment to increase all long-term care salaries and benefits by $2.00. This will help me continue to care for our residents, which I love to do.

Thank you Chairman Pollert and committee members for giving me the opportunity to visit with you today. If you have any questions I would be happy to address them at this time.

Mr. Chairman and members of the committee, my name is Leontine Gabel. I have utilized services of Quality Service Provider's (QSP's) for the last 5 plus years. I never intended on ever using this service but because of a series of unfortunate events, I was forced to turn to QSP services. My late husband had Parkinsons Disease so he required much care. Since all our children were grown I had to do it alone, so I thought. Even though, our daughter offered to assist, I was "too proud" to say yes. I felt I made vows for "in sickness and in health" so I must take care of my husband.

In May 2003 while attending a social event at our church I had a stroke. I resided in a long term facility for 5 months before returning home. We were fortunate that our daughter acquired the information from Social Services to become a Qualified Service Provider. If it had not been for QSP Services we would have been forced out of our home long before we left. Not only was this helpful to us, it also saved the government a lot of money.

QSP's are extremely in demand and deserve a decent wage. Not everyone can do this type of work and as in all professions, there are some that are dishonest etc.. Overall there are many great QSP's that go above and beyond their call of duty. Sometimes even on their own time to help someone out, for instance, taking someone to the doctor because this individual has no family here; or taking a client to lunch and paying for both just so this client can get out. Remember this; someday you like me may need this service. We never know what our future will be. Consider this in your vote on House Bill 1012.

Leontine Gabel

Leontine Gabel

1016 North 28th Street #402
Bismarck, ND 58501
223-3521

Testimony on HB 1012
Senate Appropriations
March 9, 2009

My name is Kurt Stoner and I am the administrator of Bethel Lutheran Home in Williston, ND. Bethel Lutheran Home is a 168 bed skilled nursing home and a 19 bed basic care facility. Through our Foundation we also offer senior living through 47 senior independent living apartments. I also currently serve as chairman of our North Dakota Long Term Care Association Board of Directors. I am here today on behalf of the 13,000 North Dakota residents who are provided care in basic care and nursing facilities throughout our state. This past year at Bethel we have experienced a staffing crisis that has not been equaled in my 17 years of service to that organization. We have stopped or slowed admissions numerous times throughout 2008 in an effort to maintain quality care for those we serve. In May of 2008 we increased salaries by 50¢ per hour for all of our staff in an effort to become more competitive with the local labor market. This adjustment was above and beyond the annual performance adjustment our employees are eligible on their anniversary date of employment. Although the salary adjustment did make a difference in our ability to attract staff we found we are still unable to compete in our local economy due to the heightened oil activity. In October of 2008, our Board of Directors approved an additional 50¢ per hour increase to all staff. Today our CNA's starting salary at 10.85 an hour. I am pleased to report following the second salary adjustment that our staffing improved significantly. However, the combination of slowing admissions (up to 16 open beds) while at the same time increasing our salaries is probably not an option for most nursing homes. Because of our reimbursement system in North Dakota the vast majority of these costs will not be recognized until 2010, with 8 months of the second 50¢ raise not recognized until 2011 rate year.

Bethel at this time is experiencing significant losses from operation. After our second salary adjustment our losses total over $130,000 in November and December alone. Because of funded depreciation monies that have been previously set aside we are able to pay for these salary increases until our costs are recognized in future rate years. This however is not the case for many nursing homes. Since October our staffing has improved and we currently have only 6 open beds with prospect for several more admission. My story may be unique only because my set of circumstances involves an oil boom economy. However, in Fargo or Bismarck it may not be oil, but a diverse economy with more options available for prospective employees. In smaller communities you are competing for a limited number of workers in your geographic region. The end result however is the same. If we cannot offer competitive wages we cannot attract quality, compassionate caregivers. A salary/benefit pass through, however, will provide the upfront monies to allow facilities who do not have the cash reserves to pay a living wage to their employees and get those costs recognized immediately. North Dakotans are blessed to have 83 Nursing Homes and 58 Basic Care Facilities throughout our State. The majority of these facilities are non-profit facilities whose original mission statement resonates through the quality care they provide. I want to thank you for your time and ask for your support for the Governor's proposed inflator and salary/benefit pass through that that will allow all of us the ability to maintain our history of providing quality, compassionate care. Thank you.

Kurt Stoner, Administrator
Bethel Lutheran Home
1515 2nd Ave W ♦ Williston, ND 58801 ♦(701) 572-6766
www.bethelutheranhome.com♦ kstoner@bethellutheranhome.com

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations Committee
Senator Holmberg, Chairman
March 9, 2009

Chairman Holmberg and members of the Senate Appropriations Committee, I am Jane Strommen, Director of Community of Care. I am here to testify and ask for your support of our program by including it in the Department of Human Services' budget. Community of Care is currently not part of House Bill 1012 or an OAR.

My purpose here today is to briefly summarize the work of Community of Care and explain its significant value to rural communities, their older residents, their families, and taxpayers.

Community of Care is a new membership-based non-profit organization. It began as a pilot project of the Good Samaritan Society's nursing home in Arthur. Its mission is to assure older adults and others in need in rural Cass have access to essential health, human, and spiritual services essential to their well being and offered within a community of faith. It was created to address the significant changes rural communities have experienced over the past decades and the resulting impact on older adults. The loss of farming as a main way of life, out migration of young people, and loss of local businesses have changed neighborhoods and communities in both subtle and overt ways. These changes have altered the sense of community, personal experiences and social relationships among the persons remaining in these communities. To mitigate some of the challenges of growing old in a rural environment, Community of Care has developed a number of social and

community supports identified as needed from a community planning process. Some of the services include information/referral and assistance, caregiver support, State Health Insurance Counseling, a volunteer program, health promotion, and education on relevant aging issues. Last year, over 600 unduplicated persons were served by staff, who partnered with 40+ community volunteers, with parish nurses, with civic and service clubs, with area youth, and with formal service providers. Collaboration and coordination with both formal and informal organizations helps to maximize current resources and minimize duplication. Last year, a formal interagency agreement was established between Community of Care and Cass County Social Services, Fargo-Cass Public Health, Fargo Senior Services, and the Family Caregiver Program (SEHSC). The purpose of the collaborative agreement is to assist the client in accessing eligible services so they can remain in their home or the least restrictive setting. The collaborative is a "no wrong door" approach, meaning regardless of which agency receives the initial client contact, the client is going to receive access to available services in the most simplified process possible.

Community of Care is working to improve the long-term care system in incremental, practical, commonsense ways and, at the same time, develop a model for other rural communities to create the capacity (not institution) to support its older residents. Community of Care currently has a contract with the Department through its Money Follows the Person Grant to provide planning of home and community-based service use in 10 counties.

Researchers have hypothesized that communities are perceived as 'good places to grow old' when relevant services are delivered, social ties exist,

and commitment to the needs of older residents is evident. Community of Care is striving to help rural Cass County be a good place to grow old. North Dakota faces significant challenges in being a good place to grow old because of rural depopulation, out migration of young adults, and an increasing proportion of elderly. In 2000, almost 60% of towns had a population of fewer than 250 people and, at the same time, 40 counties have been experiencing a loss in population. These trends pose serious concerns for the state in meeting the needs of its older citizens.

Community of Care is currently funded by grants, a United Way allocation, and local membership contributions from its 200+ individual and organizational members. We are requesting $120,000 during the next biennium so Community of Care can use its experience and knowledge learned to date to fully develop an efficient, flexible, local model and to conduct an evaluation to measure outcome objectives. The outcome objectives include: (1) Improve the availability and awareness of supports necessary to help older adults maintain their independence and remain in their homes and communities as long as possible; (2) Assist in re-vitalizing rural communities by providing access to healthcare and other essential services and by building community and faith-based partnerships, and (3) Realize cost savings to taxpayers by delaying utilization of institutional care and promoting more cost-effective services.

I would ask for your partnership in funding a program that could have a significant impact on the quality of life and financial well-being of many North Dakotans. I would be happy to answer any questions you may have.

Community of Care

Following are two examples of Community of Care providing care and support to individuals who otherwise would be at risk of pre-mature institutionalization or unnecessary hospitalizations:

The Need

Mr. E is a 47 year old who lives with his elderly father. He is disabled due to severe diabetes and other complicating health conditions. Last year, Mr. E developed a life-threatening infection which resulted in a lengthy hospital stay of over two months. The following months brought several re-hospitalizations and emergency room visits. Unless Mr. E's health status could be stabilized, he had few options other than being admitted to a nursing home. Community of Care was able to provide the assistance Mr. E desperately needed.

The Outcome

Mr E now has volunteers 4 days a week to get him to and from dialysis treatment, not including volunteers who provide rides for additional medical appointments. Community of Care assists Mr E with billing paying, paperwork and prescription and financial assistance. Because of his serious health condition, Community of Care provides close health monitoring directly and in collaboration with other health professionals to reduce the likelihood of unnecessary institutionalization or hospitalization. Since Community of Care started helping Mr E, he has been able to avoid a health crisis, has not had a hospital stay and has maintained a reasonable quality of life. Mr. E is a Medicaid client.

The Need

Mr. D is an 88 year old who lives alone. He lives a quiet life, keeping to himself, picking up aluminum cans in the community, and caring for his birds and cats. When he developed some health problems, his life changed. Having the flu and not being able to put weight on his legs left him bedridden and unable to summon help. It was several days before help arrived. Our Volunteer Coordinator, while stopping by for a visit, found Mr. D and was able to provide the help he critically needed.

The Outcome

Our Volunteer Coordinator was able to arrange for Mr. D to be hospitalized to get his health condition treated and stabilized. During a short-term nursing home stay for physical therapy, Mr. D was able to stay current with his bills, get his mail regularly, have someone check on his apartment, have his pets cared for, and have other errands done, as needed. Mr. D was able to leave the nursing home and return home to his apartment, pets, and friends because of Community of Care arranging and coordinating the efforts of both volunteers and health care professionals. Today, Community of Care helps manage his medical and service needs, arranges transportation, and assures his social and emotional needs are met. It is highly unlikely Mr D would be able to continue living in his own home and community without the assistance of Community of Care. Mr. D is also a Medicaid client.

Our funding request will allow us to develop an evaluation plan and gather the data to determine if the program is achieving a lower than expected incidence of institutional care or emergency room services in comparison to similar populations not served by this type of program.

A

Testimony
House Bill 1012 – Department of Human Services
Conference Committee
Representative Pollert, Chairman
April 23, 2009

Chairman Pollert and members of the Conference Committee, I am Jane Strommen, Director of Community of Care. Thank you for the opportunity to be here today to briefly summarize the work of Community of Care and explain its significant value to rural communities, their older residents, their families, and taxpayers.

Community of Care is a new membership-based non-profit organization. It began as a pilot project of the Good Samaritan Society's nursing home in Arthur. Its mission is to assure older adults and others in need in rural Cass have access to essential health, human, and spiritual services essential to their well being and offered within a community of faith. It was created to address the significant changes rural communities have experienced over the past decades and the resulting impact on older adults. To mitigate some of the challenges of growing old in a rural environment, Community of Care has developed a number of social and community supports identified as needed from a community planning process. Some of the services include information/referral and assistance, caregiver support, State Health Insurance Counseling, a volunteer program, health promotion, and education on relevant aging issues. Last year, over 600 unduplicated persons were served by staff, who partnered with 40+ trained volunteers, parish nurses, civic and service clubs, area youth, and formal service providers. Collaboration and coordination with both formal and informal organizations helps to maximize current resources and minimize duplication. Last year, a

formal interagency agreement was established between Community of Care and Cass County Social Services, Fargo-Cass Public Health, Fargo Senior Services, and the Family Caregiver Program (SEHSC). The purpose of the collaborative agreement is to assist the client in accessing eligible services so they can remain in their home or the least restrictive setting. The collaborative is a "no wrong door" approach, meaning regardless of which agency receives the initial client contact, the client is going to receive access to available services in the most simplified process possible. Here is one example of how Community of Care is working to keep people in their homes: Volunteer medical transportation is being provided to a 47 year old male who requires dialysis four times per week. He is a Medicaid client. Each day of dialysis, a volunteer drives 50 miles and gives six hours of his or her time. In addition, Community of Care staff provides assistance with bill paying and paperwork completion. Care coordination with family members, public health and county social services is provided so this gentleman's health care needs are met, preventing costly hospital stays, ER visits, and nursing home admission.

Community of Care is a unique model and different from the Aging and Disability Resource Center (ADRC) concept in the following ways:

- It is a flexible, non-bureaucratic organization that can respond effectively to local needs.
- It is a community-based program with a sense of ownership demonstrated through volunteerism, governance, and financial support.
- It is specifically a "rural" program that utilizes culturally sensitive approaches to reach and serve people.

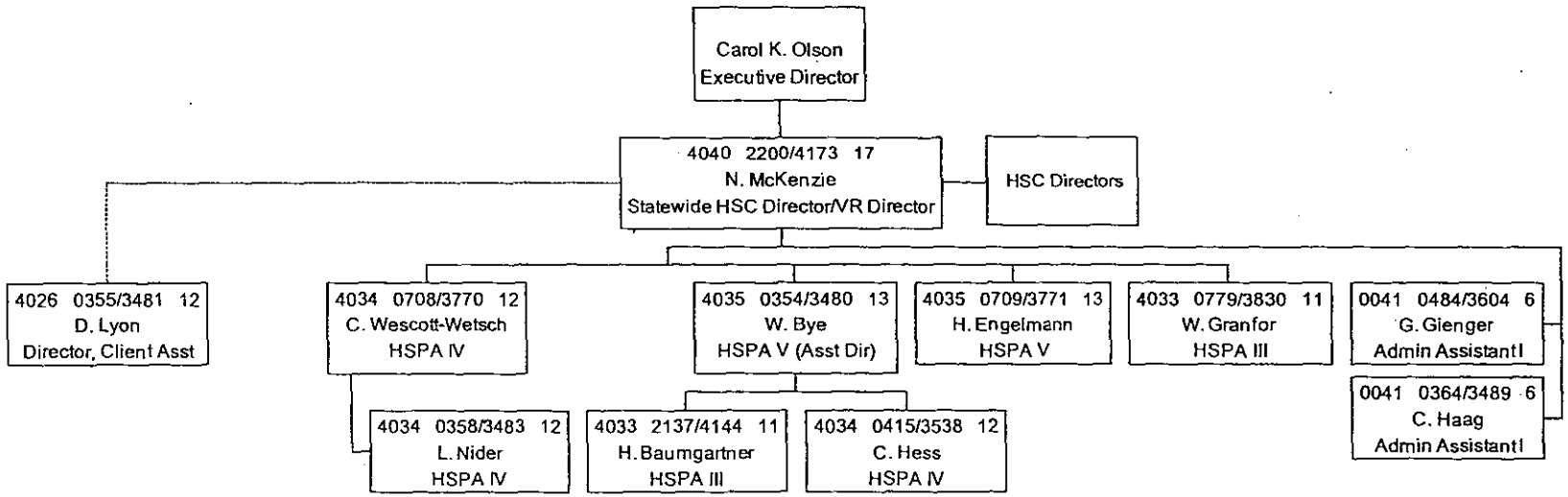
- Community of Care has collaborated with community leaders and key service providers to develop needed services in the area.
- It does not have the stigma associated with county social service agencies.
- There is a demonstrated willingness of people to support and pay for this type of program, through membership and charitable gifts.

Community of Care has an annual budget of $175,000, with current revenue coming from foundation grants, charitable contributions, government contracts/grants, and a United Way allocation. We are requesting $120,000 during the next biennium so Community of Care can use its experience and knowledge learned to date to fully develop an efficient, flexible, local model and to conduct an evaluation to measure outcome objectives. Following are just a few of the benefits of this program:

- Addresses services found to be lacking or insufficient.
- Possesses a strong volunteer component as part of the program.
- Increases knowledge and awareness to help people access the current system of services.
- Promotes individual and community responsibility and support.
- Delays institutional care and promotes more cost effective services.

Community of Care is working to improve the current long-term care system in incremental, practical, commonsense ways, and at the same time, develop a model for other rural communities. I would ask for your approval of this funding request. Thank you.

North Dakota Department of Human Services
Vocational Rehabilitation

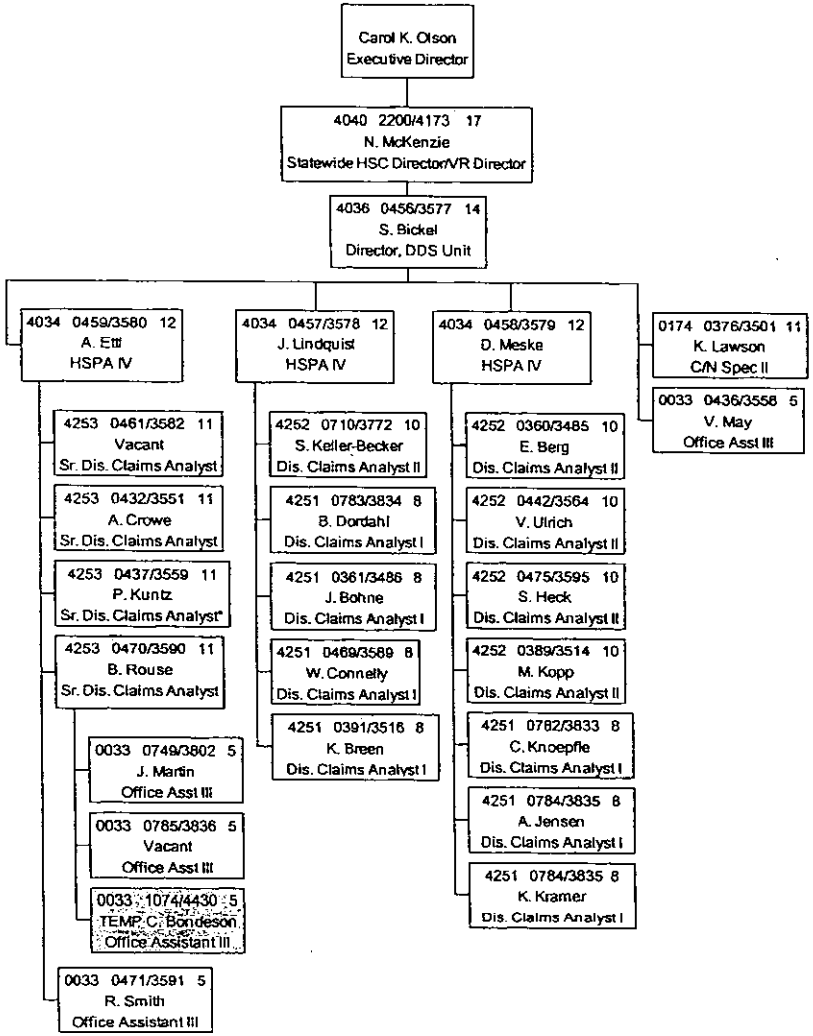


Position #0501/3620 listed under DD Org Chart

2007 - 2009 Budget: 11 FTEs

Revised 1/7/09

North Dakota Department of Human Services
Disability Determination Services



*Pending Reclassification

2007 - 2009 Budget
24 FTEs

Revised 1/7/09

Testimony
House Bill 1012 – Department of Human Services
House Appropriations Human Resources Division
Representative Pollert, Chairman
January 13, 2009

Chairman Pollert, members of the House Appropriations Human Resources Division, I am Nancy McKenzie, Director of the Vocational Rehabilitation Division (VR) which includes the Disabilities Determination Services (DDS) unit of the Department of Human Services (DHS). I am here today to provide you with an overview of the program trends and budget requests in these two programs. Staff are responsible for administrative and policy direction in regard to a range of services for individuals with disabilities.

Programs

Vocational Rehabilitation is made up of 10 FTEs who are responsible for the administration of Titles I, VI, and VII of the Rehabilitation Act, as amended. As such, they are responsible for needs assessment, staff training, site plan development and outcome monitoring, development of policy, quality assurance, client advocacy through the Client Assistance Program, oversight of expenditure of federal VR funds, and compliance with federal rules.

To carry out these responsibilities, VR unit staff work with regional VR staff at the human services centers, with community business partners, schools and universities, Job Service, the State Rehabilitation Council, the State Independent Living Council, Centers for Independent Living, federal oversight agencies, and other private and public entities involved in rehabilitation services.

Statewide Trends

- Veterans' Needs: Projections indicate that there is a growing population of returning veterans with traumatic brain injury problems. We anticipate increased need in this area, and VR is working with the Veterans Administration to prepare for this.
- Workforce Development: VR works closely with the Governor's Workforce Development initiative, to assist in preparing individuals for employment in those sectors of highest need in the state. Individuals with disabilities are an important part of the total job pool for North Dakota.
    - Job Market Impact: North Dakota's low rate of unemployment and number of available open positions has resulted in fewer individuals seeking VR assistance. We are focusing on assisting employers to not only continue recruiting, but to retain employees with disabilities who may need workplace evaluations or modifications.
- Transition-age Youth: This population sector presents special needs in the areas of employment and independent living.
- Increased Federal Accountability Requirements:
    - Both the RSA and the Social Security Administration are placing great emphasis on achievement of state plan outcomes and adherence to federal outcome guidelines. Failure to meet these expectations can result in sanctions including plans of correction and possible loss of funds.
    - RSA review of VR programs in November 2008 showed North Dakota to be achieving its goals and standards; we are awaiting the written report with recommendations for

changes, particularly in the areas of quality improvement and long-range fiscal planning.

- SSA determines annual workload goals, goals for quality and goals for claims completion time in the DDS unit.

Accomplishments

- 903 individuals were assisted into employment following VR services during FFY 2008.
  - Of these, 88% were individuals with a significant disability.
  - Over 98% receive pay at or above minimum wage.
  - Average hours worked per week changed from 10 to 33; average earnings increased from $92.92/week to $377.46/week at closure.
  - Client Payback: for every $1.00 spent by VR for FFY 2008, clients pay back $2.01 in taxes.
- The Social Security Administration reimbursed the VR program $315,735 in FFY 2008. This represents reimbursement for 33 successful closures of individuals previously receiving disability payments.
- VR co-chairs the state Transition Steering Committee, which brings together multiple service providers for youth, to improve services and reduce duplication. The Community of Practice model includes working groups in all regions of the state.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase/ Decrease
Salary and Wages	3,322,451	4,155,296	832,845
Operating	1,522,560	2,102,575	580,015
Grants	18,817,218	19,750,721	933,503
Total	23,662,229	26,008,592	2,346,363
General Funds	4,259,542	5,200,705	941,163
Federal Funds	19,295,687	20,717,664	1,421,977
Other Funds	107,000	90,223	(16,777)
Total	23,662,229	26,008,592	2,346,363
FTE	34.00	34.00	0.00

- The salary and wages line item increased by $832,845, and can be attributed to the following:
  - $377,913 in total funds of which $92,506 is general fund to fund the Governor's salary package for state employees.
  - $21,770, of which $17,019 is general fund, to continue the second year of the 4% salary increase.
  - The remaining $433,162, which includes a decrease of $46,883 in general fund, is a combination of increases and decreases needed to sustain the salary of the 34 FTE in this area of the budget.

- The operating line item increased by $580,015 (6%). This includes $92,620 in general funds and is a combination of the increases expected next biennium which are offset by decrease as follows:
  - Increase of $48,584 in rentals/leases for building space;
  - Increase of $157,935 in travel to required federal meetings;
  - Increase in operating fees and services: in VR, this includes $343,180 for the public awareness media campaign. Public

input meetings have regularly indicated that this is a critical part of reaching out to our target population.
    - Increase of $57,520 in printing costs;
    - Increase of $43,319 in professional development and professional fees;
    - Decreases of $70,523 in office furniture, supplies, and postage offset these increases.

- The grants line item increases by $933,503. $800,000 of this increase is general funds, related to the Governor's budget increase for independent living services. This increase will continue the effort to expand that program statewide, reaching more individuals who can be assisted to remain living in their homes in the community.
    - The remaining $133,503 includes increases in federal funds of $154,602 and is offset by decreases in general fund of $14,099 and other funds of $7,000.

- FTE: There are no FTE changes in this budget.

This concludes my testimony; I would be happy to answer any questions you may have. Thank you.

Vocational Rehabilitation

Detail of Budget Account Code 712000 - Grants, Benefits and Claims

Grants	Amount	General	Federal/Other
Older Blind Vision Services - client purchases	76,657	7,666	68,991
Randolph Sheppard program	90,000	-	90,000
Technical Assistance for Individuals with Disabilities - IPAT contract	1,200,982	500,000	700,982
Basic Support transition services	397,500	84,668	312,832
Basic Support	13,922,870	2,564,171	11,358,699
Independent Living - contracts with CILs	2,144,539	1,330,958	813,581
Extended Services	142,173	142,173	-
Supported Employment	450,000	-	450,000
Disability Determination Services	1,326,000	-	1,326,000
Total Grants Budget Account Code	19,750,721	4,629,636	15,121,085

C

Department of Human Services
HB1012
Travel Increase - Vocational Rehabilitation

Department Wide Travel Rates used in Budget Preparation

Budgeted Travel Rates				
In-State Travel	07-09 Biennium	09-11 Biennium	Difference	% Difference
Meals	25	25	0	
IRS Meals Taxable	10	10	0	
Lodging (Includes Taxes)	55	61	6	9.84%
Mileage (Non-State Employee or Personal Vehicle)	0.375	0.45	0.075	16.67%
Motor Pool Mileage	0.37	0.40	0.03	7.50%
Out of State Travel				
Meals	64	64	0	
Lodging (Includes Taxes)	140	140	0	
Mileage	0.375	0.45	0.075	16.67%
Airfare	600	800	200	25.00%
Other Transportation (Taxi, parking, etc.)	60	60	0	

	07-09		09-11		Breakdown of Rate Increases			Rate	Utilization	Total
	Trips	Budget	Trips	Budget	Lodging	Mileage	Airfare	Increase	Increase*	
Total Non-Employee Trips	132	$ 26,210	179	$ 45,427	$ 600	$ 573	$ 2,000	$ 3,173	$ 16,044	$ 19,217
Total In-State Trips	370	$ 48,065	426	$ 96,798	$ 3,012			$ 3,012	$ 45,721	$ 48,733
Total Out-of-State Trips	60	$ 90,363	96	$ 180,348			$ 12,000	$ 12,000	$ 77,985	$ 89,985
Total		$ 164,638		$ 322,573	$ 3,012	$ 573	$ 12,000	$ 18,185	$ 139,750	$ 157,935

*Explanation of usage increases:

Non-Employee Trips increased due to increased participation by members of State Rehab Council and the need to have a DDS medical consultant provide outreach services. Out-of-state trips are for State Independent Living Council (SILC) members to attend the National SILC Congress and the National CIL conference. One trip has been included for one of the DDS medical consultants.

In-State Trips increased due to needs for additional monitoring required by federal regulations.

Out-of-State Trips increased due to meetings required by federal governing agencies for VR and DDS. Also, the Social Security Administration (SSA) is beginning the work to replace their current computer system and is requiring multiple meetings on the development of the new system.

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code		Prior Biennium Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-51 VOC REHAB									
32530	B	611000	Professional Development	79,479	85,125	37,499	23,175	0	108,300
32530	B	621000	Operating Fees and Services	140,100	149,980	184,070	343,180	0	493,160
32530	B	623000	Fees - Professional Services	604,940	561,480	336,409	20,144	0	581,624
32530	B	625000	Medical, Dental and Optical	617	0	0	0	0	0
			Subtotal:	1,575,931	1,522,560	926,945	580,015	0	2,102,575
32530	F	F_3991	Operating - General Fund	214,808	131,161	143,079	92,620	0	223,781
32530	F	F_3992	Operating - Federal Funds	1,360,834	1,382,525	782,896	496,046	0	1,878,571
32530	F	F_3993	Operating - Other Funds	289	8,874	970	(8,651)	0	223
			Subtotal:	1,575,931	1,522,560	926,945	580,015	0	2,102,575
32560	B	712000	Grants, Benefits & Claims	16,387,205	18,817,218	7,504,192	933,503	0	19,750,721
			Subtotal:	16,387,205	18,817,218	7,504,192	933,503	0	19,750,721
32560	F	F_6991	Grants - General Fund	640,598	3,843,735	841,520	785,901	0	4,629,636
32560	F	F_6992	Grants - Federal Funds	15,654,105	14,876,483	6,622,344	154,602	0	15,031,085
32560	F	F_6993	Grants - Other Funds	92,502	97,000	40,328	(7,000)	0	90,000
			Subtotal:	16,387,205	18,817,218	7,504,192	933,503	0	19,750,721
			Subdivision Budget Total:	20,900,464	23,662,229	10,061,880	1,968,450	377,913	26,008,592
			General Funds:	1,299,287	4,259,542	1,176,768	848,657	92,506	5,200,705
			Federal Funds:	19,508,369	19,295,687	8,842,688	1,136,570	285,407	20,717,664
300-51 VOC REHAB			**Other Funds:**	92,808	107,000	42,424	(16,777)	0	90,223
			SWAP Funds:	0	0	0	0	0	0
			County Funds:	0	0	0	0	0	0
			IGT Funds:	0	0	0	0	0	0
			Subdivision Funding Total:	20,900,464	23,662,229	10,061,880	1,968,450	377,913	26,008,592

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code		Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 300-51 VOC REHAB									
		S101 FULL-TIME EQUIVALENTS (FTEs)		33.100	34.000	0.000	0.000	0.000	34.000
32510	B	511000 Salaries - Permanent		2,079,019	2,341,107	1,143,184	408,968	1	2,750,076
32510	B	513000 Temporary Salaries		45,752	30,600	28,214	(600)	0	30,000
32510	B	514000 Overtime		8,665	1,704	624	(696)	0	1,008
32510	B	516000 Fringe Benefits		803,892	949,040	458,721	47,260	139,356	1,135,656
32510	B	599110 Salary Increase		0	0	0	0	204,268	204,268
32510	B	599160 Benefit Increase		0	0	0	0	34,288	34,288
			Subtotal:	2,937,328	3,322,451	1,630,743	454,932	377,913	4,155,296
32510	F	F_1991 Salary - General Fund		443,881	284,646	192,169	(29,864)	92,506	347,288
32510	F	F_1992 Salary - Federal Funds		2,493,430	3,036,679	1,437,448	485,922	285,407	3,808,008
32510	F	F_1993 Salary - Other Funds		17	1,126	1,126	(1,126)	0	0
			Subtotal:	2,937,328	3,322,451	1,630,743	454,932	377,913	4,155,296
32530	B	521000 Travel		149,358	164,638	85,579	157,935	0	322,573
32530	B	531000 Supplies - IT Software		32,658	31,114	20,078	(8,064)	0	23,050
32530	B	532000 Supply/Material-Professional		4,250	6,868	735	(1,228)	0	5,640
32530	B	534000 Bldg, Grounds, Vehicle Supply		71	0	0	0	0	0
32530	B	535000 Miscellaneous Supplies		15,985	13,700	4,264	(900)	0	12,800
32530	B	536000 Office Supplies		33,965	18,483	9,747	(2,983)	0	15,500
32530	B	541000 Postage		44,967	50,580	11,098	(37,950)	0	12,630
32530	B	542000 Printing		70,013	43,780	29,023	57,520	0	101,300
32530	B	551000 IT Equip under $5,000		0	100	13	1,900	0	2,000
32530	B	552000 Other Equip under $5,000		5,500	12,121	12,121	(12,121)	0	0
32530	B	553000 Office Equip & Furniture-Under		10,378	14,000	5,210	(9,500)	0	4,500
32530	B	581000 Rentals/Leases-Equip & Other		11,040	15,960	8,880	16,624	0	32,584
32530	B	582000 Rentals/Leases - Bldg/Land		366,962	345,374	177,494	31,960	0	377,334
32530	B	591000 Repairs		2,651	4,300	4,270	200	0	4,500
32530	B	601000 IT - Data Processing		571	389	11	2,141	0	2,530
32530	B	602000 IT-Communications		2,117	4,528	404	(1,978)	0	2,550
32530	B	603000 IT Contractual Services and Re		309	40	40	(40)	0	0

Department of Human Services
HB 1012
Vocational Rehabilitation Salary Changes Detail

	DDS	VR	Total	Percentage
Payouts for Retirement	63,564	62,047	125,611	29.00%
Reclassifications & Workload increases	140,135	4,928	145,063	33.00%
Position Transfer from Southeast HSC (vacant VR 1.0 FTE)	0	162,488	162,488	38.00%
Total	203,699	229,463	433,162	100.00%
General	0	45,814	45,814	11.00%
Federal	203,699	183,649	387,348	89.00%

Vocational Rehabilitation

Detail of Budget Account Code 582000 - Rentals/Leases

Rentals & Leases	Amount	General	Federal Other
Vocational Rehabilitation			
Staff located at Prairie Hills Plaza - $14.05 per sq foot	82,794	13,929	68,865
Miscellaneous booth and meeting room rental	14,050	2,856	11,194
Disability Determination Services			
Staff located at Prairie Hills Plaza - $14.05 per sq foot	280,490	0	280,490
Total Rentals & Leases Budget Account Code	377,334	16,785	360,549

Vocational Rehabilitation

Detail of Budget Account Code 621000 - Operating Fees & Services

Operating Fees & Services	Amount	General	Federal/Other
Vocational Rehabilitation			
Years of Service Awards	1,600	160	1,440
Duplication of self-employment & transition DVDs	13,000	2,769	10,231
121 Good Health TV campaign	90,000	19,170	70,830
Public awareness media campaign	375,000	79,875	295,125
Duplication of business card CDs	5,000	1,065	3,935
SILC meeting announcements in papers	1,970	778	1,192
Freight	240	37	203
Disability Determination Services			
Employee service awards	2,000	0	2,000
Analyst staff awards	300	0	300
Security system - SSA requirement	3,000	0	3,000
Medical licenses	800	0	800
Background checks	100	0	100
Storage costs for backup tapes	150	0	150
Total Operating Fees & Services Budget Account Code	493,160	103,854	389,306

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations Committee
Senator Holmberg, Chairman
March 4, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, I am Nancy McKenzie from the Department of Human Services (DHS). I am here today to provide you with an overview of the program trends and budget requests for the Vocational Rehabilitation Division, which includes the Disability Determination Unit. Staff in these areas are responsible for administrative and policy direction in regard to a range of services for individuals with disabilities.

Programs

Vocational Rehabilitation is made up of 10 FTEs who are responsible for the administration of Titles I, VI, and VII of the Rehabilitation Act, as amended. As such, they are responsible for needs assessment, staff training, site plan development and outcome monitoring, development of policy, quality assurance, client advocacy through the Client Assistance Program, oversight of expenditure of federal VR funds, and compliance with federal rules.

To carry out these responsibilities, division staff work with regional VR staff at the human services centers, as well as community business partners, schools and universities, Job Service, the State Rehabilitation Council, the State Independent Living Council, Centers for Independent Living, federal oversight agencies, and other private and public entities involved in rehabilitation services.

The services are funded through federal funds received through the Department of Education, Rehabilitation Services Administration (RSA), along with the required general fund match. The federal participation level is 78.7%.

Disabilities Determination Services includes 24 FTEs who are responsible for individual eligibility determination for Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) statewide. The staff receive claims from the local Social Security offices, gather supporting data, and determine whether or not an individual meets the federal criteria for enrollment in SSDI or SSI.

DDS services are funded 100% through federal funds received from the Social Security Administration.

Clients Served

Vocational Rehabilitation – FFY 2008

- 6,472 individuals received employment services through VR. This is a decrease from the previous year, impacted by North Dakota's strong job market and availability of employment.
- 8,198 individuals received independent living services; this is an increase from the previous year, with additional funding for the Independent Living Centers supported by the 2007 Legislature.
- 319 employers hired or retained VR clients as the result of a VR contact. 3,260 total employer contacts took place.
- 1,109 individuals were served through the Older Blind Program.

Disability Determination Services – FFY 2008

- 5,563 eligibility applications were cleared for SSI/SSDI.

Statewide Trends

- Veterans' Needs: Projections indicate that there is a growing population of returning veterans with traumatic brain injury problems. We anticipate increased need in this area, and VR is working with the Veterans Administration to prepare for this.
- Workforce Development: VR works closely with the Governor's Workforce Development initiative, to assist in preparing individuals for employment in those sectors of highest need in the state. Individuals with disabilities are an important part of the total job pool for North Dakota.
    - Job Market Impact: North Dakota's low rate of unemployment and number of available open positions has resulted in fewer individuals seeking VR assistance. We are focusing on assisting employers to not only continue recruiting, but to retain employees with disabilities who may need workplace evaluations or modifications.
- Transition-age Youth: This population sector presents special needs in the areas of employment and independent living.
- Increased Federal Accountability Requirements:
    - Both the RSA and the Social Security Administration are placing great emphasis on achievement of state plan outcomes and adherence to federal outcome guidelines. Failure to meet these expectations can result in sanctions including plans of correction and possible loss of funds.
    - RSA review of VR programs in November 2008 showed North Dakota to be achieving its goals and standards; we are awaiting the written report with recommendations for changes, particularly in the areas of quality improvement and long-range fiscal planning.

- SSA determines annual workload goals, goals for quality and goals for claims completion time in the DDS unit.

Accomplishments

- 903 individuals were assisted into employment following VR services during FFY 2008.
  - Of these, 88% were individuals with a significant disability.
  - Over 98% receive pay at or above minimum wage.
  - Average hours worked per week changed from 10 to 33; average earnings increased from $92.92/week to $377.46/week at closure.
  - Client Payback: for every $1.00 spent by VR for FFY 2008, clients pay back $2.01 in taxes.
- The Social Security Administration reimbursed the VR program $315,735 in FFY 2008. This represents reimbursement for 33 successful closures of individuals previously receiving disability payments.
- VR co-chairs the state Transition Steering Committee, which brings together multiple service providers for youth, to improve services and reduce duplication. The Community of Practice model includes working groups in all regions of the state.

Overview of Budget Changes

Description	2007-2009 Budget	Increase/ Decrease	2009-2011 Budget	House Changes	To Senate
Salary and Wages	3,322,451	832,845	4,155,296	(8,119)	4,147,177
Operating	1,522,560	580,015	2,102,575	(73,338)	2,029,237
Grants	18,817,218	933,503	19,750,721	(400,000)	19,350,721
Total	23,662,229	2,346,363	26,008,592	(481,457)	25,527,135
General Funds	4,259,542	941,163	5,200,705	(419,762)	4,780,943
Federal Funds	19,295,687	1,421,977	20,717,664	(50,706)	20,666,958
Other Funds	107,000	(16,777)	90,223	(10,989)	79,234
Total	23,662,229	2,346,363	26,008,592	(481,457)	25,527,135
FTE	34.00	0.00	34.00	0.00	34.00

Budget Changes From Current Budget to Executive Budget:

- The salary and wages line item increased by $832,845, and can be attributed to the following:
  - $377,913 in total funds of which $92,506 is general fund to fund the Governor's salary package for state employees.
  - $21,770, of which $17,019 is general fund, to continue the second year of the 4% salary increase.
  - The remaining $433,162, which includes a decrease of $46,883 in general fund, is a combination of increases and decreases needed to sustain the salary of the 34 FTE in this area of the budget.

- The operating line item increased by $580,015 (6%). This includes $92,620 in general funds and is a combination of the increases expected next biennium which are offset by decrease as follows:
  - Increase of $48,584 in rentals/leases for building space;
  - Increase of $157,935 in travel to required federal meetings;

- Increase in operating fees and services: in VR, this includes $343,180 for the public awareness media campaign. Public input meetings have regularly indicated that this is a critical part of reaching out to our target population.
- Increase of $57,520 in printing costs;
- Increase of $43,319 in professional development and professional fees;
- Decreases of $70,523 in office furniture, supplies, and postage offset these increases.

- The grants line item increases by $933,503. $800,000 of this increase is general funds, related to the Governor's budget increase for independent living services. This increase will continue the effort to expand that program statewide, reaching more individuals who can be assisted to remain living in their homes in the community.
  - The remaining $133,503 includes increases in federal funds of $154,602 and is offset by decreases in general fund of $14,099 and other funds of $7,000.

- FTE: There are no FTE changes in this budget.

House Changes

- The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $2,666 general fund and $5,453 federal funds for a total of $8,119.

- The House reduced 50% of the department-wide travel increase. The VR/DDS share of this decrease is $73,338 total funds; $17,096 general fund.
- The House reduced 50% of the increase in the grants line item for Independent Living Centers, from $800,000 to $400,000, all of which is general fund.

This concludes my testimony; I would be happy to answer any questions you may have. Thank you.

A

Global Behavioral Health Initiative

Description:

Our aim in developing the Global Behavioral Health Initiative was to address as one issue those needs that have impact across the system of care for mental health and substance abuse services. Thus, this was developed to address the following specific goals:

- To more fully develop the continuum of care available to serve clients in least restrictive, community-based settings. This was determined based on input from stakeholder meetings, contracted providers, and DHS regional program staff.
- To impact the North Dakota State Hospital census, which has frequently exceeded 100% during the current biennium; and,
- To provide a consistent rate for all Human Service Center contracts with local hospitals that better meets their actual costs of providing the service. As noted in my overview testimony for the Human Service Center, the current payment structure puts us at risk of losing these local services.

njm – 1-22-09

Department of Human Services
HB 1012
Global Behavioral Health

	Total	General	Federal / Other	FTE
North Central HSC	-			
Increase Inpatient Hospital Contract	457,920	457,920	-	
8 Bed Transitional Living Facility for those with SMI	1,000,387	900,387	100,000	
Subtotal	1,458,307	1,358,307	100,000	-
Northeast HSC				
Increase Inpatient Hospital Contract	72,863	72,863	-	-
Stregnthen Community Supports -				
Social Detox	140,000	140,000	-	-
Supported Residential	149,000	67,800	81,200	-
Subtotal	361,863	280,663	81,200	-
Southeast HSC				
Increase Inpatient Hospital Contract	644,135	644,135	-	-
Add staff at SEHSC due to Cooperhouse	374,830	279,178	95,652	4.00
Contracted Program Assistant 24/7 at Cooperhouse	315,360	236,520	78,840	
Subtotal	1,334,325	1,159,833	174,492	4.00
South Central HSC				
Addiction Services Case Aid	117,008	117,008	-	1.00
West Central HSC				
Increase Inpatient Hospital Contract	279,546	279,546	-	-
Badlands HSC				
Decrease Inpatient Hospital Contract (reflected in WCHSC budget)	(105,000)	(105,000)	-	-
16 Bed Residential Facility	910,000	770,000	140,000	-
	805,000	665,000	140,000	-
HUMAN SERVICE CENTER TOTAL	4,356,049	3,860,357	495,692	5.00
State Hospital	464,419	464,419		6.00
TOTAL GLOBAL BEHAVIOR HEALTH	$ 4,820,468	$ 4,324,776	$ 495,692	11.00

B

Department of Human Services
HB 1012 - Senate amendments
Global Behavioral Health

By Location	General	Federal / Other	Total	FTE
North Central HSC				
Increase Inpatient Hospital Contract	457,920	-	457,920	
8 Bed Transitional Living Facility for those with SMI	900,387	100,000	1,000,387	
Subtotal	1,358,307	100,000	1,458,307	-
Northeast HSC				
Increase Inpatient Hospital Contract	72,863	-	72,863	-
Stregnthen Community Supports -				
Social Detox	140,000	-	140,000	-
Supported Residential	67,800	81,200	149,000	-
Subtotal	280,663	81,200	361,863	-
Southeast HSC				
Increase Inpatient Hospital Contract	644,135	-	644,135	-
Add staff at SEHSC due to Cooperhouse	309,469	104,906	414,375	4.00
Subtotal	953,604	104,906	1,058,510	4.00
South Central HSC				
Addiction Services Case Aid	127,669	-	127,669	1.00
West Central HSC				
Increase Inpatient Hospital Contract	279,546	-	279,546	-
Badlands HSC				
Decrease Inpatient Hospital Contract (reflected in WCHSC budget)	(105,000)	-	(105,000)	-
16 Bed Residential Facility	770,000	140,000	910,000	-
Subtotal	665,000	140,000	805,000	-
HUMAN SERVICE CENTER TOTAL	3,664,789	426,106	4,090,895	5.00
State Hospital - only 5 of the 6 needed	424,084		424,084	5.00
TOTAL GLOBAL BEHAVIOR HEALTH	$ 4,088,873	$ 426,106	$ 4,514,979	10.00
Already Included by the House in HB 1012				
Contracted Program Assistant 24/7 at Cooperhou	236,520	78,840	315,360	-

By Category	General	Federal / Other	Total	FTE
Hospital Contracts - Net Increase at same rebased amounts in Medicaid budget	1,349,464	-	1,349,464	-
Residential - North Central and Badlands	1,670,387	240,000	1,910,387	-
Community Supports - Northeast	207,800	81,200	289,000	
HSC Staff - Southeast - 4; South Central -1	437,138	104,906	542,044	5.00
State Hospital staff	424,084		424,084	5.00
	$ 4,088,873	$ 426,106	4,514,979	10.00

Department of Human Services
HB 1012
HSC Global Behavioral Health OAR

Hospital	A Daily Rate based on costs	B Mean plus standard deviation of 1	C Lower of A or B	D Number of days - 1500	C * D Estimated Annual Costs	D * 2 Estimated Biennial Costs
St. Alexius	751.50	1,020.48	751.50	150	112,725	225,450
Meritcare	805.79	1,020.48	805.79	650	523,764	1,047,528
Altru	954.61	1,020.48	954.61	100	95,461	190,922
MedCenter One	1,244.73	1,020.48	1,020.48	100	102,048	204,096
Trinity	657.29	1,020.48	657.29	500	328,645	657,290
				1,500	1,162,643	2,325,286

Testimony
House Bill 1012 – Department of Human Services
House Appropriations - Human Resources Division
Representative Pollert, Chairman
January 14, 2009

Chairman Pollert, members of the House Appropriations Human Resources Division, I am Nancy McKenzie, Statewide Director of the Regional Human Service Centers (HSCs) for the Department of Human Services (DHS). I am here today to provide you with an overview of the budget, program trends and direction in the regional centers. Your committee will later receive specific testimony from each of the center directors.

Human Service Centers

- The 8 Regional Human Service Centers are a network of outpatient behavioral health clinics that serve individuals whose illness, addiction, disability or conditions place them at risk of harm or institutional placement. They provide an important community safety net for our most vulnerable citizens, to ensure that services are available and accessible at the most appropriate and cost-effective level of care.
- Each of the centers provides the "Core Services" as outlined in the attached document. We continue to place a high value on alignment across the regions, operating as one public system that shares resources as needs and demands shift.
- Services are provided within the clinic setting, various rural outreach centers, in client homes, or other community settings, and include 24-hour emergency services as well as follow-up services.

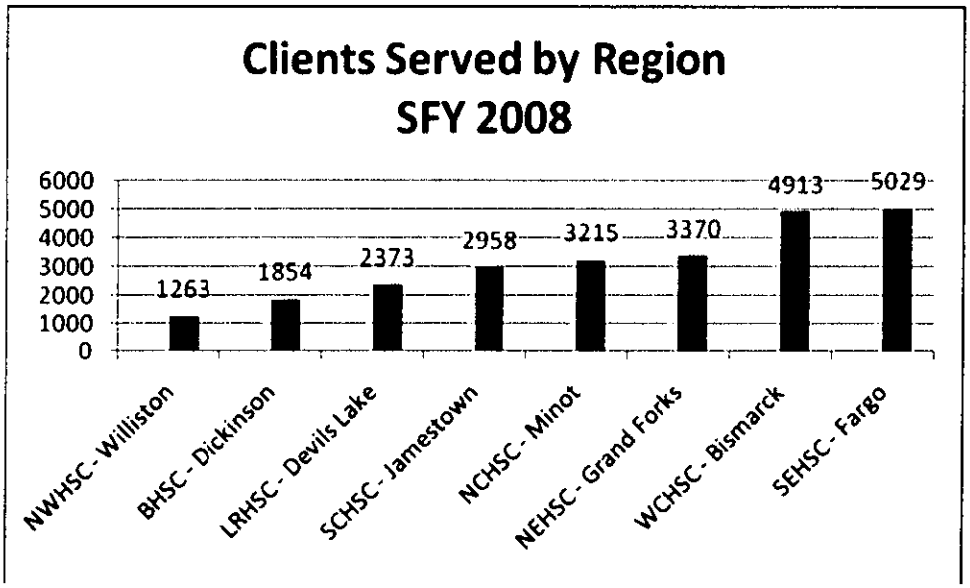
- In addition to direct evaluation and treatment services, the HSCs are responsible for program supervision and regulatory oversight of the Child Welfare services provided by county social services as well as oversight of the Aging Services programs in their regions.

Clients Served

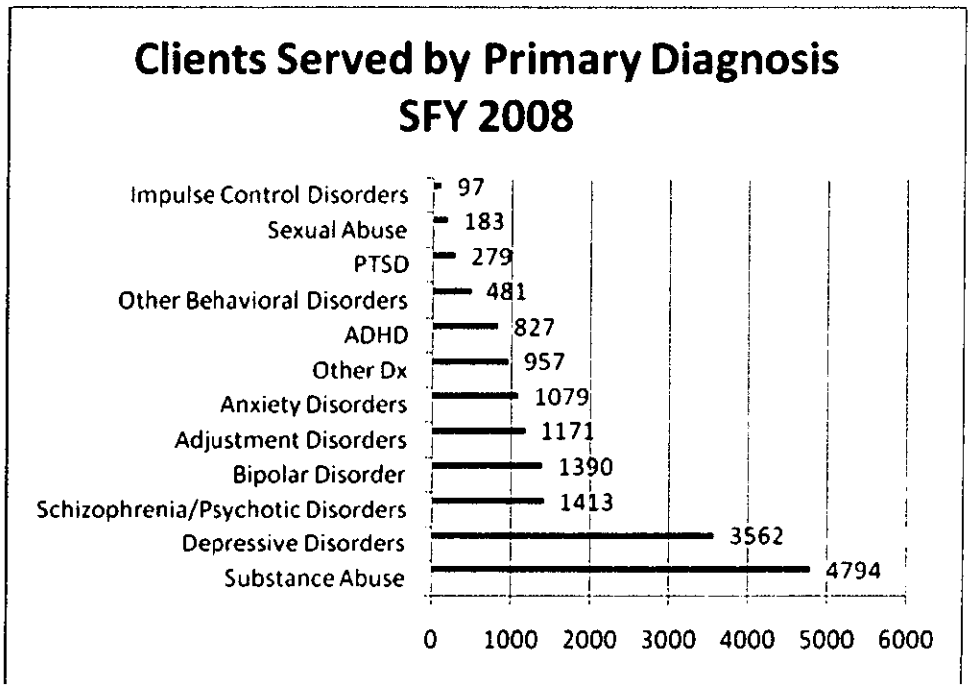
Demographics of those served in State Fiscal Year 2008 include:

- Over 24,975 individuals were served excluding Vocational Rehabilitation (VR); this is an approximately 3.5% increase over the prior year, and represents 4% of North Dakota's residents. Individual regions served from 3-6% of their population base.
- 25% of clients served were children; 75% were adults.
- Only 10% of clients are served just once (evaluation, etc.), while 90% receive services over a period of time.
- During the same period, VR served 6,472 individuals, many of whom received other HSC services as well. Older Blind programs served 1,105 individuals.
- 43% of HSC clients qualify for no fee on the sliding fee scale; of those, 21% have no third party payment source.

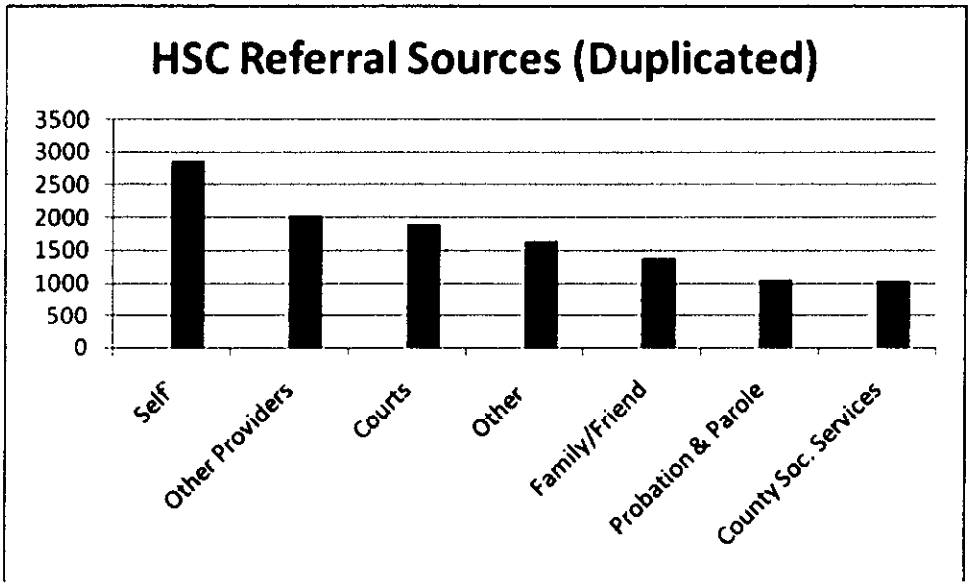
The following graphics further show the demographics of statewide HSC clients:



(Note: Despite unique regional differences/needs, clients served range in order of regional population sizes.)



(Note: 67% of clients receive a primary diagnosis; others are emergency services or DD clients.)



Statewide Trends

- Demand for services continues to stress current capacity, particularly in the more populated areas of the state. In the current biennium, the State Hospital census has exceeded 100%. There has been increasing concern from our local hospital partners due to longer lengths of stay in those facilities, often beyond available contract dollars. One of those providers, the Dickinson St. Joseph's Hospital, closed its inpatient psychiatric unit during the current biennium.
- Many of the clients served by the HSCs receive multiple services; this is not surprising when one considers that many have multiple diagnoses, a tendency to homelessness, and need for maintenance services. We work to wrap critical services around these individuals in the community, to support their stability and recovery, minimize

symptoms, and decrease the potential for more costly hospitalization.

- Primary services provided to HSC clients, in descending order of clients served, include:
    - Case Management
    - Evaluation/Intake
    - Medication Review/Therapy with Medication Review
    - Nursing Services
    - Individual Therapy
    - Information and Referral
    - Group Therapy
    - Family Therapy
    - Emergency Services
    - Other Services
- The HSCs have fallen behind in their ability to compete for and hire professional staff in the marketplace. We have worked hard on internal staff development to assist in filling addiction counselor positions, and continue to have ongoing psychology and psychiatry vacancies.
    - Staff vacancies in hard-to-fill positions result in longer client wait times. We monitor our wait times, with a goal of seeing non-emergent clients within two weeks of referral. Wait times that exceed that goal are consistently due to staff vacancies.
    - Future planning to meet recruitment and succession needs of retiring staff has been undertaken with DHS Human Resource staff, and has included additional supervisory and leadership development training.

Accomplishments

I am pleased to report progress in several initiatives undertaken by the Human Service Centers:

- Further implementation of evidence-based practices in all of the regions continues. This results in more consistent implementation of services, and better outcome tracking for specific interventions. As further testimony will describe, evidence-based practices are now implemented in all regions and for several client populations (children with emotional disturbances, adults with serious mental illness, adults with dual diagnoses, etc.). A strong focus on recovery principles results in clients working closely with staff to determine appropriate goals and needed supports.
- Community residential capacity for clients needing additional living supports increased in the current biennium, the result of funding supported by the 2007 Legislature. This enables us to provide appropriate alternatives to hospitalization and to have available a more complete continuum of community services.
- We continue to collaborate with the Department of Correction and Rehabilitation (DOCR) to provide timely and appropriate follow-up treatment services for individuals following release from prison. Advance release planning has resulted in more prompt psychiatric follow-up upon release from prison.
- Flexible models of service delivery such as telemedicine are being successfully utilized and will continue to be expanded. This has had a positive impact in our rural state for individuals who have difficulty accessing needed treatment. I anticipate continued growth in the use of telemedicine by our own psychiatrists, which will help us meet needs in difficult-to-fill rural positions.

Overview of Budget Changes – Human Service Centers Combined

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / (Decrease)
HSCs / Institutions	128,741,073	152,511,350	23,770,277
General Funds	62,736,289	79,878,717	17,142,428
Federal Funds	59,773,910	65,670,482	5,896,572
Other Funds	6,230,874	6,962,151	731,277
FTE	836.48	847.48	11.00

The major changes can be explained as follows:

- The Governor's salary package recommendation requires $9.6 million total funds (40% the overall increase) with $7.2 million being from the general fund.
- The cost to continue the July 2008 4% salary increase for 24 months versus the current 12 months of funding requires $1.5 million total funds with $1.1 million being from the general fund.
- In order to address resource needs at the Regional level for individuals who need more structured, supervised care, while simultaneously addressing capacity issues at the State Hospital, the budget includes funding across the Human Service Center system of $4.4 million total funds with $3.9 being from the general fund. This funding is to accomplish the following:
    - Provides consumers with more appropriate levels of care and to reduce our dependence on the ND State Hospital, and includes funding for crisis beds in the Minot region, supported residential and detox services in the Grand Forks region, staffing needs as it relates to the Cooper House residential project in the Fargo region (4 FTEs), an addition of a case manager in the Jamestown region to assist with addiction

caseloads, and long term residential services in the Dickinson region.

  - Provides for a consistent rate of payment for local inpatient hospitalization of our clients who are indigent, which will be on par with the newly proposed Medicaid rebased reimbursement rate.

- An increase of 6 FTEs, mainly for capacity issues, requires $600,000 total funds with $300,000 being from the general fund.
- Other salary changes have been required to meet critical market shortages or to provide temporary staff to meet increased consumer demand requires $1.6 million total funds, with approximately $710,000 being from the general fund.
- Provides for young adult transitional residential services in the Bismarck and Fargo regions. Total increase is $1.2 million with $835,000 being from the general fund.
- Provides for a 7% inflationary increase for each year of the biennium for contracted services - $2.7 million total increase with $2.5 million being from the general fund.
- Provides $1.9 million in total with approximately $867,000 from the general fund for the continuation of contracted services in the regions and the unforeseen funding issues for the providers we currently contract with predominately in the Minot, Grand Forks and Bismarck Regions.

In summary, while client needs/complexity present challenges, the HSCs have taken a number of positive steps to meet needs in a cost-effective manner. The proposed 2009-20011 budget will allow us to continue and improve those efforts. This concludes my overview testimony for the Human Service Centers; I would be happy to answer any questions.

SUMMARY OF CORE SERVICES
DEPARTMENT OF HUMAN SERVICES
REGIONAL HUMAN SERVICE CENTERS

Aging Services:

- Aging Services Administration
- Vulnerable Adult Protective Services
- Long-Term Care Ombudsman Program
- Adult Family Foster Care Licensure

Developmental Disabilities

- Case Management
- Day Supports (Southeast)
- Extended Services (Northwest and Badlands)

Vocational Rehabilitation

- Assessment for eligibility and rehabilitation needs
- Counseling and Guidance
- Information and Referral
- Job related services
- Vision Services
- Supported Employment Services
- Rehabilitation Technology Services
- Business Services including ADA Consultation and Assessment

Child Welfare Services

- Program Supervision – Regional Reps and Child Care Licensing Specialists
- Parental Capacity Evaluation
- Foster Parent Support Services
- Acute/Clinical Services as deemed clinically appropriate

Children's Mental Health

- Level I Criteria
  - Care Coordination
  - Acute/Clinical Services as deemed appropriate
- Level II Criteria
  - Care Coordination
  - Case Aide Services
  - Crisis Residential/Safe beds
  - Flexible funding
  - Acute Clinical Services as deemed appropriate

Serious Mental Illness (Extended Care Coordination)

- Care Coordination
- Case Aide Services
- Needs-based array of residential services
- Community Support Services
- Medical Management
- Acute/Clinical Services as deemed clinically appropriate

Acute Clinical Services

- Core Populations:
  - Self Harm/Suicide
  - Child Abuse and Neglect
  - Foster Care/ Subsidized Adoption
  - Acute Psychiatric
- Services
  - Psychological evaluation and testing
  - Psychiatric evaluation
  - Clinical evaluation
  - Individual Therapy
  - Group Therapy
  - Family Therapy
  - Clinical Case Management
  - Medication Management
  - Crisis Residential
  - Short Term Hospital
  - Lab and Clinical Screening

Substance Abuse Services

- Care Coordination/Case Aide
- Evaluation
- Social and Medical Detoxification Services
- Needs based array of primary treatment services
  - Low intensity outpatient
  - Intensive outpatient
  - Day treatment
- Needs validated residential services
- Medication/Medical monitoring/Management

Crisis/Emergency Response Services

- 24-hour a day/7-days a week crisis call response from a designated, trained Center employee
- Regional Intervention Services
  - Screening
  - Gatekeeping/referral

Note: Funding varies depending upon the service and the financial status of the client for a combination of federal funding sources, general funds, and third party collections including private pay and insurance.

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations Committee
Senator Holmberg, Chairman
March 4, 2009

Chairman Holmberg and members of the Senate Appropriations Committee, I am Nancy McKenzie, Statewide Director of the Regional Human Service Centers (HSCs) for the Department of Human Services (DHS). I am here today to provide you with an overview of the budget, program trends and direction in the regional centers. Your committee will also receive specific written testimony from each of the center directors.

Human Service Centers

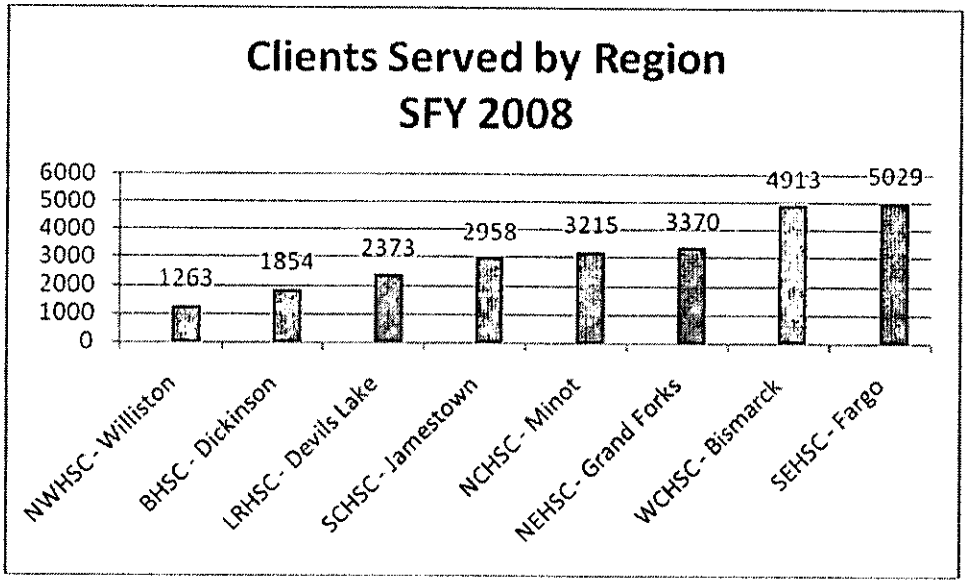
- The 8 Regional Human Service Centers are a network of outpatient clinics that serve individuals whose illness, addiction, disability or conditions place them at risk of harm or institutional placement. They provide the community safety net for our most vulnerable citizens, to ensure that services are available and accessible at the most appropriate and cost-effective level of care.
- Each of the centers provides the "Core Services" as outlined in the attached document. We continue to place a high value on alignment across the regions, operating as one public system that shares resources as needs and demands shift.
- Services are provided within the clinic setting, various rural outreach centers, in client homes, or other community settings, and include 24-hour emergency services as well as follow-up services.
- In addition to direct evaluation and treatment services, the HSCs are responsible for program supervision and regulatory oversight of the Child Welfare services provided by county social services as well as oversight of the Aging Services programs in their regions.

Clients Served

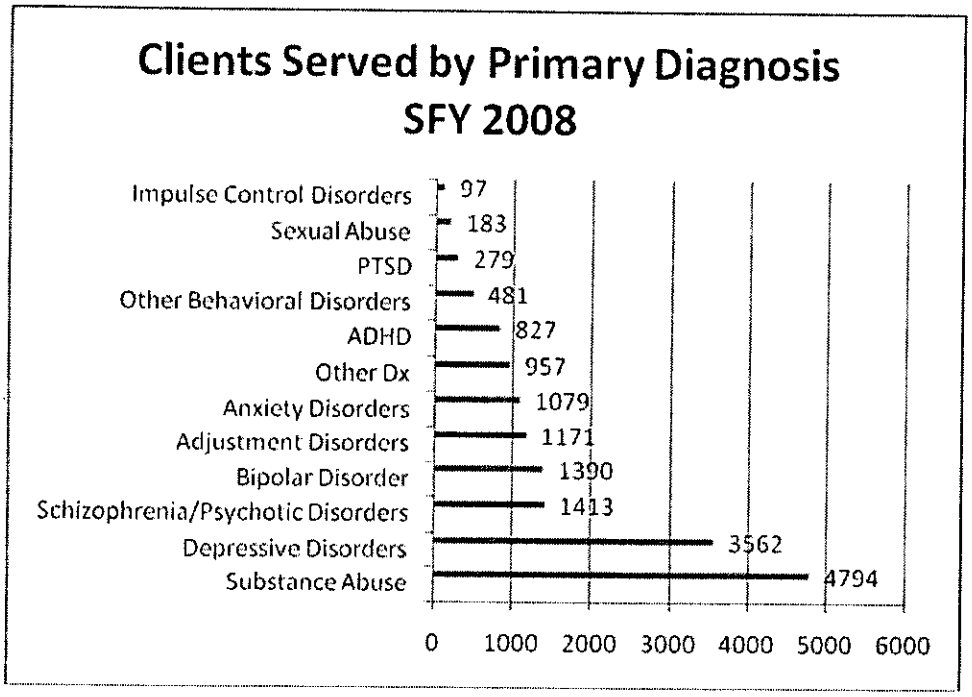
Demographics of those served in State Fiscal Year 2008 include:

- Over 24,975 individuals were served excluding Vocational Rehabilitation (VR); this is an approximately 3.5% increase over the prior year, and represents 4% of North Dakota's residents. Individual regions served from 3-6% of their population base.
- 25% of clients served were children; 75% were adults.
- Only 10% of clients are served just once (evaluation, etc.), while 90% required services over a period of time.
- During the same period, VR served 6,472 individuals, many of whom received other HSC services as well. Older Blind programs served 1,105 individuals.
- 43% of HSC clients qualify for no fee on the sliding fee scale; of those, 21% have no third party payment source.

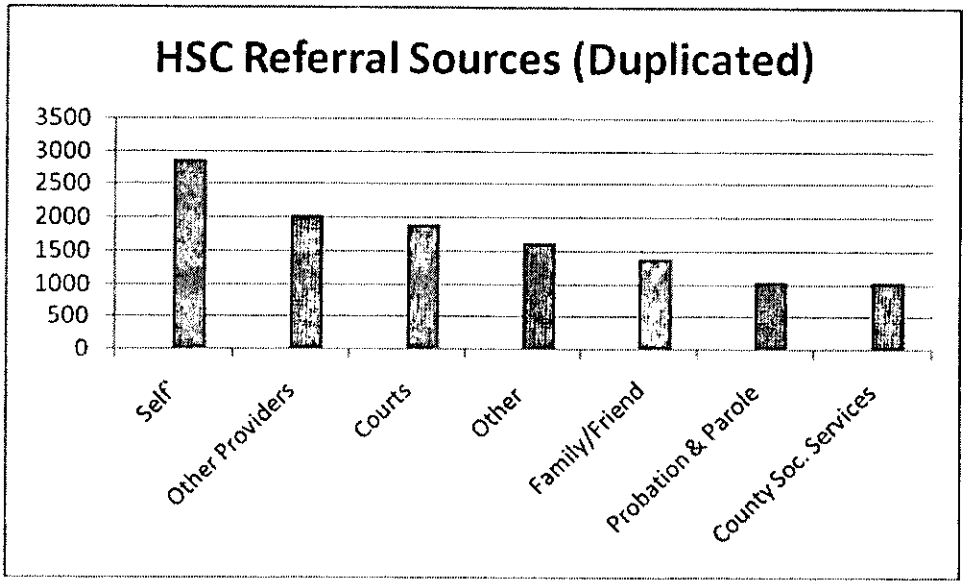
The following charts further show the demographics of those we serve.



(Note: Despite unique regional differences/needs, clients served range in order of regional population sizes.)



(Note: 67% of clients receive a primary diagnosis; others are emergency services or DD clients.)



Statewide Trends

- Demand for services continues to stress current capacity, particularly in the more populated areas of the state. In the current biennium, the State Hospital census has frequently exceeded 100%. There has been increasing concern expressed by our local hospital partners due to longer lengths of stay in those facilities, often beyond available contract dollars. One of those providers, the Dickinson St. Joseph's Hospital, closed its inpatient psychiatric unit during the current biennium, which creates new challenges for clients needing access to inpatient care.
- Many of the clients served by the HSCs receive multiple services; this is not surprising when one considers that many have multiple diagnoses, a tendency to homelessness, and need for maintenance services. We work to wrap critical services around these individuals in the community, to support their stability and recovery, minimize symptoms, and decrease the potential for more costly services.
- Primary services provided to HSC clients, in descending order of clients served, include:
    - Case Management
    - Evaluation/Intake
    - Medication Review/Therapy with Medication Review
    - Nursing Services
    - Individual Therapy
    - Information and Referral
    - Group Therapy
    - Family Therapy
    - Emergency Services
    - Other Services

- The HSCs have fallen behind in their ability to compete for and hire professional staff in the marketplace. We have worked on internal staff development to assist in filling addiction counselor positions, and continue to have ongoing psychology and psychiatry vacancies.
    - Staff vacancies in hard-to-fill positions result in longer client wait times. We monitor our wait times, with a goal of seeing non-emergent clients within two weeks of referral. Wait times that exceed that goal are consistently due to staff vacancies.
    - Future planning to meet recruitment and succession needs of retiring staff has been undertaken with DHS Human Resource staff, and has included additional supervisory and leadership development training.

Accomplishments

I am pleased to report progress in several initiatives undertaken by the Human Service Centers:

- Further implementation of evidence-based practices in all of the regions continues. This results in more consistent implementation of services, and better outcome tracking for specific interventions. As further testimony will describe, evidence-based practices are now implemented in all regions and for several client populations (children with emotional disturbances, adults with serious mental illness, adults with dual diagnoses, etc.). A strong focus on recovery principles results in clients working closely with staff to determine appropriate goals and needed supports.
- Community residential capacity for clients needing additional living supports increased in some areas of the state in the current biennium, the result of funding supported by the 2007 Legislature.

This enables us to provide more alternatives to hospitalization and to have available a more complete continuum of community services.

- We continue to collaborate with the Department of Correction and Rehabilitation (DOCR) to provide timely and appropriate follow-up treatment services for individuals following release from prison. Advance release planning has resulted in more prompt psychiatric treatment upon release from prison.
- Flexible models of service delivery such as telemedicine are being successfully utilized and will continue to be expanded. This has a positive impact for individuals who have difficulty accessing needed treatment in our rural state. We are planning for more use of telemedicine by our own psychiatrists, which will help us meet needs in difficult-to-fill rural positions.

Overview of Budget Changes – Human Service Centers Combined

Description	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget	House Changes	To Senate
HSCs / Institutions	128,741,073	23,770,277	152,511,350	(8,982,834)	143,528,516
General Funds	62,736,289	17,142,428	79,878,717	(6,117,746)	73,760,971
Federal Funds	59,773,910	5,896,572	65,670,482	(2,557,626)	63,112,856
Other Funds	6,230,874	731,277	6,962,151	(307,462)	6,654,689
FTE	836.48	11.00	847.48	(11.00)	836.48

Budget Changes From Current Budget to Executive Budget:

- The Governor's salary package recommendation requires $9.6 million total funds (40% the overall increase) with $7.2 million being from the general fund.
- The cost to continue the July 2008 4% salary increase for 24 months versus the current 12 months of funding requires $1.5 million total funds with $1.1 million being from the general fund.
- In order to address resource needs at the Regional level for individuals who need more structured, supervised care, while simultaneously addressing capacity issues at the State Hospital, the Department submitted an OAR we termed Global Behavioral Health, which was funded in the Executive Budget. This portion of the budget included funding across the Human Service Center system of $4.4 million total funds with $3.9 being from the general fund. This funding is to accomplish the following:
    - Provides consumers with more appropriate levels of care and to reduce our dependence on the ND State Hospital, and includes funding for crisis beds in the Minot region, supported residential and detox services in the Grand Forks region, staffing needs as it relates to the Cooper House residential project in the Fargo region (4 FTEs), an addition of a case manager in the Jamestown region to assist with addiction caseloads, and long term residential services in the Dickinson region. These funds will directly contribute to our managing clients in the community and keeping the State Hospital census from exceeding capacity.
    - Provides for a consistent rate of payment for local inpatient hospitalization of our clients who are indigent, which will be on par with the newly proposed Medicaid rebased

reimbursement rate. Without continuing partnerships with these providers, clients will not be able to be served closer to home and the State Hospital capacity will be greatly exceeded.

- An increase of 6 FTEs, to meet local capacity needs requires $600,000 total funds with $300,000 being from the general fund.
- Other salary changes have been required to meet critical market shortages or to provide temporary staff to meet increased consumer demand. This requires $1.6 million total funds, with approximately $710,000 being from the general fund.
- Provides for young adult transitional residential services in the Bismarck and Fargo regions. Total increase is $1.2 million with $835,000 being from the general fund. This is a portion of our population whose needs have been noted by interim committees as well as families and advocates.
- Provides for a 7% inflationary increase for each year of the biennium for contracted services - $2.7 million total increase with $2.5 million being from the general fund. Our contract providers are facing increased cost and challenges with staff turnover rates.
- Provides $1.9 million in total with approximately $867,000 from the general fund for the continuation of contracted services in the regions and the unforeseen funding issues for the providers we currently contract with predominately in the Minot, Grand Forks and Bismarck Regions.

House Changes:

The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $856,667 - general fund and $1,752,266 – federal and other funds for a total of $2,608,933.

The House reduced 50% of the department-wide travel increase. The overall human service center share of this decrease is $103,641 - total funds; $62,870 – general fund.

The House removed all funding for the Global Behavioral Health OAR which was funded in the Executive Budget, except for the contracted 24/7 staffing for Cooper House in the Fargo region. This amendment removed funding for crisis beds in the Minot region, supported residential and detox services in the Grand Forks region, staffing needs as it relates to the capacity issues at the Southeast Human Service Center (4 FTEs), an addition of a case manager in the Jamestown region to assist with addiction caseloads, and long term residential services in the Dickinson region. Also removed was the provision for a consistent rate of methodology for local inpatient hospitalization of our clients who are indigent, which would have been on par with the newly proposed Medicaid rebased reimbursement rate. The total decrease is $4,090,895; $3,664,789 - general fund.

The young adult transitional residential services in the Bismarck and Fargo regions included in the Executive Budget were removed. The total decrease to the Executive Budget is $1,176,844; $834,622 – general fund.

6 newly proposed FTE added in the Executive Budget to address capacity issues were removed. The total decrease is $619,646; $369,810 – general fund.

The House amended the provider inflation amounts from 7% per year to 6% per year. This resulted in a total decrease of $382,875; $329,790 - general fund.

In summary, while client needs/complexity present challenges, the HSCs have taken a number of positive steps to meet needs in a cost-effective manner. The proposed 2009-20011 Executive budget will allow us to continue and improve those efforts. This concludes my overview testimony for the Human Service Centers; I would be happy to answer any questions.

B

Testimony
House Bill 1012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
January 22, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, I am Marilyn Rudolph, Director of Northwest Human Service Center(NWHSC) in Williston and North Central Human Service Center (NCHSC) in Minot for the Department of Human Services (DHS). I am submitting this testimony to provide an overview of the budget for both centers.

Northwest Human Service Center

Northwest Human Service Center serves Divide, McKenzie and Williams counties. Outreach offices are located in Crosby, Tioga and Watford City.

Caseload / Customer Base

- Northwest Human Service Center provided services to 1,263 consumers in SFY 2008; 883 adults and 379 children were served. This is an increase since last biennium. We are serving more individuals covered by insurance. This may be a result of high employment in the oil industries.
- Northwest Human Service Center provided Vocational Rehabilitation services to an additional 332 consumers in 2008.

Program Trends

- The challenge facing Northwest Human Service Center is recruitment of professional and paraprofessional staff. We now

have two vacant PhD level psychologist positions. One position has been vacant since February 2008. The second was vacated November 1, 2008. We have worked with DHS Human Resources to advertise to no avail. Currently, we are utilizing nine hours a week of psychological services from a recently retired psychologist. Licensure requires a psychologist participate on our multidisciplinary diagnostic team. We have partnered with West Central Human Service Center to provide tele-staffing with one of their psychologists for multidisciplinary staffing, which worked well; however, we cannot offer the full psychological evaluation service with this limited arrangement. We have also had a Mental Health Technician position vacancy since May of 2008. This is a job coach position. The work is demanding and is often shift work. Often eligible applicants can work for more money per hour in less demanding positions. We have found that applicants who have ties to western North Dakota are more likely to accept positions here. As I stated in 2007, recruiting and retaining skilled staff in a very competitive market will be a major challenge.

Accomplishments

- A successful venture has been the Peer Support model administered by Western Sunrise, the consumer run, non-profit corporation. This model has provided the basis for peer training and support for 12 matches in Region I and two support groups weekly. This model has been extended to Region II and VI to date. Region II, Minot, has 24 matches and four support groups. Region VI, Jamestown, is serving 64 people in recovery groups. The Recovery model promotes peer support, self help and employment as pillars of

support to prevent exacerbation of serious mental illness and hospitalization. This model is cost effective and sustainable.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / Decrease
Northwest HSC	7,476,823	8,562,127	1,085,304
General Funds	4,279,976	4,881,955	601,979
Federal Funds	2,851,727	3,328,518	476,791
Other Funds	345,120	351,654	6,534
Total	7,476,823	8,562,127	1,085,304
FTE	44.75	44.75	0

- Salary changes include:
  - The Governor's salary package recommendation requires $512,678 total funds with $392,469 being from the general fund.
  - The cost to continue the July 2008 4% salary increase for 24 months versus the current 12 months of funding requires $84,216 total funds with $68,998 being from the general fund.

- Changes in operating include:
  - Travel increased $54,549. Prior to North Central's move to its new location the director slept in space at the center that was not being used. Now she is using a motel when traveling. Administrative travel has been increased $12,276. Usage and Department of Transportation rate increases account for the additional $42,273.

- Building rent increased $34,069. The yearly maximum lease adjustment for the center's Williston office has been increased from $10,000 to $20,000 per year to allow for increases in utilities, taxes, insurance and building maintenance and upkeep. The rent for the center's outreach office in Watford City has increased by $50 per month. Until earlier in this biennium the center had been receiving space in Crosby rent free from the county. Due to the county's need for additional space the center is now renting space elsewhere in town for $250 per month.

- Grants increased $424,279. The demand for services for Seriously Mentally Ill clients account for $209,306. Inflationary increases are $194,526 of which $140,512 is general fund.
- Federal funds from Medical Assistance and other federal sources have increased $476,791. Other funds increased $6,534.

North Central Human Service Center

North Central Human Service Center serves seven counties: Bottineau, Burke, McHenry, Mountrail, Pierce, Renville and Ward. Outreach is provided in New Town, Rugby, Bottineau and Stanley.

Caseload / Customer Base

- North Central Human Service Center provided services to 3,215 individuals in SFY 2008. (2,464 adults and 75 children were served.)
- North Central Human Service Center Vocational Rehabilitation served 802 individuals in 2008.

Program Trends

- North Central Human Service Center has requested $1,458,307 as part of the Global Behavioral Health Initiative to procure a crisis residential unit to serve individuals identified as seriously mentally ill. We have had a contractual agreement with Trinity Hospital to provide hospitalization and stabilization to individuals with serious mental illness. Many of these individuals were then sent to the North Dakota State Hospital. In 2007, Trinity admitted 291 individuals with a total of 1,164 days hospitalized. The cost of hospitalization far exceeds our ability to pay. Sending these individuals to the North Dakota State Hospital exceeds the capacity of the State Hospital. Our intention is to contract for an eight bed facility with skilled staff to stabilize and transition individuals in the community. This will alleviate the burden on the private community hospital and reduce the stressed capacity at North Dakota State Hospital.

Accomplishments

North Central Human Service Center Addiction Services has achieved a high level of diversification in their offering of treatment options.

The Matrix model is an evidence-based intensive evening outpatient program. This program requires specific training and competency. North Central Human Service Center's Matrix program has been certified by the Matrix Institute on Addictions.

An innovative approach to rural services is the Outreach Program for Aging Services. Outreach is the establishment of eligibility for Aging Services programs such as Meals on Wheels and health and wellness programs. We provide information and referral services to seniors (individuals 60 or over) in their homes. The goal is to provide connection for seniors to available services. The coordinator manages referrals and assigns QSP's (qualified service providers) to go into homes in the seven county region.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / Decrease
North Central HSC	16,894,368	20,923,799	4,029,431
General Funds	8,755,623	12,098,437	3,342,814
Federal Funds	7,285,751	7,976,026	690,275
Other Funds	852,994	849,336	(3,658)
Total	16,894,368	20,923,799	4,209,431
FTE	116.78	117.68	1.00

- Salary changes to the budget include:
  - The Governor's salary package recommendation requires $1.3 million total funds with $1.0 million being from the general fund.
  - The cost to continue the July 2008 4% salary increase for 24 months versus the current 12 months of funding requires $197,825 total funds with $180,101 being from the general fund.
  - Additional changes in the salary area are a result of the addition of one FTE for a DD Case Manager. The budget for this position is $100,626 of which $50,313 is from the general

fund. The realignment of staff to meet client needs total $234,044 of which $163,830 is general funds. North Central employs a temporary part-time psychiatrist with a budget of $56,016, as well as one counselor position from Bottineau to provide services in that area with a budget of $38,760, and staff to provide necessary coverage at the center's transitional living facility with salaries of $26,448. General funds for these temporary positions are $84,857.

- The budget for operating expenses has increased $39,932 or 2.3%.

- Grants increased $2,211,526.
  - The cost to continue the current services for Seriously Mentally Ill clients is $305,893.
  - Inflationary increases are $408,959 of which $387,170 is general fund.
  - Additional community based services for the Seriously Mentally Ill, designed to fill gaps in the continuum of care, increase payment to the local hospital, and assist the state hospital to manage its patient census is budgeted for $1,458,307 of which $1,358,307 is general fund.

- General funds increased by $3,342,814, with $1,055,295 related to salaries, benefits and the one FTE in Developmental Disabilities. Inflationary increases for service providers and the development of community based services for the Seriously Mentally Ill have $1,745,478 in general fund budgeted. The remaining $542,041 is related to ongoing costs to continue operations.

- Federal Funds from Medical Assistance and other federal sources have increased $690,275. Other Funds decreased $3,658.

This concludes my testimony on the 2009 – 2011 budget request for Northwest Human Service Center and North Central Human Service Center. I would be happy to answer any questions.

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
March 04, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, this is written testimony prepared by Marilyn Rudolph, Director of Northwest Human Service Center (NWHSC) in Williston and North Central Human Service Center (NCHSC) in Minot for the Department of Human Services (DHS). It is being submitted to provide an overview of the budget for both centers.

Northwest Human Service Center

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- Northwest Human Service Center provided Vocational Rehabilitation services to an additional 332 consumers in 2008.

Program Trends

- The challenge facing Northwest Human Service Center is recruitment of professional and paraprofessional staff. We now

have two vacant PhD level psychologist positions. One position has been vacant since February 2008. The second was vacated November 1, 2008. We have worked with DHS Human Resources to advertise to no avail. Currently, we are utilizing nine hours a week of psychological services from a recently retired psychologist. Licensure requires a psychologist participate on our multidisciplinary diagnostic team. We have partnered with West Central Human Service Center to provide tele-staffing with one of their psychologists for multidisciplinary staffing, which worked well; however, we cannot offer the full psychological evaluation service with this limited arrangement. We have also had a Mental Health Technician position vacancy since May of 2008. This is a job coach position. The work is demanding and is often shift work. Often eligible applicants can work for more money per hour in less demanding positions. We have found that applicants who have ties to western North Dakota are more likely to accept positions here. As I stated in 2007, recruiting and retaining skilled staff in a very competitive market will be a major challenge.

Accomplishments

- A successful venture has been the Peer Support model administered by Western Sunrise, the consumer run, non-profit corporation. This model has provided the basis for peer training and support for 12 matches in Region I and two support groups weekly. This model has been extended to Region II and VI to date. Region II, Minot, has 24 matches and four support groups. Region VI, Jamestown, is serving 64 people in recovery groups. The Recovery model promotes peer support, self help and employment as pillars of

support to prevent exacerbation of serious mental illness and hospitalization. This model is cost effective and sustainable.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase/ Decrease	2009 - 2011 Budget	House Changes	To Senate
Northwest HSC	7,476,823	1,085,304	8,562,127	(352,995)	8,209,132
General Funds	4,279,976	601,979	4,881,955	(144,819)	4,737,136
Federal Funds	2,851,727	476,791	3,328,518	(184,880)	3,143,638
Other Funds	345,120	6,534	351,654	(23,296)	328,358
Total	7,476,823	1,085,304	8,562,127	(352,995)	8,209,132
FTE	44.75	0.00	44.75	0.00	44.75

Budget Changes from Current Budget to Executive Budget:

- Salary changes include:
  - The Governor's salary package recommendation requires $512,678 total funds with $392,469 being from the general fund.
  - The cost to continue the July 2008 4% salary increase for 24 months versus the current 12 months of funding requires $84,216 total funds with $68,998 being from the general fund.

- Changes in operating include:
  - Travel increased $54,549. Prior to North Central's move to its new location the director slept in space at the center that was not being used. Now she is using a motel when traveling. Administrative travel has been increased $12,276. Usage and

Department of Transportation rate increases account for the additional $42,273.

- Building rent increased $34,069. The yearly maximum lease adjustment for the center's Williston office has been increased from $10,000 to $20,000 per year to allow for increases in utilities, taxes, insurance and building maintenance and upkeep. The rent for the center's outreach office in Watford City has increased by $50 per month. Until earlier in this biennium the center had been receiving space in Crosby rent free from the county. Due to the county's need for additional space, the center is now renting space elsewhere in town for $250 per month.

- Grants increased $424,279. The demand for services for Seriously Mentally Ill clients account for $209,306. Inflationary increases are $194,526 of which $140,512 is general fund.
- Federal funds from Medical Assistance and other federal sources have increased $476,791. Other funds increased $6,534.

House Changes:

- The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $97,561 – general fund; $181,792 – federal funds; and $17,764 – other funds for a total of $297,117.
- The House reduced 50% of the department-wide travel increase. Northwest Human Service Center's share of this decrease is $28,089 total funds; $19,621 general fund.
- The House reduced the budgeted inflationary increase for contracted providers from 7/7 to 6/6. Northwest Human Service

Center's share of this decrease is $27,789 total funds; $27,637 general fund.

North Central Human Service Center

North Central Human Service Center serves seven counties: Bottineau, Burke, McHenry, Mountrail, Pierce, Renville and Ward. Outreach is provided in New Town, Rugby, Bottineau and Stanley.

Caseload / Customer Base

- North Central Human Service Center provided services to 3,215 individuals in SFY 2008. (2,464 adults and 75 children were served.)
- North Central Human Service Center Vocational Rehabilitation served 802 individuals in 2008.

Program Trends

- North Central Human Service Center has requested $1,458,307 as part of the Global Behavioral Health OAR to procure a crisis residential unit to serve individuals identified as seriously mentally ill. We have had a contractual agreement with Trinity Hospital to provide hospitalization and stabilization to individuals with serious mental illness. Many of these individuals were then sent to the North Dakota State Hospital. In 2007, Trinity admitted 291 individuals with a total of 1,164 days hospitalized. The cost of hospitalization far exceeds our ability to pay. Sending these

individuals to the North Dakota State Hospital exceeds the capacity of the State Hospital. Our intention is to contract for an eight bed facility with skilled staff to stabilize and transition individuals in the community. This will alleviate the burden on the private community hospital and reduce the stressed capacity at North Dakota State Hospital.

Accomplishments

North Central Human Service Center Addiction Services has achieved a high level of diversification in their offering of treatment options.

The Matrix model is an evidence-based intensive evening outpatient program. This program requires specific training and competency. North Central Human Service Center's Matrix program has been certified by the Matrix Institute on Addictions.

An innovative approach to rural services is the Outreach Program for Aging Services. Outreach is the establishment of eligibility for Aging Services programs such as Meals on Wheels and health and wellness programs. We provide information and referral services to seniors (individuals 60 or over) in their homes. The goal is to provide connection for seniors to available services. The coordinator manages referrals and assigns QSP's (qualified service providers) to go into homes in the seven county region.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase/ Decrease	2009 - 2011 Budget	House Changes	To Senate
North Central HSC	16,894,368	4,029,431	20,923,799	(2,006,026)	18,917,773
General Funds	8,755,623	3,342,814	12,098,437	(1,597,511)	10,500,926
Federal Funds	7,285,751	690,275	7,976,026	(370,500)	7,605,526
Other Funds	852,994	(3,658)	849,336	(38,015)	811,321
Total	16,894,368	4,029,431	20,923,799	(2,006,026)	18,917,773
FTE	116.78	1.00	117.78	(1.00)	116.78

Budget Changes from Current Budget to Executive Budget:

- Salary changes to the budget include:
  - The Governor's salary package recommendation requires $1.3 million total funds with $1.0 million being from the general fund.
  - The cost to continue the July 2008 4% salary increase for 24 months versus the current 12 months of funding requires $197,825 total funds with $180,101 being from the general fund.
  - Additional changes in the salary area are a result of the addition of one FTE for a DD Case Manager. The budget for this position is $100,626 of which $50,313 is from the general fund. The realignment of staff to meet client needs total $234,044 of which $163,830 is general funds. North Central employs a temporary part-time psychiatrist with a budget of

$56,016, as well as one counselor position from Bottineau to provide services in that area with a budget of $38,760, and staff to provide necessary coverage at the center's transitional living facility with salaries of $26,448. General funds for these temporary positions are $84,857.

- The budget for operating expenses has increased $39,932 or 2.3%.

- Grants increased $2,211,526.
  - The cost to continue the current services for Seriously Mentally Ill clients is $305,893.
  - Inflationary increases are $408,959 of which $387,170 is general fund.
  - Additional community based services for the Seriously Mentally Ill, designed to fill gaps in the continuum of care, increase payment to the local hospital, and assist the state hospital to manage its patient census is budgeted for $1,458,307 of which $1,358,307 is general fund.

- General funds increased by $3,342,814, with $1,055,295 related to salaries, benefits and the one FTE in Developmental Disabilities. Inflationary increases for service providers and the development of community based services for the Seriously Mentally Ill have $1,745,478 in general fund budgeted. The remaining $542,041 is related to ongoing costs to continue operations.

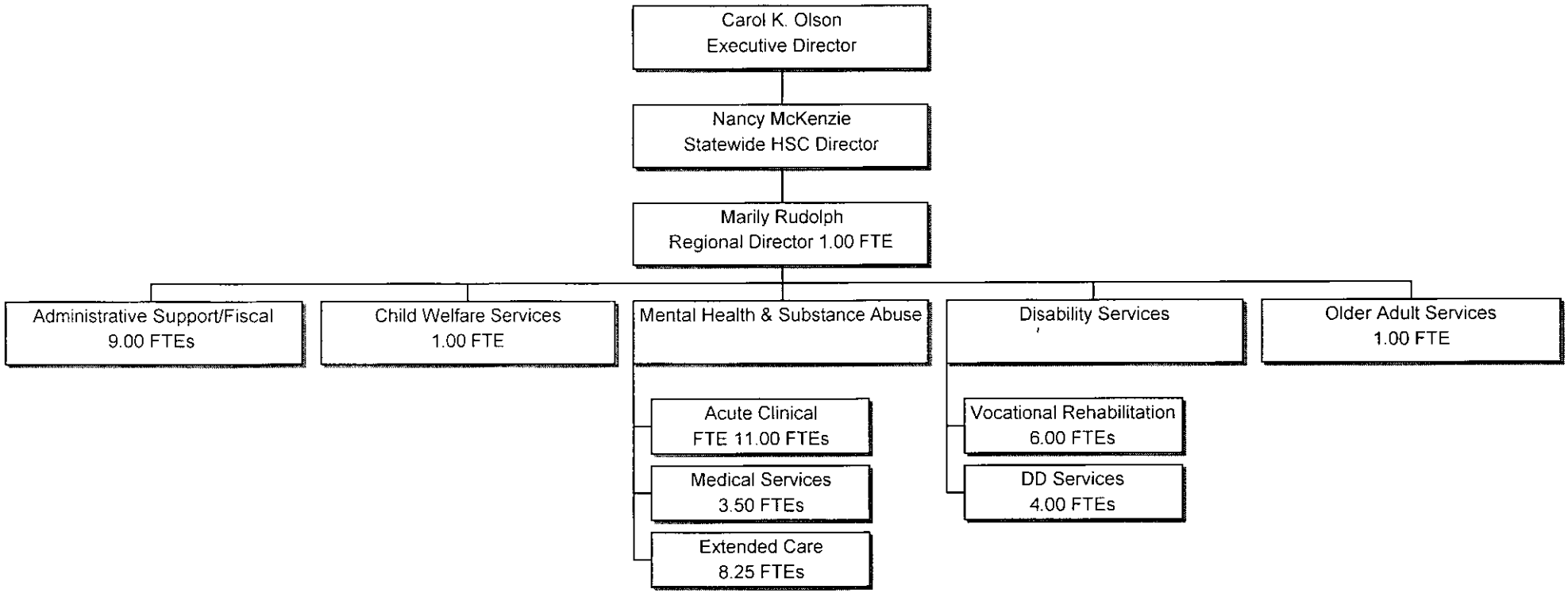
- Federal Funds from Medical Assistance and other federal sources have increased $690,275. Other Funds decreased $3,658.

House Changes:

- The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $122,969 – general fund; $214,395 – federal funds; and $37,132 – other funds for a total of $374,496.
- The House reduced 50% of the department-wide travel increase. North Central Human Service Center's share of this decrease is $3,653 total funds; $2,132 general fund.
- The House reduced the budgeted inflationary increase for contracted providers from 7/7 to 6/6. North Central Human Service Center's share of this decrease is $58,423 total funds; $55,310 general fund.
- The House removed the Global Behavioral Health OAR from the Department's budget. North Central Human Service Center's share of this OAR is $1,458,307 total funds; $1,358,307 general fund.
- The House removed one FTE for an additional DD Case Manager. Funding for this position was $58,793 in general funds and $52,354 in federal funds for a total of $111,147.

This concludes the testimony on the 2009 – 2011 budget requests for Northwest Human Service Center and North Central Human Service Center.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
NORTHWEST HUMAN SERVICE CENTER



2009-2011
Authorized 44.75 FTEs

Northwest Human Service Center
Detail of Budget Account Code 582000
For the 2009 - 2011 Biennium Budget

1/21/2009

Rentals & Leases	Rate per Sq.Ft.	Amount	General	Fed/Other
Human Service Center Building Rent	$8.50	418,902	250,261	168,641
Outreach Office - Watford City		8,400	5,093	3,307
Outreach Office - Crosby		6,000	3,638	2,362
Total Rentals & Leases Budget Account Code		**433,302**	**258,992**	**174,310**

Northwest Human Service Center
Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2009 - 2011 Biennium

Operating Fees & Services	Amount	General	Fed/Other
Advertising Services	658	438	220
DD Infant and Toddlers Part C (spending authorized by central office)	35,000	0	35,000
Freight & Express	2,663	1,849	814
Licenses & Taxes	3,150	1,933	1,217
Other Operating Fees	2,758	1,672	1,086
Purchase of Services & Coop Agreement	17,576	7,275	10,301
Research Fees	356	258	98
Years of Service Awards	1,223	892	331
Total Operating Fees & Services Budget Account Code	**63,384**	**14,317**	**49,067**

The majority of the Purchase of Services & Coop Agreement ($9,100) is used by the center's MH Partnership program and SMI Services for the Homeless. These funds assist families to reduce the risk of having to place a child outside of their home or to help seriously mentally ill individuals stay in their own home or assist them in obtaining housing. The remaining funds are used in multiple center programs for expenditures that do not fit into another accounting code.

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 410-71 NORTHWEST HSC								
		S101 FULL-TIME EQUIVALENTS (FTEs)	45.750	44.750	0.000	0.000	0.000	44.750
32570	B	511000 Salaries - Permanent	3,250,608	3,608,665	1,715,689	80,449	1	3,689,115
32570	B	513000 Temporary Salaries	191,125	215,099	117,638	16,741	(2)	231,838
32570	B	514000 Overtime	10,151	7,000	2,579	(7,000)	0	0
32570	B	516000 Fringe Benefits	1,162,813	1,378,446	632,252	(18,818)	180,256	1,539,884
32570	B	521000 Travel	154,439	154,776	65,080	54,549	0	209,325
32570	B	531000 Supplies - IT Software	7,166	5,400	5,196	5,272	0	10,672
32570	B	532000 Supply/Material-Professional	17,632	14,821	6,985	(2,751)	0	12,070
32570	B	533000 Food and Clothing	4,302	3,268	1,684	649	0	3,917
32570	B	534000 Bldg, Grounds, Vehicle Supply	2,324	4,379	2,917	(1,232)	0	3,147
32570	B	535000 Miscellaneous Supplies	14,947	27,741	18,879	(18,884)	0	8,857
32570	B	536000 Office Supplies	9,618	12,000	3,856	(3,946)	0	8,054
32570	B	541000 Postage	18,955	15,583	1,599	2,033	0	17,616
32570	B	542000 Printing	8,525	3,000	1,447	(275)	0	2,725
32570	B	551000 IT Equip under $5,000	68	0	0	0	0	0
32570	B	553000 Office Equip & Furniture-Under	12,572	5,871	5,871	(5,871)	0	0
32570	B	571000 Insurance	4	0	0	0	0	0
32570	B	581000 Rentals/Leases-Equip & Other	3,484	3,000	1,295	(12)	0	2,988
32570	B	582000 Rentals/Leases - Bldg/Land	407,681	399,233	212,538	34,069	0	433,302
32570	B	591000 Repairs	58,765	51,405	31,211	3,561	0	54,966
32570	B	599110 Salary Increase	0	0	0	0	284,512	284,512
32570	B	599160 Benefit Increase	0	0	0	0	47,911	47,911
32570	B	602000 IT-Communications	64,290	63,913	34,555	5,362	0	69,275
32570	B	611000 Professional Development	6,099	9,150	5,721	6,185	0	15,335
32570	B	621000 Operating Fees and Services	73,410	65,126	37,248	(1,742)	0	63,384
32570	B	625000 Medical, Dental and Optical	186	289	131	8	0	297
32570	B	712000 Grants, Benefits & Claims	1,315,045	1,428,658	672,944	424,279	0	1,852,937
		Subtotal:	6,794,209	7,476,823	3,577,315	572,626	512,678	8,562,127
32570	F	F_7091 HSCs & Institutions - Gen Fund	3,614,896	4,279,976	2,645,015	209,510	392,469	4,881,955
32570	F	F_7092 HSCs & Institutions - Fed Fnds	2,875,811	2,851,727	835,135	358,236	118,555	3,328,518
32570	F	F_7093 HSCs & Institutions - Oth Fnds	303,502	345,120	97,165	4,880	1,654	351,654

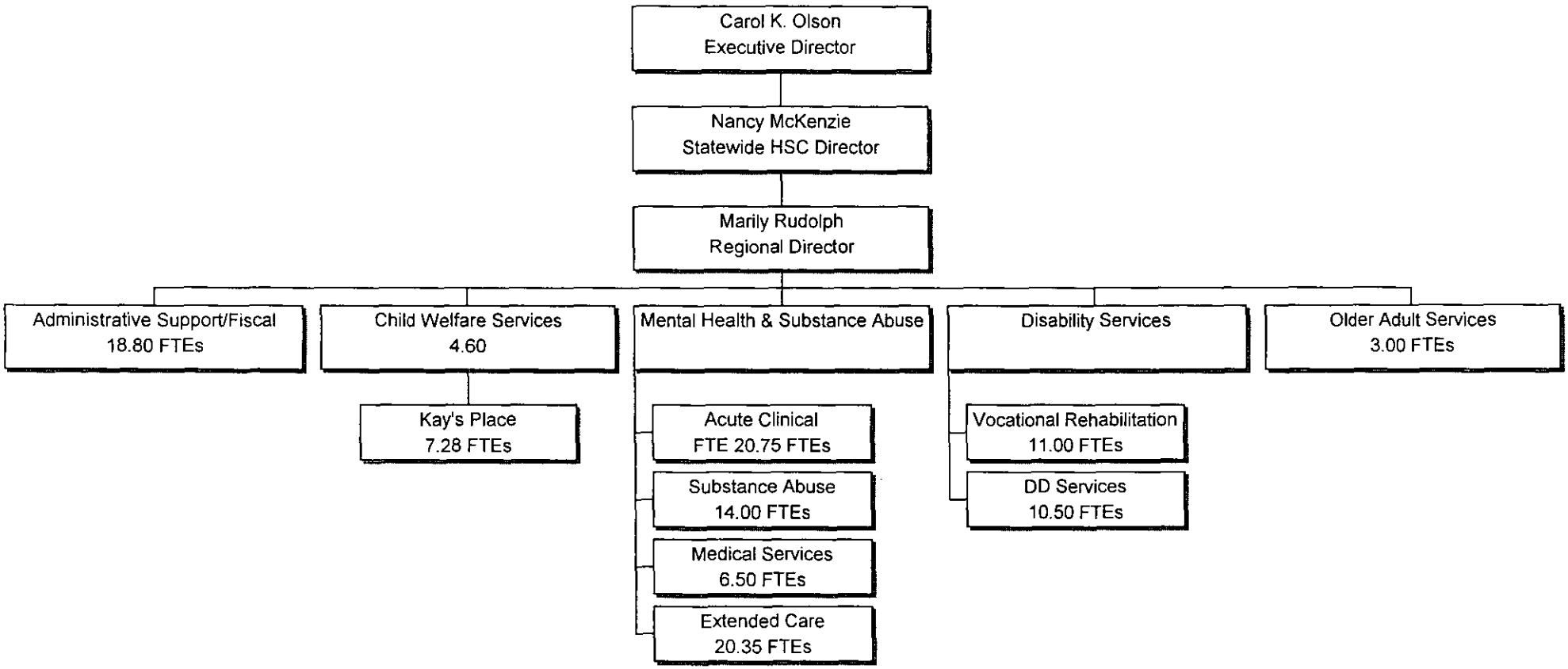
Grants Summary

Department of Human Services

Northwest Human Service Center

Description	Funding	2007-09 Appropriation	2009-11 Budget Recommendation	Total Changes
Inpatient Hospitalization	General Funds	264,059	330,013	65,954
Addiction--$687,960	Federal Funds	407,864	429,403	21,539
Provider Inflation--$71,456		671,923	759,416	87,493
Psych Social Club	General Funds	153,826	180,798	26,972
Psych Social Club--$157,488		153,826	180,798	26,972
Provider Inflation--$23,310				
Psychiatric / Psychological / Medical Services	General Funds	305,533	339,723	34,190
Psychiatric Services--$141,960	Federal Funds	132,343	198,215	65,872
Medication Monitor--$345,360	Special Funds	40,492	20,190	(20,302)
Title XIX evaluations--$3,500		478,368	558,128	79,760
Provider Inflation--$67,308				
Residential Services	General Funds	124,541	99,587	(24,954)
SMI Residential--$322,143	Special Funds	-	255,008	255,008
Provider Inflation--$32,452		124,541	354,595	230,054
TOTAL GRANTS		**1,428,658**	**1,852,937**	**424,279**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
NORTH CENTRAL HUMAN SERVICE CENTER



2009-2011
116.78 Budgeted FTEs

North Central Human Service Center
Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2009 - 2011 Biennium

Operating Fees & Services	Amount	General	Fed/Other
Advertising Services	250	213	37
DD Infant and Toddlers Part C (spending authorized by central office)	7,500	0	7,500
Extermination Services	1,500	1,117	383
Freight & Express	689	449	240
Licenses & Taxes	10,770	5,809	4,961
Other Operating Fees	41,915	23,802	18,113
Purchase of Services & Coop Agreement	33,000	1,044	31,956
Research Fees	310	239	71
Years of Service Awards	4,111	3,505	606
Total Operating Fees & Services Budget Account Code	**100,045**	**36,178**	**63,867**

North Central's Purchase of Services & Coop Agreements is divided between the center's Respite Care ($25,000) program and SMI Services for the Homeless ($8,000). Respite care provides parents or guardians of a serious emotionally disturb or developmentally disabled child the ability to take a short break from the care required by these children. SMI Services for the Homeless help seriously mentally ill individuals stay in their own home or assist them to obtain housing.

Other Operating Funds are used in multiple center programs for expenditures that do not fit into another accounting code. The largest single expenditure is the $15,000 budgeted for the MH Partnership program. These funds assist families to reduce the risk of having to place a child outside of their home. Other services include cable television at the center's residential facilities, shredding services, floor mats for center entries, fees for security checks, line charges for security systems and fees for security monitoring at the center and the center's residential facilities, and after hours answering services.

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 410-72 NORTH CENTRAL HSC								
S101		FULL-TIME EQUIVALENTS (FTEs)	116.780	116.780	0.000	1.000	0.000	117.780
32570	B	511000 Salaries - Permanent	7,249,133	8,531,450	3,928,458	306,260	3	8,837,713
32570	B	512000 Salaries-Other	12,001	16,920	6,598	10,248	0	27,168
32570	B	513000 Temporary Salaries	73,534	64,488	58,980	125,016	0	189,504
32570	B	514000 Overtime	23,587	24,674	22,661	(10,994)	0	13,680
32570	B	516000 Fringe Benefits	2,759,368	3,428,607	1,583,998	37,231	495,694	3,961,532
32570	B	521000 Travel	257,017	266,569	101,400	7,285	0	273,854
32570	B	531000 Supplies - IT Software	14,709	15,000	10,376	1,800	0	16,800
32570	B	532000 Supply/Material-Professional	27,152	12,902	5,996	(3,943)	0	8,959
32570	B	533000 Food and Clothing	56,528	55,000	26,266	6,000	0	61,000
32570	B	534000 Bldg, Grounds, Vehicle Supply	8,035	11,127	10,270	(3,027)	0	8,100
32570	B	535000 Miscellaneous Supplies	84,924	30,899	28,850	4,187	0	35,086
32570	B	536000 Office Supplies	11,516	14,000	6,472	2,449	0	16,449
32570	B	541000 Postage	29,693	28,535	9,855	1,408	0	29,943
32570	B	542000 Printing	24,253	17,307	4,418	(2,265)	0	15,042
32570	B	551000 IT Equip under $5,000	108	0	0	0	0	0
32570	B	552000 Other Equip under $5,000	41,471	5,340	5,340	(5,340)	0	0
32570	B	553000 Office Equip & Furniture-Under	13,386	7,397	7,397	(7,397)	0	0
32570	B	561000 Utilities	593	4,632	4,632	6,518	0	11,150
32570	B	582000 Rentals/Leases - Bldg/Land	1,002,205	936,151	487,926	(15,434)	0	920,717
32570	B	591000 Repairs	33,685	54,180	31,732	11,872	0	66,052
32570	B	599110 Salary Increase	0	0	0	0	698,351	698,351
32570	B	599160 Benefit Increase	0	0	0	0	116,164	116,164
32570	B	602000 IT-Communications	154,555	137,456	67,839	(612)	0	136,844
32570	B	611000 Professional Development	16,334	14,398	6,881	24,651	0	39,049
32570	B	621000 Operating Fees and Services	132,281	72,987	50,944	27,058	0	100,045
32570	B	623000 Fees - Professional Services	3,995	507	507	2,093	0	2,600
32570	B	625000 Medical, Dental and Optical	18,972	25,000	5,814	(17,371)	0	7,629
32570	B	691000 Equipment Over $5000	80,091	0	0	0	0	0
32570	B	712000 Grants, Benefits & Claims	3,099,993	3,118,842	1,329,301	2,211,526	0	5,330,368
		Subtotal:	15,229,119	16,894,368	7,802,911	2,719,219	1,310,212	20,923,799

Grants Summary

Department of Human Services

North Central Human Service Center

Description	Funding	2007-09 Appropriation	2009-11 Budget Recommendation	Total Changes
Case Aide	General Funds	$107,250	$134,482	$27,232
Partnership--$182,074	Federal Funds	$62,916	$74,213	$11,297
Provider Inflation--$26,621		$170,166	$208,695	$38,529
Crisis Care / Safe Beds	General Funds	$6,303	$7,387	$1,084
Crisis Beds--$10,000	Federal Funds	$3,697	$4,076	$379
Provider Inflation--$1,463		$10,000	$11,463	$1,463
DD Services	Federal Funds	$40,000	$38,724	($1,276)
Experienced Parent--$35,000		$40,000	$38,724	($1,276)
Provider Inflation--$3,724				
Inpatient Hospitalization	General Funds	$81,263	$679,200	$597,937
SMI--$457,920		$81,263	$679,200	$597,937
Provider Inflation--$21,280				
Psych Social Club	General Funds	$164,815	$182,255	$17,440
Psych Social Club--$164,729		$164,815	$182,255	$17,440
Provider Inflation--$17,526				
Psychiatric / Psychological / Medical Services	General Funds	$254,217	$475,171	$220,954
Psychiatric Services--$490,819	Federal Funds	$234,521	$270,961	$36,440
Medication Monitor--$249,600	Special Funds	$64,525	$91,527	$27,002
Provider Inflation--$97,240		$553,263	$837,659	$284,396
Residential Services	General Funds	$626,275	$2,028,777	$1,402,502
CD Residential--$2,030,880	Federal Funds	$1,346,145	$1,202,554	($143,591)
SMI Residential--$1,000,387	Special Funds	$26,915	$30,296	$3,381

Grants Summary

Department of Human Services

North Central Human Service Center

Description	Funding	2007-09 Appropriation	2009-11 Budget Recommendation	Total Changes
Provider Inflation--$230,360		$1,999,335	$3,261,627	$1,262,292
Substance Abuse Treatment and Prevention	Federal Funds	$100,000	$110,745	$10,745
Native American Access--$100,000		$100,000	$110,745	$10,745
Provider Inflation--$10,745				
TOTAL GRANTS		**$3,118,842**	**$5,330,368**	**$2,211,526**

B

Testimony
HB 1012 – Department of Human Services
House Appropriations – Human Resource Division
Representative Pollert, Chairman
January 22, 2009

Chairman Pollert and members of the House Appropriations Human Resource Division, I am Tim Sauter, Director of West Central Human Service Center(WCHSC) and Badlands Human Service Center (BHSC) for the Department of Human Services (DHS). I am submitting this testimony to provide you an overview of the budget for both of these centers.

West Central Human Service Center

West Central Human Service Center serves the residents of Burleigh, Emmons, Grant, Kidder, McLean, Mercer, Morton, Oliver, Sheridan, and Sioux counties.

Caseload/Customer Base

- 4,913 individuals received service in Fiscal Year 2008 (3,681 adults and 1,232 children).
- 1,566 individuals received vocational rehabilitation services.
- A high percentage of adults who receive services (95 percent) and parents whose children receive services (83 percent) report satisfaction.
- 91% of Vocational Rehabilitation Service clients report satisfaction.

Program Trends

- The number of individuals with developmental disabilities receiving services has increased from 1,021 in State Fiscal Year (SFY) 2006 to 1,133 in SFY 2008.

- There is an increasing need for residential services for children, particularly transition age with severe emotional disorders, and children with dual disorders.
- Alcohol remains the biggest drug problem, there is a slight decrease in methamphetamine numbers, but increasing numbers of clients who have polysubstance abuse problems.
- Increasing numbers of referrals come from the Department of Corrections and Rehabilitation; this comprises 72 percent of WCHSC adult addiction clients.
- Staff recruitment and retention continue to be a challenge, due to market salary equity problems.

Accomplishments

- WCHSC has implemented several evidenced-based models of treatment.
- Adult and adolescent drug courts continue to produce positive results.
- The WCHSC Vocational Rehabilitation Unit has assisted the start-up of two new businesses and assisted six farm ranch operations to address disability issues and remain in business.
- We have successfully implemented residential services for adolescents receiving substance abuse treatment and safe beds for children.
- The WCHSC Aging Services Unit received a $10,000 grant to establish an Elder Justice Coalition.
- WCHSC nursing staff have successfully assisted 350 consumers to obtain medication from pharmaceutical companies through their Indigent Medication Programs.

- We continue to have a minimal number of residents from Region VII enter the North Dakota State Hospital or the Developmental Center.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase/ Decrease
West Central HSC	$21,028,858	$26,008,933	$4,980,075
General Funds	$10,172,407	$13,315,641	$3,143,234
Federal Funds	$9,940,424	$11,482,159	$ 1,541,735
Other Funds	$ 916,027	$ 1,211,133	$ 295,106
Total	$21,028,858	$26,008,933	$4,980,075

FTE	135.30	136.30	1.00

- The Governor's salary and benefit package adds $1,552,214 in total funds of which $1,163,095 is general fund.
- The cost to continue the July 2008 4% salary increases, for 24 months, totaled $232,921 of which $175,569 is general funds.
- Additional changes in the salary area are a result of one additional FTE for DD Case Management, totaling $100,626 of which $50,313 is general funds, and realignment of staff to meet client needs totaled $723,488 of which $95,095 is general funds.
- Changes to the Operating budget include:
    - Travel increased $46,142 based on Department of Transportation 2009-2011 rates.

- Information Technology Equipment under $5,000 increased by $15,000 based on the need to update equipment in the Rehabilitation Services technical equipment lab.
- Building Rent increased $203,074 based on a $0.54 per square foot increase on 35,521 square feet and an additional 5,210 square feet at a cost of $16.00. The additional space is being occupied by our Rehabilitation Services unit and was needed to alleviate the problem of multiple clinical staff sharing offices, as well as the need for group room space.
- Operating Fees and Services increased by $15,390. The increased funding is for wraparound services and flexible funding for services with the Homeless Program.
- Equipment over $5,000 increased by $16,500 and will be used to replace our primary network copier.

- Grants increased by $2,059,222. Major increases include $304,546 to address local capacity levels and rates for inpatient hospitalization, $496,900 for provider inflationary increases, $750,000 for residential services for young adults transitioning from the Partnership program to the adult system of care, $383,328 for contracted CD adolescent residential and safe bed services, $60,500 to cover a rate increase for contracted Title XIX Evaluation services and $40,124 for increased costs tied to contracted CD Residential services for adults.
- General funds increased by $3,143,234 with $1,484,072 related to salaries and benefits, $1,540,893 related primarily to contracted services for inpatient hospitalization, provider inflation and the proposed residential program for young adults. The remaining $118,269 is related to ongoing costs to continue operations.

- Federal Funds increased by $1,541,735, based on additional Medical Assistance and Foster Care IV-E Case Management, generated through client services and open-ended federal funding sources such as Basic Support for Rehabilitation Services.
- Other Funds increased by $295,106, based on additional collections for services generated through direct client and third party payments.

Badlands Human Service Center

Badlands Human Service Center (BHSC) serves the people of Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope, and Stark counties.

Caseload/Customer Base

- Badlands served 1,854 individuals (1,308 adults and 546 children) in SFY 2008.
- 311 individuals received vocational rehabilitation services.
- 89% of adults receiving services, and 98% of the parents whose children receive services, report satisfaction with those services.
- 91% of clients receiving vocational rehabilitation services report satisfaction.

Service Trends

- The number of individuals receiving developmental disabilities services has stabilized since SFY 2006.
- Clients continue to present with complex problems including dual diagnosis and polysubstance abuse.

- The number of referrals from the Department of Corrections and Rehabilitation has increased; this now comprises 55% of individuals in adult addiction programs in this region.
- There is a need for long term residential services for persons with chronic addictions and for persons with severe and persistent mental illness.
- Staff recruitment and retention issues continue to be difficult, due to market equity problems.
- There has been an increase in referrals to North Dakota State Hospital due to the closing of the local hospital's inpatient psychiatric unit.

Accomplishments

- BHSC, along with the other Regional Human Service Centers, has implemented evidence-based practice models.
- We increased the number of residential beds available to adults with mental illness and for those who have substance abuse problems from 9 to 16.
- We successfully contracted with an independent psychiatrist and a telemedicine provider.
- We initiated contracts with the medical centers in Bismarck to provide psychiatric stabilization of indigent clients from Region VIII.
- BHSC in partnership with other providers implemented an addiction counselor training consortium.
- To meet the need of rural areas, we have enhanced our outreach services in Adams, Bowman, Hettinger and Golden Valley counties.

Overview of Budget Changes

Description	2007 – 2009 Budget	2009 – 2011 Budget	Increase/ Decrease
Badlands HSC	$9,905,399	$11,694,235	$1,788,836
General Funds	$4,911,935	$6,264,582	$1,352,647
Federal Funds	$4,096,595	$4,614,839	$ 518,244
Other Funds	$ 896,869	$ 814,814	$ (82,055)
Total	$9,905,399	$11,694,235	$1,788,836

FTE	72.7	72.7	0

- The Governor's salary and fringe benefit package for state employees increased total funds by $776,794 of which $592,676 is general fund.
- The cost to continue the July 2008 4% salary increase, for 24 months, requires $123,157 total funds of which $95,188 are general funds.
- Due to staffing realignment during the 07-09 biennium, we have a decrease in salary of ($29,085) of which ($24,932) are general funds.
- Operating expenses increased by $88,276. The primary contributors to this increase are:
    - Rentals for Office space increased by $91,461. Due to increase in utility and labor costs, the rental rate at Pulver Hall, our main office, will increase from $9.50 to $12.50 per square foot. There are other minor rental increases, but this increase accounts for the majority of the change.

- Other changes in our operating expenses result in a net decrease of ($3,185).

- Grants increase by $829,694. Major contributors to this increase are the proposed new 16 bed residential facility and the 7% / 7% inflationary increase for our providers.
- The general fund request increased by $1,352,647, with $770,000 attributed to the proposed residential facility; $592,676 of this increase is related to the Governor's salary package for state employees; offset by a decrease of ($10,029) attributed to the ongoing costs to continue operations.
- Federal funds increased by $518,244, based on additional Medical Assistance and Foster Care IV-E Case Management generated through client services and open-ended federal funding sources such as Basic Support for Rehabilitation Services.
- Other funds have decreased by ($82,055) based on our current trend in patient fee collections.

This concludes my testimony for West Central Human Service Center and Badlands Human Service Center. I would be happy to answer any questions you may have.

Testimony
HB 1012 – Department of Human Services
Senate Appropriations Committee
March 4, 2009

Chairman Holmberg and members of the Senate Appropriations Committee, this is written testimony prepared by Tim Sauter, Director of West Central Human Service Center (WCHSC) and Badlands Human Service Center (BHSC) for the Department of Human Services (DHS). This is being submitted to provide you an overview of the budget for both of these centers.

West Central Human Service Center

West Central Human Service Center serves the residents of Burleigh, Emmons, Grant, Kidder, McLean, Mercer, Morton, Oliver, Sheridan, and Sioux counties.

Caseload/Customer Base

- 4,913 individuals received service in Fiscal Year 2008 (3,681 adults and 1,232 children).
- 1,566 individuals received vocational rehabilitation services.
- A high percentage of adults who receive services (95 percent) and parents whose children receive services (83 percent) report satisfaction.
- 91% of Vocational Rehabilitation Service clients report satisfaction.

Program Trends

- The number of individuals with developmental disabilities receiving services has increased from 1,021 in State Fiscal Year (SFY) 2006 to 1,133 in SFY 2008.

- There is an increasing need for residential services for children, particularly transition age with severe emotional disorders, and children with dual disorders.
- Alcohol remains the biggest drug problem, there is a slight decrease in methamphetamine numbers, but increasing numbers of clients who have polysubstance abuse problems.
- Increasing numbers of referrals come from the Department of Corrections and Rehabilitation; this comprises 72 percent of WCHSC adult addiction clients.
- Staff recruitment and retention continue to be a challenge, due to market salary equity problems.

Accomplishments

- WCHSC has implemented several evidenced-based models of treatment.
- Adult and adolescent drug courts continue to produce positive results.
- The WCHSC Vocational Rehabilitation Unit has assisted the start-up of two new businesses and assisted six farm ranch operations to address disability issues and remain in business.
- We have successfully implemented residential services for adolescents receiving substance abuse treatment and safe beds for children.
- The WCHSC Aging Services Unit received a $10,000 grant to establish an Elder Justice Coalition.
- WCHSC nursing staff have successfully assisted 350 consumers to obtain medication from pharmaceutical companies through their Indigent Medication Programs.

- We continue to have a minimal number of residents from Region VII enter the North Dakota State Hospital or the Developmental Center.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget	House Changes	To Senate
West Central HSC	21,028,858	4,980,075	26,008,933	(1,646,465)	24,362,468
General Funds	10,172,407	3,143,234	13,315,641	(1,207,194)	12,108,447
Federal Funds	9,940,424	1,541,735	11,482,159	(384,635)	11,097,524
Other Funds	916,027	295,106	1,211,133	(54,636)	1,156,497
Total	21,028,858	4,980,075	26,008,933	(1,646,465)	24,362,468
FTE	135.30	1.00	136.30	(1.00)	135.30

Budget Changes from Current Budget to Executive Budget:

- The Governor's salary and benefit package adds $1,552,214 in total funds of which $1,163,095 is general fund.
- The cost to continue the July 2008 4% salary increases, for 24 months, totaled $232,921 of which $175,569 is general funds.
- Additional changes in the salary area are a result of one additional FTE for DD Case Management, totaling $100,626 of which $50,313 is general funds, and realignment of staff to meet client needs totaled $723,488 of which $95,095 is general funds.
- Changes to the Operating budget include:
    - Travel increased $46,142 based on Department of Transportation 2009-2011 rates.
    - Information Technology Equipment under $5,000 increased by $15,000 based on the need to update equipment in the Rehabilitation Services technical equipment lab.

- Building Rent increased $203,074 based on a $0.54 per square foot increase on 35,521 square feet and an additional 5,210 square feet at a cost of $16.00. The additional space is being occupied by our Rehabilitation Services unit and was needed to alleviate the problem of multiple clinical staff sharing offices, as well as the need for group room space.
- Operating Fees and Services increased by $15,390. The increased funding is for wraparound services and flexible funding for services with the Homeless Program.
- Equipment over $5,000 increased by $16,500 and will be used to replace our primary network copier.

- Grants increased by $2,059,222. Major increases include $304,546 to address local capacity levels and rates for inpatient hospitalization, $496,900 for provider inflationary increases, $750,000 for residential services for young adults transitioning from the Partnership program to the adult system of care, $383,328 for contracted CD adolescent residential and safe bed services, $60,500 to cover a rate increase for contracted Title XIX Evaluation services and $40,124 for increased costs tied to contracted CD Residential services for adults.
- General funds increased by $3,143,234 with $1,484,072 related to salaries and benefits, $1,540,893 related primarily to contracted services for inpatient hospitalization, provider inflation and the proposed residential program for young adults. The remaining $118,269 is related to ongoing costs to continue operations.
- Federal Funds increased by $1,541,735, based on additional Medical Assistance and Foster Care IV-E Case Management, generated through client services and open-ended federal funding sources such as Basic Support for Rehabilitation Services.

- Other Funds increased by $295,106, based on additional collections for services generated through direct client and third party payments.

House Changes:

The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $135,157 - general fund, $227,169 – federal funds and $49,287 – other funds for a total of $411,613.

The House reduced 50% of the department-wide travel increase. West Central HSC's share of this decrease is $23,173 total funds; $13,677 – general fund, $4,147 federal funds and $5,349 other funds.

The House reduced department-wide provider inflation from 7 percent per year to 6 percent per year. West Central HSC's share of this decrease is $70,986 total funds; $70,021 – general fund, $965 - federal funds.

The House reduced 100% of the department-wide Global Behavioral Health OAR. West Central HSC's share of this decrease is $279,546 total funds; $279,546 – general funds.

The House removed funding for a Young Adult Transitional Services OAR totaling $750,000; $650,000 – general fund and $100,000 federal funds.

The House removed funding for one additional DD Case Manager FTE totaling $111,147; $58,793 – general fund and $52,354 federal funds.

Badlands Human Service Center

Badlands Human Service Center (BHSC) serves the people of Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope, and Stark counties.

Caseload/Customer Base

- Badlands served 1,854 individuals (1,308 adults and 546 children) in SFY 2008.
- 311 individuals received vocational rehabilitation services.
- 89% of adults receiving services, and 98% of the parents whose children receive services, report satisfaction with those services.
- 91% of clients receiving vocational rehabilitation services report satisfaction.

Service Trends

- The number of individuals receiving developmental disabilities services has stabilized since SFY 2006.
- Clients continue to present with complex problems including dual diagnosis and polysubstance abuse.
- The number of referrals from the Department of Corrections and Rehabilitation has increased; this now comprises 55% of individuals in adult addiction programs in this region.
- There is a need for long term residential services for persons with chronic addictions and for persons with severe and persistent mental illness.
- Staff recruitment and retention issues continue to be difficult, due to market equity problems.

- There has been an increase in referrals to North Dakota State Hospital due to the closing of the local hospital's inpatient psychiatric unit.

Accomplishments

- BHSC, along with the other Regional Human Service Centers, has implemented evidence-based practice models.
- We increased the number of residential beds available to adults with mental illness and for those who have substance abuse problems from 9 to 16.
- We successfully contracted with an independent psychiatrist and a telemedicine provider.
- We initiated contracts with the medical centers in Bismarck to provide psychiatric stabilization of indigent clients from Region VIII.
- BHSC in partnership with other providers implemented an addiction counselor training consortium.
- To meet the need of rural areas, we have enhanced our outreach services in Adams, Bowman, Hettinger and Golden Valley counties.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget	House Changes	To Senate
Badlands HSC	9,905,399	1,788,836	11,694,235	(931,239)	10,762,996
General Funds	4,911,935	1,352,647	6,264,582	(683,757)	5,580,825
Federal Funds	4,096,595	518,244	4,614,839	(239,557)	4,375,282
Other Funds	896,869	(82,055)	814,814	(7,925)	806,889
Total	9,905,399	1,788,836	11,694,235	(931,239)	10,762,996
FTE	72.70	0.00	72.70	0.00	72.70

- The Governor's salary and fringe benefit package for state employees increased total funds by $776,794 of which $592,676 is general fund.
- The cost to continue the July 2008 4% salary increase, for 24 months, requires $123,157 total funds of which $95,188 are general funds.
- Due to staffing realignment during the 07-09 biennium, we have a decrease in salary of ($29,085) of which ($24,932) are general funds.
- Operating expenses increased by $88,276. The primary contributors to this increase are:
  - Rentals for Office space increased by $91,461. Due to increase in utility and labor costs, the rental rate at Pulver Hall, our main office, will increase from $9.50 to $12.50 per square foot. There are other minor rental increases, but this increase accounts for the majority of the change.
  - Other changes in our operating expenses result in a net decrease of ($3,185).
- Grants increase by $829,694. Major contributors to this increase are the proposed new 16 bed residential facility and the 7% / 7% inflationary increase for our providers.
- The general fund request increased by $1,352,647, with $770,000 attributed to the proposed residential facility; $592,676 of this increase is related to the Governor's salary package for state employees; offset by a decrease of ($10,029) attributed to the ongoing costs to continue operations.
- Federal funds increased by $518,244, based on additional Medical Assistance and Foster Care IV-E Case Management generated

through client services and open-ended federal funding sources such as Basic Support for Rehabilitation Services.

- Other funds have decreased by ($82,055) based on our current trend in patient fee collections.

House Changes:

The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $40,139 - general fund, $74,273 – federal funds and $7,829 – other funds for a total decrease of $122,241.

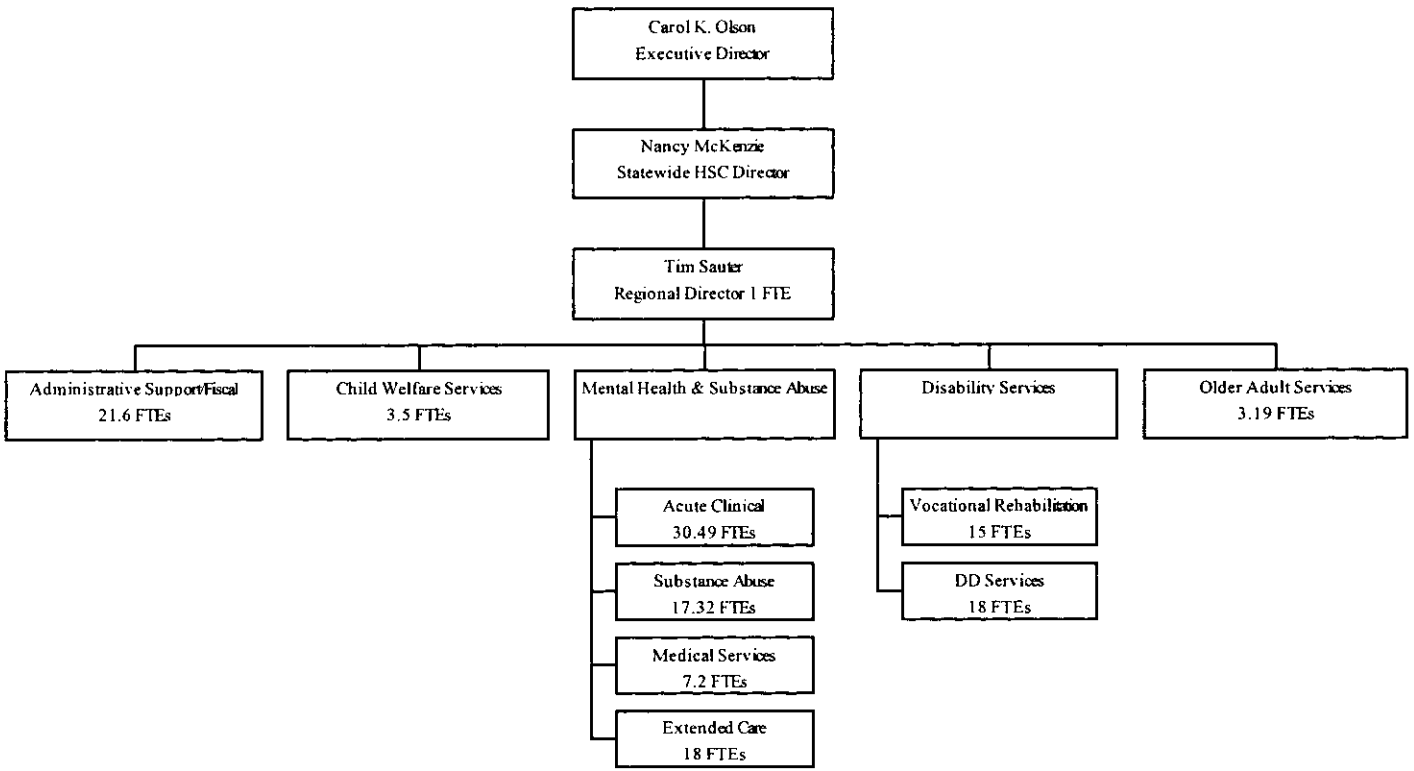
The House reduced 50% of the department-wide travel increase. Badlands HSC's share of this decrease is $395 total funds; $232 – general funds, $67 federal funds and $96 other funds.

The House reduced department-wide provider inflation from 7 percent per year to 6 percent per year. Badlands HSC's share of this decrease is $3,603 total funds; an increase of $21,614 – general fund, and a decrease of $25,217 - federal funds. OMB had originally funded the full 7 percent inflationary increase with federal funds, this has now been corrected.

The House reduced 100% of the department-wide Global Behavioral Health OAR. Badlands HSC's share of this decrease is $805,000 total funds; $665,000 – general funds, and $140,000 – federal funds.

This concludes the testimony on the 2009–2011 budget request for the WCHSC and BHSC portions of the DHS budget.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
WEST CENTRAL HUMAN SERVICE CENTER



2007-2009 Budget:
Authorized: 135.3 FTEs

Revised 1/5/09

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 410-77 WEST CENTRAL HSC								
S101		FULL-TIME EQUIVALENTS (FTEs)	131.550	135.300	0.000	1.000	0.000	136.300
32570	B	511000 Salaries - Permanent	8,747,937	10,561,137	5,097,176	797,583	(6)	11,358,714
32570	B	513000 Temporary Salaries	112,780	81,597	33,442	17,345	1	98,943
32570	B	514000 Overtime	10,199	9,600	8,403	0	1	9,601
32570	B	516000 Fringe Benefits	3,063,599	3,765,583	1,840,299	242,107	534,932	4,542,622
32570	B	521000 Travel	392,109	438,513	189,598	46,142	0	484,655
32570	B	531000 Supplies - IT Software	30,644	29,600	10,663	0	0	29,600
32570	B	532000 Supply/Material-Professional	42,226	41,560	18,282	(800)	0	40,760
32570	B	533000 Food and Clothing	4,654	6,800	2,939	200	0	7,000
32570	B	534000 Bldg, Grounds, Vehicle Supply	4,086	2,200	933	0	0	2,200
32570	B	535000 Miscellaneous Supplies	514	0	0	0	0	0
32570	B	536000 Office Supplies	41,296	41,400	26,218	6,600	0	48,000
32570	B	541000 Postage	35,723	44,330	21,320	0	0	44,330
32570	B	542000 Printing	29,754	29,625	13,023	0	0	29,625
32570	B	551000 IT Equip under $5,000	4,601	0	0	15,000	0	15,000
32570	B	552000 Other Equip under $5,000	5,798	0	0	0	0	0
32570	B	553000 Office Equip & Furniture-Under	67,077	26,721	26,721	0	0	26,721
32570	B	561000 Utilities	2,343	0	0	0	0	0
32570	B	571000 Insurance	72	0	0	0	0	0
32570	B	581000 Rentals/Leases-Equip & Other	1,879	0	0	0	0	0
32570	B	582000 Rentals/Leases - Bldg/Land	973,143	1,021,506	511,172	203,074	0	1,224,580
32570	B	591000 Repairs	13,719	12,000	4,134	(500)	0	11,500
32570	B	599110 Salary Increase	0	0	0	0	875,143	875,143
32570	B	599160 Benefit Increase	0	0	0	0	142,143	142,143
32570	B	601000 IT - Data Processing	579	0	0	0	0	0
32570	B	602000 IT-Communications	120,791	155,483	74,849	2,199	0	157,682
32570	B	611000 Professional Development	15,536	34,450	10,768	7,799	0	42,249
32570	B	621000 Operating Fees and Services	89,777	66,575	33,703	15,390	0	81,965
32570	B	623000 Fees - Professional Services	6,069	5,752	5,557	0	0	5,752
32570	B	625000 Medical, Dental and Optical	37,093	20,000	8,117	0	0	20,000
32570	B	691000 Equipment Over $5000	13,279	0	0	16,500	0	16,500
32570	B	712000 Grants, Benefits & Claims	3,778,785	4,634,426	2,066,147	2,059,222	0	6,693,648

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 410-77 WEST CENTRAL HSC							
	Subtotal:	17,646,062	21,028,858	10,003,464	3,427,861	1,552,214	26,008,933
32570 F	F_7091 HSCs & Institutions - Gen Fund	8,852,183	10,172,407	5,163,158	1,980,139	1,163,095	13,315,641
32570 F	F_7092 HSCs & Institutions - Fed Fnds	8,036,569	9,940,424	4,310,317	1,176,490	365,245	11,482,159
32570 F	F_7093 HSCs & Institutions - Oth Fnds	757,310	916,027	529,989	271,232	23,874	1,211,133
	Subtotal:	17,646,062	21,028,858	10,003,464	3,427,861	1,552,214	26,008,933
	Subdivision Budget Total:	17,646,062	21,028,858	10,003,464	3,427,861	1,552,214	26,008,933
410-77 WEST CENTRAL HSC	**General Funds:**	8,852,183	10,172,407	5,163,158	1,980,139	1,163,095	13,315,641
	Federal Funds:	8,036,569	9,940,424	4,310,317	1,176,490	365,245	11,482,159
	Other Funds:	757,310	916,027	529,989	271,232	23,874	1,211,133
	SWAP Funds:	0	0	0	0	0	0
	County Funds:	0	0	0	0	0	0
	IGT Funds:	0	0	0	0	0	0
	Subdivision Funding Total:	17,646,062	21,028,858	10,003,464	3,427,861	1,552,214	26,008,933

West Central Human Service Center
Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2009 - 2011 Biennium

Operating Fees & Services	Amount	General	Fed/Other
Advertising Services	2,500	2,115	385
DD Infant and Toddler Services	10,000	0	10,000
Flexible Funds for Services to the Homeless	8,000	2,958	5,042
Freight and Shipping	2,000	1,692	308
Program Fees related to Client Activities	10,990	3,344	7,646
Research Fees	2,000	1,692	308
Shredding Services for Confidential Documents	1,500	1,259	241
Staff License Renewal Fees	10,475	3,200	7,275
Storage and Handling Fees for Client Records	3,000	2,517	483
Wrap Around Services	25,000	0	25,000
Years of Service Awards	6,500	5,499	1,001
Total Operating Fees & Services Budget Account Code	**81,965**	**24,276**	**57,689**

Grants Summary

Department of Human Services

West Central Human Service Center

Description	Funding	2007-2009 Appropriation	2009-2011 Budget Recommendation	Total Changes
Adult Protective Services	General Funds	$556	$95	($461)
Adult Protective Service--$1,000	Federal Funds	$5,355	$905	($4,450)
		$5,911	$1,000	($4,911)
Care Coordination	General Funds	$14,595	$29,169	$14,574
Care Coordination--$35,000	Federal Funds	$19,565	$9,520	($10,045)
Provider Inflation--$3,724	Special Funds	$840	$35	($805)
		$35,000	$38,724	$3,724
Case Aide	General Funds	$673,001	$784,684	$111,683
SMI adult--$587,991	Federal Funds	$502,459	$518,069	$15,610
Partnership--$581,588	Special Funds	$15,944	$21,577	$5,633
CD--$27,385		$1,191,404	$1,324,330	$132,926
Provider Inflation--$127,366				
Crisis Care / Safe Beds	General Funds	$21,587	$95,355	$73,768
Partnership Safe Beds--$114,415	Federal Funds	$28,937	$31,121	$2,184
Provider Inflation--$12,175	Special Funds	$1,242	$114	($1,128)
		$51,766	$126,590	$74,824
DD Services	Federal Funds	$80,000	$80,000	$0
Experienced Parent--$80,000		$80,000	$80,000	$0
Detoxification	General Funds	$9,661	$32,971	$23,310
Social Detox--$29,800	Federal Funds	$17,784	$0	($17,784)
Provider Inflation--$3,171		$27,445	$32,971	$5,526
Evaluation Services - VR	General Funds	$1,704	$1,704	$0
Psychological Consultation--$8,000	Federal Funds	$6,296	$6,296	$0
		$8,000	$8,000	$0

Grants Summary

Department of Human Services
West Central Human Service Center

Description	Funding	2007-2009 Appropriation	2009-2011 Budget Recommendation	Total Changes
Flex Funds - Partnership	General Funds	$25,020	$43,620	$18,600
Flexible Funding--$60,000	Federal Funds	$33,540	$16,320	($17,220)
	Special Funds	$1,440	$60	($1,380)
		$60,000	$60,000	$0
Inpatient Hospitalization	General Funds	$64,468	$357,358	$292,890
SMI--$193,296	Federal Funds	$53,798	$60,308	$6,510
Addiction--$236,250	Special Funds	$6,734	$11,880	$5,146
		$125,000	$429,546	$304,546
Psych Social Club	General Funds	$196,122	$225,705	$29,583
Psych Social Club--$204,000	Federal Funds		$0	$0
Provider Inflation--$21,705		$196,122	$225,705	$29,583
Psychiatric / Psychological / Medical Services	General Funds	$90,779	$154,227	$63,448
Medication Monitor--$146,000	Federal Funds	$96,312	$112,266	$15,954
Title XIX evaluations--$102,500	Special Funds	$36,749	$46,515	$9,766
CD medical assessments--$5,000		$223,840	$313,008	$89,168
CD acupuncture--$33,280				
Provider Inflation--$26,228				
Residential Services	General Funds	$1,813,475	$2,732,673	$919,198
CD Residential Adult--$1,023,950	Federal Funds	$579,173	$1,043,325	$464,152
CD Residential Adolescent--$600,679	Special Funds	$85,290	$130,776	$45,486
SMI Residential--$1,225,614		$2,477,938	$3,906,774	$1,428,836
Clinical Services Residential--$4,000				
Young Adult Transition Residential Services--$750,000				
Provider Inflation--$302,531				
Respite Care	Federal Funds	$52,000	$47,000	($5,000)
Respite Care--$47,000		$52,000	$47,000	($5,000)

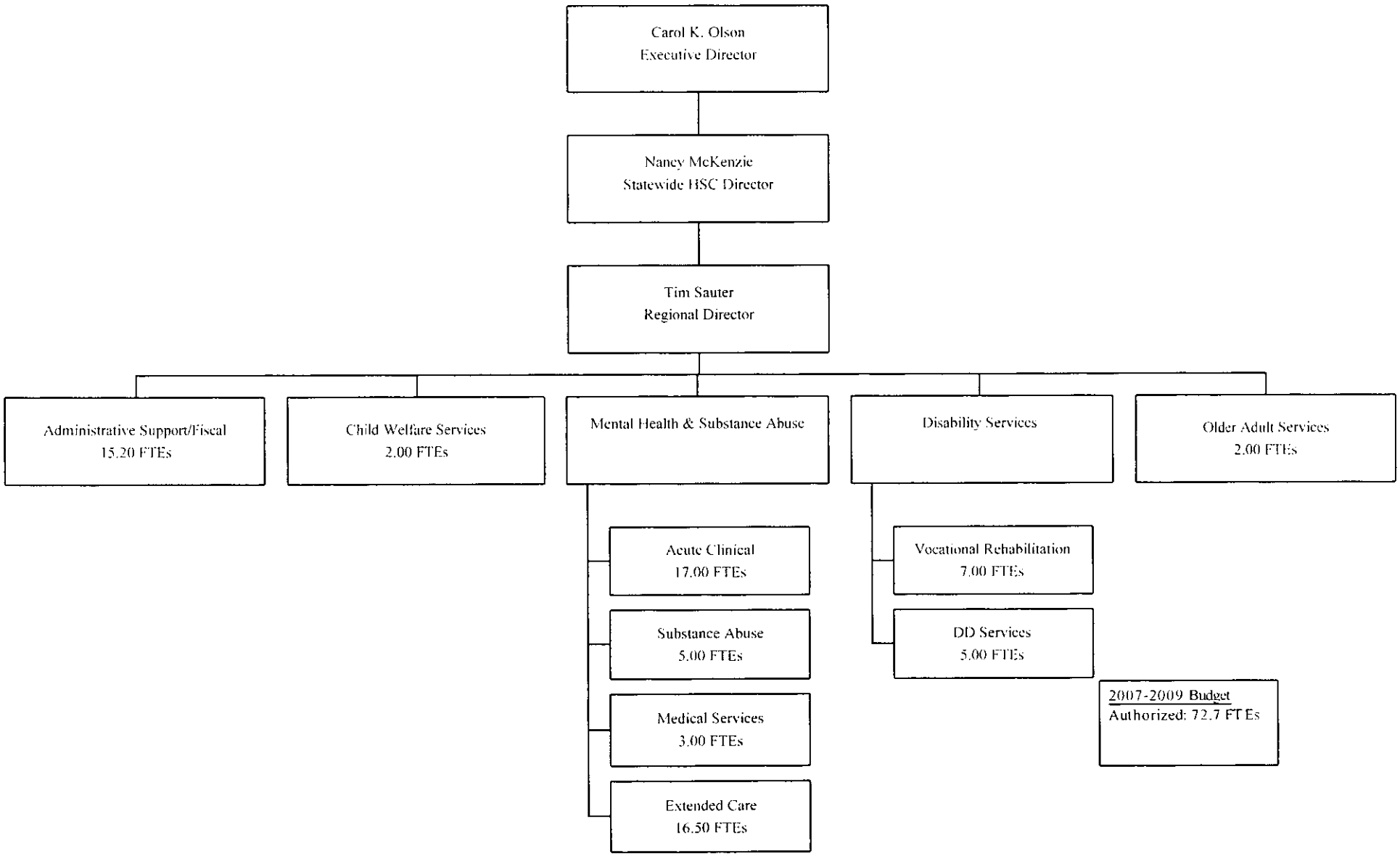
Grants Summary

Department of Human Services

West Central Human Service Center

Description		Funding	2007-2009 Appropriation	2009-2011 Budget Recommendation	Total Changes
Substance Abuse Treatment and Prevention		General Funds	$18,200	$12,500	($5,700)
Native American Access Program--$100,000		Federal Funds	$72,700	$73,100	$400
		Special Funds	$9,100	$14,400	$5,300
			$100,000	$100,000	$0
	TOTAL GRANTS		**$4,634,426**	**$6,693,648**	**$2,059,222**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
BADLANDS HUMAN SERVICE CENTER



DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 410-78 BADLANDS HSC								
		S101 FULL-TIME EQUIVALENTS (FTEs)	72.950	72.700	0.000	0.000	0.000	72.700
32570	B	511000 Salaries - Permanent	4,696,244	5,362,281	2,409,010	38,443	1	5,400,725
32570	B	512000 Salaries-Other	5,276	0	0	7,008	0	7,008
32570	B	513000 Temporary Salaries	104,501	222,683	96,368	36,637	0	259,320
32570	B	514000 Overtime	2,356	0	0	0	0	0
32570	B	516000 Fringe Benefits	1,749,535	2,065,200	941,706	11,984	287,510	2,364,694
32570	B	521000 Travel	161,083	161,113	85,325	787	0	161,900
32570	B	531000 Supplies - IT Software	19,015	18,200	7,399	(1,300)	0	16,900
32570	B	532000 Supply/Material-Professional	32,025	25,505	9,534	0	0	25,505
32570	B	533000 Food and Clothing	15,625	46,875	20,531	0	0	46,875
32570	B	534000 Bldg, Grounds, Vehicle Supply	29	0	0	0	0	0
32570	B	535000 Miscellaneous Supplies	35,760	13,760	9,687	0	0	13,760
32570	B	536000 Office Supplies	16,738	24,000	8,675	0	0	24,000
32570	B	541000 Postage	20,016	21,450	8,849	0	0	21,450
32570	B	542000 Printing	2,487	5,793	2,277	0	0	5,793
32570	B	553000 Office Equip & Furniture-Under	38,929	8,000	5,006	0	0	8,000
32570	B	561000 Utilities	16,256	53,000	17,258	(3,000)	0	50,000
32570	B	581000 Rentals/Leases-Equip & Other	75	500	0	0	0	500
32570	B	582000 Rentals/Leases - Bldg/Land	434,452	641,760	332,573	91,461	0	733,221
32570	B	591000 Repairs	14,729	13,382	6,296	0	0	13,382
32570	B	599110 Salary Increase	0	0	0	0	418,670	418,670
32570	B	599160 Benefit Increase	0	0	0	0	70,613	70,613
32570	B	602000 IT-Communications	76,100	84,819	43,322	12,003	0	96,822
32570	B	611000 Professional Development	5,059	9,300	4,770	(300)	0	9,000
32570	B	621000 Operating Fees and Services	42,178	81,455	25,352	(11,375)	0	70,080
32570	B	623000 Fees - Professional Services	50	0	0	0	0	0
32570	B	625000 Medical, Dental and Optical	166	15,000	128	0	0	15,000
32570	B	632000 Other Expenses	39	0	0	0	0	0
32570	B	712000 Grants, Benefits & Claims	864,631	1,031,323	395,264	829,694	0	1,861,017
		Subtotal:	8,353,354	9,905,399	4,429,330	1,012,042	776,794	11,694,235
32570	F	F_7091 HSCs & Institutions - Gen Fund	4,217,964	4,911,935	2,496,406	759,971	592,676	6,264,582

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 410-78 BADLANDS HSC							
32570 F	F_7092 HSCs & Institutions - Fed Fnds	3,318,823	4,096,595	1,609,404	348,940	169,304	4,614,839
32570 F	F_7093 HSCs & Institutions - Oth Fnds	816,567	896,869	323,520	(96,869)	14,814	814,814
	Subtotal:	8,353,354	9,905,399	4,429,330	1,012,042	776,794	11,694,235
	Subdivision Budget Total:	8,353,354	9,905,399	4,429,330	1,012,042	776,794	11,694,235
410-78 BADLANDS HSC	**General Funds:**	4,217,964	4,911,935	2,496,406	759,971	592,676	6,264,582
	Federal Funds:	3,318,823	4,096,595	1,609,404	348,940	169,304	4,614,839
	Other Funds:	816,567	896,869	323,520	(96,869)	14,814	814,814
	SWAP Funds:	0	0	0	0	0	0
	County Funds:	0	0	0	0	0	0
	IGT Funds:	0	0	0	0	0	0
	Subdivision Funding Total:	8,353,354	9,905,399	4,429,330	1,012,042	776,794	11,694,235

Badlands Human Service Center
Detail of Budget Account Code 582000
For the 2009 - 2011 Biennium Budget

1/20/2009

Rentals & Leases	Rate per Sq.Ft.	Amount	General	Fed/Other
Human Service Center Building Rent:				
Main Offices	$ 12.50	$ 433,792	$ 250,662	$ 183,130
Vocational Rhabilitation Offices	$ 10.00	$ 79,469	$ 15,692	$ 63,777
Outreach Office - Beach	$ 9.14	$ 1,920	$ 794	$ 1,126
Outreach Office - Bowman		$ 6,000	$ 2,034	$ 3,966
Residential Facility		$ 206,400	$ 54,543	$ 151,857
Supported Living Offices	$ 8.81	$ 5,640	$ 5,640	$ -
Total Rentals & Leases Budget Account Code		**$ 733,221**	**$ 329,365**	**$ 403,856**

Badlands Human Service Center
Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2009 - 2011 Biennium

Operating Fees and Services	Amount	General	Fed/Other
Cable TV	1,200		1,200
Homeless Flex Funds	8,000	8,000	
Other Misc. Operating Fees:	7,380	6,373	1,007
(Snow removal, minor janitorial services, client incentives, etc.)			
Part-C General Expenses	2,500		2,500
Partnership Flex Funds	5,000	3,192	1,808
Staff Licenses	4,500	2,127	2,373
Staff Recruitment, including background checks etc.	5,000	3,192	1,808
Worker's Comp Premium and Payments	4,000	3,454	546
Wrap Around / Repsite Care	30,000	21,418	8,582
Years of Service Awards	2,500	2,159	341
Total Operating Fees & Services Budget Account Code	**70,080**	**49,915**	**20,165**

Grants Summary

Department of Human Services
Badlands Human Service Center

Description	Funding	2007-2009 Appropriation	2009-2011 Budget Recommendation	Total Changes
Psychiatric / Psychological / Medical Services	General Funds	$203,552	$333,630	$130,078
Psychiatric Services--$584,800	Federal Funds	$313,977	$267,170	($46,807)
Medical Consultation (VR)-- $4,000	Special Funds	$87,532	$50,000	($37,532)
Outreach Services--$30,000		$605,061	$650,800	$45,739
CD Accupuncture--$32,000				
Care Coordination	General Funds	$2,788	$0	($2,788)
Care Coordination--$15,000	Federal Funds	$33,474	$15,000	($18,474)
		$36,262	$15,000	($21,262)
DD Services	Federal Funds	$40,000	$44,469	$4,469
ICC/Experienced Parent - $40,000		$40,000	$44,469	$4,469
Provider Inflation - $4,469				
Psych / Social Club	General Funds	$195,000	$195,000	$0
Psych Social Club--$195,000	Federal Funds	$0	$20,748	$20,748
Provider Inflation-- $20,748		$195,000	$215,748	$20,748
Residential Services	General Funds	$0	$770,000	$770,000
CD Residential Adult--$455,000	Federal Funds		$140,000	$140,000
SMI Residential--$455,000		$0	$910,000	$910,000
Inpatient Hospitalization	General Funds	$155,000	$25,000	($130,000)
Addiction--$25,000		$155,000	$25,000	($130,000)
TOTAL GRANTS		**$1,031,323**	**$1,861,017**	**$829,694**

#C

Testimony
House Bill 1012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
January 22, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, I am Candace Fuglesten, Director of Southeast Human Service Center (SEHSC) and South Central Human Service Center (SCHSC) for the Department of Human Services (DHS). I am here today to provide you an overview of the budget for both centers.

Southeast Human Service Center

SEHSC provides community behavioral health and safety net services to individuals who live primarily in Steele, Traill, Cass, Ransom, Sargent and Richland counties, in Region V of our State. The region is comprised of 173,781 residents (27.2 percent of the state's population) as estimated by the 2007 US Census estimates.

Caseload / Customer Base

- SEHSC provided behavioral health services to 5,029 individuals in SFY 2008 (3,931 adults - 1,098 seventeen years of age or younger). This number increased 1.5 percent since last biennium, but this represents a slowing in the growth of clients from previous years. Fifty-five percent of these individuals qualified to receive services at 100 percent discount due to having incomes that fell 100 percent or more below the poverty index. Forty-one percent of the individuals had no third party payment or insurance coverage of any kind.

- SEHSC provided Vocational Rehabilitation (VR) services to 1,539 individuals. Within the Developmental Disability (DD) service area we served 1,185 individuals in FY 2008.
- SFY 2008 data shows that 13 percent of the behavioral health clients carry dual diagnoses of serious mental illness and chronic addiction. Due to demand issues and capacity limitations, SEHSC provides all of the established human service center core services, but prioritizes serving the most vulnerable individuals who cannot access services elsewhere in the community/region. Our Admission staff assist individuals requesting non-urgent services, who have the potential to access other community providers, by discussing alternative resources with the caller. Many of these individuals then seek those services from other local providers.
- Due to the high demand for case management services for individuals with serious mental illness and/or chronic addiction, we have identified criteria/levels of care to determine those most in need of these services; i.e. individuals at highest risk of rehospitalization or harm to self or others. Individuals who receive case management services require multiple services, and these capacity demands are reflected in our budget.
- Nineteen percent of all admissions to the North Dakota State Hospital (NDSH) in FY 2008 came from this region. This is actually a decrease of four percent from the previous biennium. Short-term inpatient hospitalization for indigent clients is provided at MeritCare Hospital through a contract with SEHSC.
- We also contract for crisis beds for children with severe emotional disorders and crisis/social detox beds for adolescents with substance abuse issues. The addiction crisis beds provide

an intensive level of substance abuse residential care in a family setting. Outcomes in this area have been very positive with increased school attendance, reduction in substance use, and successful reintegration into the parental home.

- Many of our clients are involved in the correctional system either at the local jail and court system or after release from prison and under the supervision of Probation and Parole. We receive a daily census report from the jail, so that we can monitor clients who may be incarcerated and continue to provide psychiatric and medication follow-up. Our regional intervention staff work with the jail to triage and identify new individuals that need immediate psychiatric evaluations that are completed at the jail. Cass County was awarded a Department of Justice grant to work with community partners in a pilot project of a post-booking diversion program for eligible offenders with mental health diagnoses. With this grant the jail has hired a mental health professional and SEHSC receives funds for a 0.75 percent case management FTE who will work with offenders that the court sentences to this program. Both the jail and the prison work with us to plan for aftercare as much as possible with appointments made as often as possible for the day of release.
- The demand for outreach addiction treatment services for both adults and adolescents in our region continues to grow. We have expanded hours in both Lisbon and Wahpeton to meet this demand.

Program Trends

- The impact from New American settlement continues in the Region with West Fargo Schools reporting they have gone from five English Language Learners (ELL) in 1996 to over 500 in the current school year. They represent 21 countries and about 7 percent of the total school population. Fargo school district's ELL speak 113 languages and represent 10 percent of the school's enrollment. SEHSC serves 10 percent minority consumers (not all are ELL) and provides, through contract, translation services in twelve languages.
- The Fargo area has a strong job market with a low unemployment rate. This creates challenges in terms of placing us in a very competitive market for healthcare professionals. Our staff turnover rate for CY 2007 was 14.61 percent, which is an improvement from the last biennium, but still significant. We have had licensed psychologist positions open for over a year and continue to recruit in that area. Turnover of case management staff is also very high, which impacts service delivery in one of the highest need areas.
- The estimated poverty rate in the metropolitan statistical area, which consists of Cass and Clay counties, jumped from 10.1 percent in 2006 to 13.4 percent last year, according to the U.S. Census Bureau's annual American Community Survey.
- Region V has 51 percent (91 individuals) of the long term homeless population in North Dakota according to the latest point in time study conducted in January 2008. "That definition is used to describe individuals or families with disabling conditions who have been homeless continuously for at least

one year, or more than four times in the last three years (ND Interagency Council on Homelessness)."

- As of December 1, 2008, there were 80 children from Region V in the custody of the Department of Human Services, which is an increase from last biennium. Sixty-four of the 80 children entered into custody within the last two years with 54 adoptions occurring during that same timeframe. More than 60 percent of the children are 10 years or under, which indicated a trend that children coming into custody of the State from our region are getting younger.

Accomplishments

I am pleased to report a number of significant accomplishments for SEHSC:

- We have just finished our second full year of implementing the evidence -based practice of Integrated Dual Disorder Treatment (IDDT) which has been proven to improve the quality of life for individuals with co-occurring mental and chronic substance use disorders. In February 2007, we started our second IDDT program for individuals who have a primary chronic substance use disorder. In seeking an improved way to work with our growing population of individuals with both serious mental illness and substance abuse, we noted that IDDT research indicated outcomes which include **reduced** rates of relapse, hospitalization, arrest, incarceration, and utilization of high cost services while **increasing** continuity of care, quality of life outcomes, stable housing, employment, and independent living. This model provides staff with very specific strategies for delivering service. The DHS-Mental Health and Substance Abuse Division is working

with us on the implementation of this practice and has implemented a number of research and data gathering efforts to measure outcomes. Preliminary results are positive, and there are plans to implement the program in other areas of the State.

- SEHSC has continued to increase the number of other evidence-based practices, and to date, in addition to the IDDT program, offers Dialectal Behavioral Treatment, Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), Trauma Based Focused Cognitive Behavioral Therapy, Matrix, Motivational Interviewing, and Person Centered Treatment Planning.
- In conjunction with the University of North Dakota Medical School, SEHSC provides a psychiatric residency training site for a number of doctors each year. This has assisted with recruitment of psychiatrists both at our Center and within the State.
- SEHSC continues to be approved as a training site for the Association of Psychology Postdoctoral and Internship Centers (APPIC), and each year selects two students from across the country to participate in a nine-month internship program. A number of these trainees have gone on to employment with DHS or within the State. We also are currently in the process of completing an application to be an approved American Psychological Association intern site, so that we can better attract North Dakota graduates to our intern program, which we believe will assist us with recruitment of licensed psychologists.
- In July 2008 we expanded our crisis bed availability to 14 beds (15 when new licensure standards were approved in January 2009). There continues to be high utilization of these beds and a wait list and triage process is used for admission access.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / Decrease
SEHSC	26,590,526	32,020,964	5,430,438
General	11,548,288	16,054,906	4,506,618
Federal	13,823,577	14,576,889	753,312
Other	1,218,661	1,389,169	170,508
FTEs	182.35	188.35	6.00

- The Governor's salary package of 5/5 and the health insurance increase which adds $2,151,073 in total funds of which $1,632,355 is general fund.
- Additional increases in the salary area of $557,870 are a result of the addition of six FTE's to address capacity concerns for global behavioral health, DD case management and Partnership care coordination which have increased the general fund by $436,961.
- This budget also includes $338,039, of which $239,501 is general funds, to continue the July 2008 salary increases for the entire biennium.
- Operating increases of $65,436 are the result of increased rent of $9,010 for the MI/CD facility; $9,800 increase for computers, travel and supplies for the six additional staff; and an $18,862 inflationary increase for janitorial and drug testing services. Other increases are $9,312 for the increased cost of the accreditation survey for our sheltered workshop; $6,276 in motor pool costs due to the increase in gasoline prices and increased outreach to vulnerable clients in rural areas of the region; $3,058 for staff training; and $8,989 increase in building

repair costs for needed upkeep: e.g. carpeting, painting, repairs to parking lot and building. The increases have $59,813 of general fund.

- Capital assets decreased by $55,897, due the bonds for the Southeast facility being fully paid off in December of 2007. This decreased the general fund by $41,069.
- Grants increased by $2,028,067, primarily based on the following: inflationary increases for providers of $387,427; an increase of $426,844 for an eight bed youth transitional housing facility; $315,360 for a twenty-four hour program coordinator contract for the Cooper House; $192,000 for an adult drug court budget that was moved from Corrections to DHS-SEHSC; $50,000 for respite care expansion; $100,000 for a supported employment project for individuals with mental illness; and $644,135 for the increased need of hospital services for HSC clients who are indigent, along with an increased rate for those services, which is now consistent among all HSCs. These increases account for $1,643,635 of general funds.
- Other changes in the general fund include an increase of $91,734 due to a decrease in the FMAP percentage for Medicaid reimbursement. General fund was also increased by $443,688 due to federal fund limitations required to maintain services in the hold-even budget.

South Central Human Service Center

SCHSC provides community services to individuals who live primarily in Foster, Wells, Griggs, Barnes, Stutsman, LaMoure, Dickey, McIntosh and Logan Counties. This region is comprised of 55,593 residents (8.7 percent of the State's population) as estimated by the 2007 US Census estimates and covers 10,441 square miles.

Caseload / Customer Base

- SCHSC continues to provide clinical services in Valley City, Oakes, Carrington, Cooperstown, LaMoure, Wishek and Fessenden. In addition, clinicians who work with individuals with serious mental illness, vocational rehabilitation needs and developmental disabilities travel to each of the nine counties in Region VI providing services.
- SCHSC provided behavioral health services to 2,958 individuals in SFY 2008 (2,220 adults and 738 children received services). This represents a three percent overall increase in numbers served from last biennium. In addition, 605 individuals received Vocational Rehabilitation Services and 166 individuals received Older Blind Services.
- SCHSC has the only full-time community psychiatrist in Region VI.
- Admissions to the North Dakota State Hospital (NDSH) remain in the 25-30 per month range. As Region VI has no private inpatient mental health treatment facility, the NDSH is utilized for acute inpatient needs as well as for longer term hospitalization needs. Individuals from Region VI also access out-of-region private psychiatric hospitals.
- Referrals for services for individuals from the Court and Correction sectors continue to be high.

- Admissions to the Crisis Residential Unit dipped slightly in CY 2007, but increased in CY 2008 and are currently projected to be approximately 224 admissions for the year.
- Requests for emergency service interventions continued to increase over the course of the last SFY. SCHSC provided 584 emergent interventions in SFY 2008, which was the highest number in the State. In corresponding efforts to reduce potential NDSH admissions, SCHSC developed a formal Regional Intervention Unit (RIS) in an effort to have more highly skilled screeners with increased knowledge of treatment alternatives to assist in consumer treatment and reduction of admissions to the NDSH.
- 27.4 percent (122 of 444) of North Dakota's reported adult abuse and neglect incidents during FFY 2007 occurred within Region VI.
- SCHSC Family Caregiver Support Program has consistently served the largest number of caregivers in the state, with a caseload range of 65-70 at any one time. SCHSC utilizes both in-home and inpatient respite for our caregivers. As of today, 40 percent of our families are in-home care providers for someone with Alzheimer's or related dementia. The Family Caregiver Support Program allows families to delay transitioning of a loved one to a care facility. We can anticipate with a growing population of adults age 60 and over within Region VI that program needs will continue to grow and be impacted by the availability of staffing resources and programmatic funds in the future.

Program Trends

- Citizens (age 60+) comprised 27.2 percent of the total population in Region VI. The South Central region has the oldest average age in the state.
- The baby boomers, the large cohort of individuals born between 1946 and 1964, will continue to create a sizable bulge in the region's future age distribution. Projections indicate that between 2010 and 2015, 34 percent of the region's residents will be age 60 and over.
- The changing age profile of Region VI will have important implications for both the Caregiver Program and Adult Abuse and Neglect reporting and interventions. Requests for interventions can be anticipated to remain strong due to several factors. Declining health status of older adults; poverty which hits certain old age subgroups the hardest; and advanced age adds to this group's vulnerability. These factors, in conjunction with our strong desire to assist this population to remain independent as long as possible, will impact referrals and workloads of SCHSC staff.

Accomplishments

- In conjunction with the NDSH and Progress Enterprises, Inc., the 15 bed Bridgepointe transitional living facility was established. The residential program is providing community-based living and treatment for 15 long-term hospital patients with serious mental illness. This program development has resulted in more availability of bed space at the NDSH for treatment of individuals with acute and long-term mental health treatment needs.

- "Grow our own" efforts associated with training and filling addiction counselor positions have resulted in South Central's Addiction Unit being fully staffed, thus reducing consumer wait times for evaluation and treatment services. The demand for addiction services is high in this region, and there are a large number of consumers with chronic treatment issues.
- An essential new element in the South Central region's recovery oriented mental health system has been the introduction and development of the Peer Support Program. As a means to model recovery and resiliency in overcoming everyday obstacles common to those who live with serious mental illness (SMI), three trained peer support volunteers (individuals who have experienced SMI) coordinate a weekly peer support group for 15-20 consumers and between 70-80 consumers actively participate in recovery-based activities. The Peer Support Program is an integral and growing part of the South Central mental health system as the provision of support by persons who have experienced mental illness is the essence of empowerment and ultimately recovery.
- South Central has continued to increase the number of evidence-based practices, and to date, offers Dialectal Behavioral Treatment, Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), Trauma Based Focused Cognitive Behavioral Therapy, Matrix, and Person Centered Treatment.
- In ongoing efforts to maximize staffing resources, South Central has successfully reduced consumer "no shows" for psychiatric evaluations and medication reviews through utilization of a Retired Senior Volunteer Program (RSVP) volunteer to complete follow up or "reminder calls" to consumers with scheduled medical appointments. Due to these cue reminder calls, the no show rates

have trended downward by 7.9 percent over the latter months of CY 2008 thus improving program efficiency.

- A workforce analysis of staff at SCHSC was completed which indicated a labor force of skilled experienced individuals with a great number of years of service in their current positions. A high percentage of individuals will reach the rule of 85 within next few years and will be eligible for State retirement. For succession planning purposes, we have made administrative and supervisory training available to interested staff to minimize impact of retirements and to prepare individuals to compete and perform in the near future in leadership roles.
- South Central continued to strengthen consumer care through multiple collaborative efforts with local inpatient and outpatient facilities on such issues as social detoxification, transportation, consumer medication distribution efforts, homelessness, licensed addiction counselor development and recruitment, outpatient sex offender evaluations, expansion of the Sheyenne Care geropsychiatric unit, and substance abuse prevention efforts.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / (Decrease)
SCHSC	14,635,176	15,913,332	1,278,156
General	8,005,783	8,943,330	937,547
Federal	5,860,748	6,216,353	355,605
Other	768,645	753,649	(14,996)
FTEs	85.50	87.50	2.00

The major changes can be explained as follows:

- The Governor's salary package recommendation requires a total increase of $1,013,085 with $788,746 being from the general fund.
- Other increases in the salary and fringe benefits portion of the budget include the addition of two FTE's, one for Vulnerable Adult Services and one for Addiction Services (all $152,182 from the general fund).
- The cost to continue the July 2008 salary increase for the entire biennium is $153,858 total funds ($117,147 general funds).
- The Operating portion of the budget increased by $5,733, mainly due to the addition of the two new FTE's. All of the increase was from the general fund.
- The Grants portion of the budget decreased by $160,363. This is due to a decrease in the amount needed for the operation of our contracted Transitional Living facility, which was a new facility that became operational just before the start of the current biennium. This decrease was offset by the 7 percent inflationary increases for contracted providers, which totaled $325,991 for the biennium. All of the decrease is from the general fund.

This concludes my testimony on the 2009–2011 budget request for the SEHSC and SCHSC portions of the DHS budgets. I would be happy to answer any questions.

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
March 4, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, this is written testimony provided by Candace Fuglesten, Director of Southeast Human Service Center (SEHSC) and South Central Human Service Center (SCHSC) for the Department of Human Services (DHS). This gives you an overview of the budget for both centers.

Southeast Human Service Center

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Caseload / Customer Base

- SEHSC provided behavioral health services to 5,029 individuals in SFY 2008 (3,931 adults - 1,098 seventeen years of age or younger). This number increased 1.5 percent since last biennium, but this represents a slowing in the growth of clients from previous years. Fifty-five percent of these individuals qualified to receive services at 100 percent discount due to having incomes that fell 100 percent or more below the poverty index. Forty-one percent of the individuals had no third party payment or insurance coverage of any kind.

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in the current school year. They represent 21 countries and about 7 percent of the total school population. Fargo school district's ELL speak 113 languages and represent 10 percent of the school's enrollment. SEHSC serves 10 percent minority consumers (not all are ELL) and provides, through contract, translation services in twelve languages.

- The Fargo area has a strong job market with a low unemployment rate. This creates challenges in terms of placing us in a very competitive market for healthcare professionals. Our staff turnover rate for CY 2007 was 14.61 percent, which is an improvement from the last biennium, but still significant. We have had licensed psychologist positions open for over a year and continue to recruit in that area. Turnover of case management staff is also very high, which impacts service delivery in one of the highest need areas.
- The estimated poverty rate in the metropolitan statistical area, which consists of Cass and Clay counties, jumped from 10.1 percent in 2006 to 13.4 percent last year, according to the U.S. Census Bureau's annual American Community Survey.
- Region V has 51 percent (91 individuals) of the long term homeless population in North Dakota according to the latest point in time study conducted in January 2008. "That definition is used to describe individuals or families with disabling conditions who have been homeless continuously for at least one year, or more than four times in the last three years (ND Interagency Council on Homelessness)."
- As of December 1, 2008, there were 80 children from Region V in the custody of the Department of Human Services, which is an increase from last biennium. Sixty-four of the 80 children

entered into custody within the last two years with 54 adoptions occurring during that same timeframe. More than 60 percent of the children are 10 years or under, which indicated a trend that children coming into custody of the State from our region are getting younger.

Accomplishments

I am pleased to report a number of significant accomplishments for SEHSC:

- We have just finished our second full year of implementing the evidence-based practice of Integrated Dual Disorder Treatment (IDDT) which has been proven to improve the quality of life for individuals with co-occurring mental and chronic substance use disorders. In February 2007, we started our second IDDT program for individuals who have a primary chronic substance use disorder. In seeking an improved way to work with our growing population of individuals with both serious mental illness and substance abuse, we noted that IDDT research indicated outcomes which include **reduced** rates of relapse, hospitalization, arrest, incarceration, and utilization of high cost services while **increasing** continuity of care, quality of life outcomes, stable housing, employment, and independent living. This model provides staff with very specific strategies for delivering service. The DHS-Mental Health and Substance Abuse Division is working with us on the implementation of this practice and has implemented a number of research and data gathering efforts to measure outcomes. Preliminary results are positive, and there are plans to implement the program in other areas of the State.

- SEHSC has continued to increase the number of other evidence-based practices, and to date, in addition to the IDDT program, offers Dialectal Behavioral Treatment, Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), Trauma Based Focused Cognitive Behavioral Therapy, Matrix, Motivational Interviewing, and Person Centered Treatment Planning.
- In conjunction with the University of North Dakota Medical School, SEHSC provides a psychiatric residency training site for a number of doctors each year. This has assisted with recruitment of psychiatrists both at our Center and within the State.
- SEHSC continues to be approved as a training site for the Association of Psychology Postdoctoral and Internship Centers (APPIC), and each year selects two students from across the country to participate in a nine-month internship program. A number of these trainees have gone on to employment with DHS or within the State. We also are currently in the process of completing an application to be an approved American Psychological Association intern site, so that we can better attract North Dakota graduates to our intern program, which we believe will assist us with recruitment of licensed psychologists.
- In July 2008 we expanded our crisis bed availability to 14 beds (15 when new licensure standards were approved in January 2009). There continues to be high utilization of these beds and a wait list and triage process is used for admission access.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget	House Changes	To Senate
SEHSC	26,590,526	5,430,438	32,020,964	(2,260,109)	29,760,855
General Funds	11,548,288	4,506,618	16,054,906	(1,482,439)	14,572,467
Federal Funds	13,823,577	753,312	14,576,889	(715,347)	13,861,542
Other Funds	1,218,661	170,508	1,389,169	(62,323)	1,326,846
FTEs	182.35	6.00	188.35	(6.00)	182.35

Budget Changes from Current Budget to Executive Budget

- The increase in salary and fringe benefits is a result of the salary and health insurance package, which adds $2,151,073 in total funds of which $1,632,355 is General Fund.
- Additional increases in the salary area of $557,870 are a result of the addition of six FTE to address capacity concerns for global behavioral health, DD case management and Partnership care coordination which have increased the general fund by $436,961. This budget also includes $338,039, of which $239,501 is general funds, which is the cost to continue the July 2008 salary increases for the entire biennium.
- Operating increases of $65,436 are the result of increased rent of $9,010 for the MI/CD facility; $9,800 increase for computers, travel and supplies for the six additional staff; and an $18,862 inflation increase for janitorial and drug testing services. Other increases are $9,312 increased cost of the accreditation survey for our sheltered workshop; $6,276 in motor pool costs due to the increase in gasoline prices and increased outreach to vulnerable clients in rural areas of the region; $3,058 for staff training; and $8,989 increase in building repair costs for needed

upkeep: e.g. carpeting, painting, repairs to parking lot and building. The increases have $59,813 of general fund.

- Capital assets decreased by $55,897 due the bonds for the Southeast facility being fully paid off in December of 2007. This decreased the general fund by $41,069.
- Grants increased by $2,028,067 primarily based on the following: inflationary increases for providers of $387,427; an increase of $426,844 for an eight bed youth transitional housing facility; $315,360 for a 24-hour program coordinator contract for the Cooper House; $192,000 for an adult drug court budget that was moved from The Department of Corrections and Rehabilitation to DHS-SEHSC; $50,000 for respite care expansion; $100,000 for a supported employment project for individuals with mental illness; and $644,135 for the increased need of hospital services for HSC clients who are indigent, along with an increased rate for those services, which is now consistent among all HSCs. These increases account for $1,643,635 of general funds.
- Other changes in the general fund include an increase of $91,734 due to a decrease in the FMAP percentage for Medicaid reimbursement. General fund was also increased by $443,688 due to federal fund limitations required to maintain services in the hold-even budget.

House Changes:

- The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $164,349 - general fund, $307,531 - federal funds and $28,636 other funds for at total of $500,516.

- The House reduced 50% of the department-wide travel increase. The Southeast share of this decrease is $3,121 total funds; $1,707 – general fund.
- Additional decreases in the salary area of $617,652 are a result of the reduction of six FTEs to address capacity concerns for global behavioral health, DD case management and Partnership care coordination which decreased the general fund by $427,634. Also included with these 6 positions is a reduction of $9,800 in office supplies. General fund decrease is $6,036.
- Provider inflation was reduced from 7% to 6% which resulted in a decrease of $58,041 in total funds; $57,874 – general fund.
- There was a decrease of $426,844 for an eight bed youth transitional housing facility; and $644,135 for the increased need and the increased rebasing rate of hospital services for HSC clients who are indigent. These decreased the general fund by $828,757, federal funds by $213,422 and other funds by $28,800

South Central Human Service Center

SCHSC provides community services to individuals who live primarily in Foster, Wells, Griggs, Barnes, Stutsman, LaMoure, Dickey, McIntosh and Logan Counties. This region is comprised of 55,593 residents (8.7 percent of the State's population) as estimated by the 2007 US Census estimates and covers 10,441 square miles.

Caseload / Customer Base

- SCHSC continues to provide clinical services in Valley City, Oakes, Carrington, Cooperstown, LaMoure, Wishek and Fessenden. In addition, clinicians who work with individuals with serious mental

illness, vocational rehabilitation needs and developmental disabilities travel to each of the nine counties in Region VI providing services.

- SCHSC provided behavioral health services to 2,958 individuals in SFY 2008 (2,220 adults and 738 children received services). This represents a three percent overall increase in numbers served from last biennium. In addition, 605 individuals received Vocational Rehabilitation Services and 166 individuals received Older Blind Services.
- SCHSC has the only full-time community psychiatrist in Region VI.
- Admissions to the North Dakota State Hospital (NDSH) remain in the 25-30 per month range. As Region VI has no private inpatient mental health treatment facility, the NDSH is utilized for acute inpatient needs as well as for longer term hospitalization needs. Individuals from Region VI also access out-of-region private psychiatric hospitals.
- Referrals for services for individuals from the Court and Correction sectors continue to be high.
- Admissions to the Crisis Residential Unit dipped slightly in CY 2007, but increased in CY 2008 and are currently projected to be approximately 224 admissions for the year.
- Requests for emergency service interventions continued to increase over the course of the last SFY. SCHSC provided 584 emergent interventions in SFY 2008, which was the highest number in the State. In corresponding efforts to reduce potential NDSH admissions, SCHSC developed a formal Regional Intervention Unit (RIS) in an effort to have more highly skilled screeners with increased knowledge of treatment

alternatives to assist in consumer treatment and reduction of admissions to the NDSH.

- 27.4 percent (122 of 444) of North Dakota's reported adult abuse and neglect incidents during FFY 2007 occurred within Region VI.
- SCHSC Family Caregiver Support Program has consistently served the largest number of caregivers in the state, with a caseload range of 65-70 at any one time. SCHSC utilizes both in-home and inpatient respite for our caregivers. As of today, 40 percent of our families are in-home care providers for someone with Alzheimer's or related dementia. The Family Caregiver Support Program allows families to delay transitioning of a loved one to a care facility. We can anticipate with a growing population of adults age 60 and over within Region VI that program needs will continue to grow and be impacted by the availability of staffing resources and programmatic funds in the future.

Program Trends

- Citizens (age 60+) comprised 27.2 percent of the total population in Region VI. The South Central region has the oldest average age in the state.
- The baby boomers, the large cohort of individuals born between 1946 and 1964, will continue to create a sizable bulge in the region's future age distribution. Projections indicate that between 2010 and 2015, 34 percent of the region's residents will be age 60 and over.
- The changing age profile of Region VI will have important implications for both the Caregiver Program and Adult Abuse and Neglect reporting and interventions. Requests for interventions

can be anticipated to remain strong due to several factors. Declining health status of older adults; poverty which hits certain old age subgroups the hardest; and advanced age adds to this group's vulnerability. These factors, in conjunction with our strong desire to assist this population to remain independent as long as possible, will impact referrals and workloads of SCHSC staff.

Accomplishments

- In conjunction with the NDSH and Progress Enterprises, Inc., the 15 bed Bridgepointe transitional living facility was established. The residential program is providing community-based living and treatment for 15 long-term hospital patients with serious mental illness. This program development has resulted in more availability of bed space at the NDSH for treatment of individuals with acute and long-term mental health treatment needs.
- "Grow our own" efforts associated with training and filling addiction counselor positions have resulted in South Central's Addiction Unit being fully staffed, thus reducing consumer wait times for evaluation and treatment services. The demand for addiction services is high in this region, and there are a large number of consumers with chronic treatment issues.
- An essential new element in the South Central region's recovery oriented mental health system has been the introduction and development of the Peer Support Program. As a means to model recovery and resiliency in overcoming everyday obstacles common to those who live with serious mental illness (SMI), three trained peer support volunteers (individuals who have experienced SMI) coordinate a weekly peer support group for 15-20 consumers and

between 70-80 consumers actively participate in recovery-based activities. The Peer Support Program is an integral and growing part of the South Central mental health system as the provision of support by persons who have experienced mental illness is the essence of empowerment and ultimately recovery.

- South Central has continued to increase the number of evidence-based practices, and to date, offers Dialectal Behavioral Treatment, Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), Trauma Based Focused Cognitive Behavioral Therapy, Matrix, and Person Centered Treatment.
- In ongoing efforts to maximize staffing resources, South Central has successfully reduced consumer "no shows" for psychiatric evaluations and medication reviews through utilization of a Retired Senior Volunteer Program (RSVP) volunteer to complete follow up or "reminder calls" to consumers with scheduled medical appointments. Due to these cue reminder calls, the no show rates have trended downward by 7.9 percent over the latter months of CY 2008 thus improving program efficiency.
- A workforce analysis of staff at SCHSC was completed which indicated a labor force of skilled experienced individuals with a great number of years of service in their current positions. A high percentage of individuals will reach the rule of 85 within next few years and will be eligible for State retirement. For succession planning purposes, we have made administrative and supervisory training available to interested staff to minimize impact of retirements and to prepare individuals to compete and perform in the near future in leadership roles.
- South Central continued to strengthen consumer care through multiple collaborative efforts with local inpatient and outpatient

facilities on such issues as social detoxification, transportation, consumer medication distribution efforts, homelessness, licensed addiction counselor development and recruitment, outpatient sex offender evaluations, expansion of the Sheyenne Care geropsychiatric unit, and substance abuse prevention efforts.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget	House Changes	To Senate
SCHSC	14,635,176	1,278,156	15,913,332	(656,012)	15,257,320
General Funds	8,005,783	937,547	8,943,330	(386,259)	8,557,071
Federal Funds	5,860,748	355,605	6,216,353	(202,814)	6,013,539
Other Funds	768,645	(14,996)	753,649	(66,939)	686,710
FTE	85.50	2.00	87.50	(2.00)	85.50

Budget Changes from Current Budget to Executive Budget:

The major changes can be explained as follows:

- The Governor's salary package recommendation requires a total increase of $1,013,085 with $788,746 being from the general fund.
- Other increases in the salary and fringe benefits portion of the budget include the addition of two FTEs, one for Vulnerable Adult Services and one for Addiction Services (all $152,182 from the general fund).
- The cost to continue the July 2008 salary increase for the entire biennium is $153,858 total funds ($117,147 general funds).

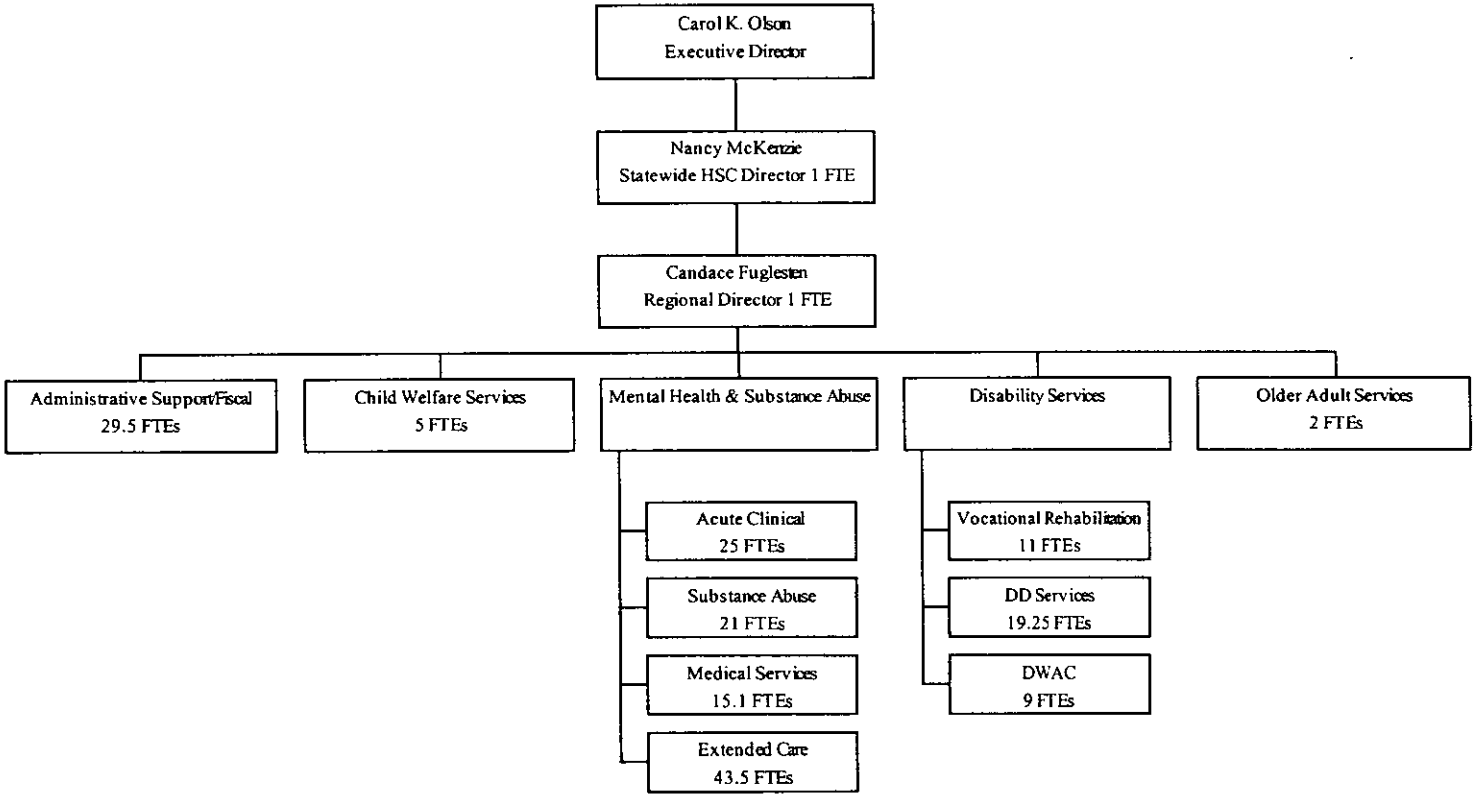
- The Operating portion of the budget increased by $5,733, mainly due to the addition of the two new FTEs. All of the increase was from the general fund.
- The Grants portion of the budget decreased by $160,363. This is due to a decrease in the amount needed for the operation of our contracted Transitional Living facility, which was a new facility that became operational just before the start of the current biennium. This decrease was offset by the 7 percent inflationary increases for contracted providers, which totaled $325,991 for the biennium. All of the decrease is from the general fund.

House Changes:

- The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $128,661 - general fund and $263,169 – federal and other funds for a total of $391,830.
- The House reduced 50% of the department-wide travel increase. South Central's share of this decrease is $16,815 total funds; $10,231 – general fund.
- Additionally, the House removed the 2 new requested FTEs, along with the operating associated with these FTEs. The total decrease is $200,797, all general fund.
- Finally, the House reduced the provider inflation amounts from 7% per year to 6% per year. This resulted in a total decrease of $46,570, all general fund.

This concludes the testimony on the 2009–2011 budget request for the SEHSC and SCHSC portions of the DHS budget.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
SOUTHEAST HUMAN SERVICE CENTER



2007-2009 Budget:
Authorized: 182.35 FTEs

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 410-75 SOUTHEAST HSC								
		S101 FULL-TIME EQUIVALENTS (FTEs)	177.350	182.350	0.000	6.000	0.000	188.350
32570	B	511000 Salaries - Permanent	12,943,892	14,688,042	7,142,055	872,905	(7)	15,560,940
32570	B	513000 Temporary Salaries	436,851	499,640	235,109	208,640	0	708,280
32570	B	514000 Overtime	30,170	27,624	15,562	(27,624)	0	0
32570	B	516000 Fringe Benefits	4,496,948	5,463,096	2,582,458	187,838	761,108	6,412,042
32570	B	521000 Travel	339,835	384,951	212,660	6,276	0	391,227
32570	B	531000 Supplies - IT Software	24,439	20,690	8,725	0	0	20,690
32570	B	532000 Supply/Material-Professional	28,238	32,755	17,123	0	0	32,755
32570	B	533000 Food and Clothing	7,222	8,408	2,394	0	0	8,408
32570	B	534000 Bldg, Grounds, Vehicle Supply	24,261	28,657	16,944	0	0	28,657
32570	B	535000 Miscellaneous Supplies	78,397	46,191	31,184	0	0	46,191
32570	B	536000 Office Supplies	45,612	47,616	23,329	27,513	0	75,129
32570	B	541000 Postage	46,525	39,453	17,753	0	0	39,453
32570	B	542000 Printing	25,402	23,747	14,279	0	0	23,747
32570	B	552000 Other Equip under $5,000	0	9,405	3,801	0	0	9,405
32570	B	553000 Office Equip & Furniture-Under	9,300	12,143	9,916	0	0	12,143
32570	B	561000 Utilities	147,053	162,932	73,732	0	0	162,932
32570	B	571000 Insurance	30	180	120	0	0	180
32570	B	581000 Rentals/Leases-Equip & Other	18,251	12,715	6,715	0	0	12,715
32570	B	582000 Rentals/Leases - Bldg/Land	106,246	196,096	98,907	9,010	0	205,106
32570	B	591000 Repairs	226,339	233,724	119,207	8,989	0	242,713
32570	B	599110 Salary Increase	0	0	0	0	1,197,099	1,197,099
32570	B	599160 Benefit Increase	0	0	0	0	192,873	192,873
32570	B	601000 IT - Data Processing	0	7	7	0	0	7
32570	B	602000 IT-Communications	207,892	241,159	116,876	0	0	241,159
32570	B	611000 Professional Development	37,648	75,988	28,718	3,058	0	79,046
32570	B	621000 Operating Fees and Services	122,836	101,848	64,800	1,278	0	103,126
32570	B	623000 Fees - Professional Services	10,268	28,363	8,075	9,312	0	37,675
32570	B	625000 Medical, Dental and Optical	64,782	13,838	6,239	0	0	13,838
32570	B	683000 Other Capital Payments	551,615	55,897	55,765	(55,897)	0	0
32570	B	691000 Equipment Over $5000	30,914	19,000	12,762	0	0	19,000
32570	B	712000 Grants, Benefits & Claims	3,154,343	4,116,361	1,556,727	2,028,067	0	6,144,428

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 410-75 SOUTHEAST HSC							
	Subtotal:	23,215,309	26,590,526	12,481,942	3,279,365	2,151,073	32,020,964
32570 F	F_7091 HSCs & Institutions - Gen Fund	9,934,499	11,548,288	6,279,449	2,874,263	1,632,355	16,054,906
32570 F	F_7092 HSCs & Institutions - Fed Fnds	12,288,891	13,823,577	5,536,278	263,992	489,320	14,576,889
32570 F	F_7093 HSCs & Institutions - Oth Fnds	991,919	1,218,661	666,215	141,110	29,398	1,389,169
	Subtotal:	23,215,309	26,590,526	12,481,942	3,279,365	2,151,073	32,020,964
	Subdivision Budget Total:	23,215,309	26,590,526	12,481,942	3,279,365	2,151,073	32,020,964
410-75 SOUTHEAST HSC	**General Funds:**	9,934,499	11,548,288	6,279,449	2,874,263	1,632,355	16,054,906
	Federal Funds:	12,288,891	13,823,577	5,536,278	263,992	489,320	14,576,889
	Other Funds:	991,919	1,218,661	666,215	141,110	29,398	1,389,169
	SWAP Funds:	0	0	0	0	0	0
	County Funds:	0	0	0	0	0	0
	IGT Funds:	0	0	0	0	0	0
	Subdivision Funding Total:	23,215,309	26,590,526	12,481,942	3,279,365	2,151,073	32,020,964

Southeast Human Service Center
Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2009 - 2011 Biennium

Operating Fees & Services	Amount	General	Fed/Other
Advertising Services for Position Vacancies	51,717	23,638	28,079
Background Checks	3,022	1,381	1,641
Freight	4,195	1,917	2,278
Miscellaneous Fees	6,121	2,797	3,324
Purchase of Services - Drug Testing and Security Guards	16,626	7,599	9,027
Staff Licenses and Taxes on Property Special Assess	14,912	6,816	8,096
Years of Service Awards	6,533	2,986	3,547
Total Operating Fees & Services Budget Account Code	**103,126**	**47,134**	**55,992**

Southeast Human Service Center
Detail of Budget Account Code 582000
For the 2009 - 2011 Biennium Budget

1/20/2009

Rentals & Leases	Rate per Sq.Ft.	Amount	General	Fed/Other
Off- Main Facility Rent	12.01	189,192	94,464	94,728
Rent of Rooms for Off Site Meetings/Miscellaneous		15,914	10,065	5,849
Total Rentals & Leases Budget Account Code		**205,106**	**104,529**	**100,577**

Grants Summary

Department of Human Services
Southeast Human Service Center

Description		Funding	2007-09 Appropriation	2009-11 Budget Recommendation	Total Changes
Adult Protective Services		General Funds	$0	$13,430	$13,430
Protective services-- $84,832		Federal Funds	$80,800	$80,000	($800)
Provider Inflation-- $8,598			$80,800	$93,430	$12,630
Care Coordination		General Funds	$27,164	$9,437	($17,727)
Care Coordination-- $59,571		Federal Funds	$40,720	$68,182	$27,462
Wrap Around-- $19,274		Special Funds	$10,961	$7,565	($3,396)
Provider Inflation-- $6,339			$78,845	$85,184	$6,339
Case Aide		General Funds	$449,897	$497,049	$47,152
SMI adult--581,367		Federal Funds	$579,142	$748,582	$169,440
CD adult--387,578		Special Funds	$58,176	$57,153	($1,023)
Partnership-- $118,170			$1,087,215	$1,302,784	$215,569
Supported Employment-- $100,000					
Provider Inflation-- $115,669					
Crisis Care / Safe Beds		General Funds	$111,830	$302,850	$191,020
Partnership Safe Beds--$155,328		Federal Funds	$274,134	$151,439	($122,695)
Crisis Beds-- $241,764		Special Funds	$43,888	$21,299	($22,589)
Crises Line $32,760			$429,852	$475,588	$45,736
Provider Inflation-- $45,736					
DD Services		General Funds	$5,605	$7,134	$1,529
Behavioral Therapy-- $16,986		Federal Funds	$71,689	$70,160	($1,529)
Experienced Parent--$60,308			$77,294	$77,294	$0
Detoxification		General Funds	$8,865	$9,808	$943
Social Detox-- $8,865		Federal Funds	$0		$0
Provider Inflation-- $943			$8,865	$9,808	$943

Grants Summary

Department of Human Services

Southeast Human Service Center

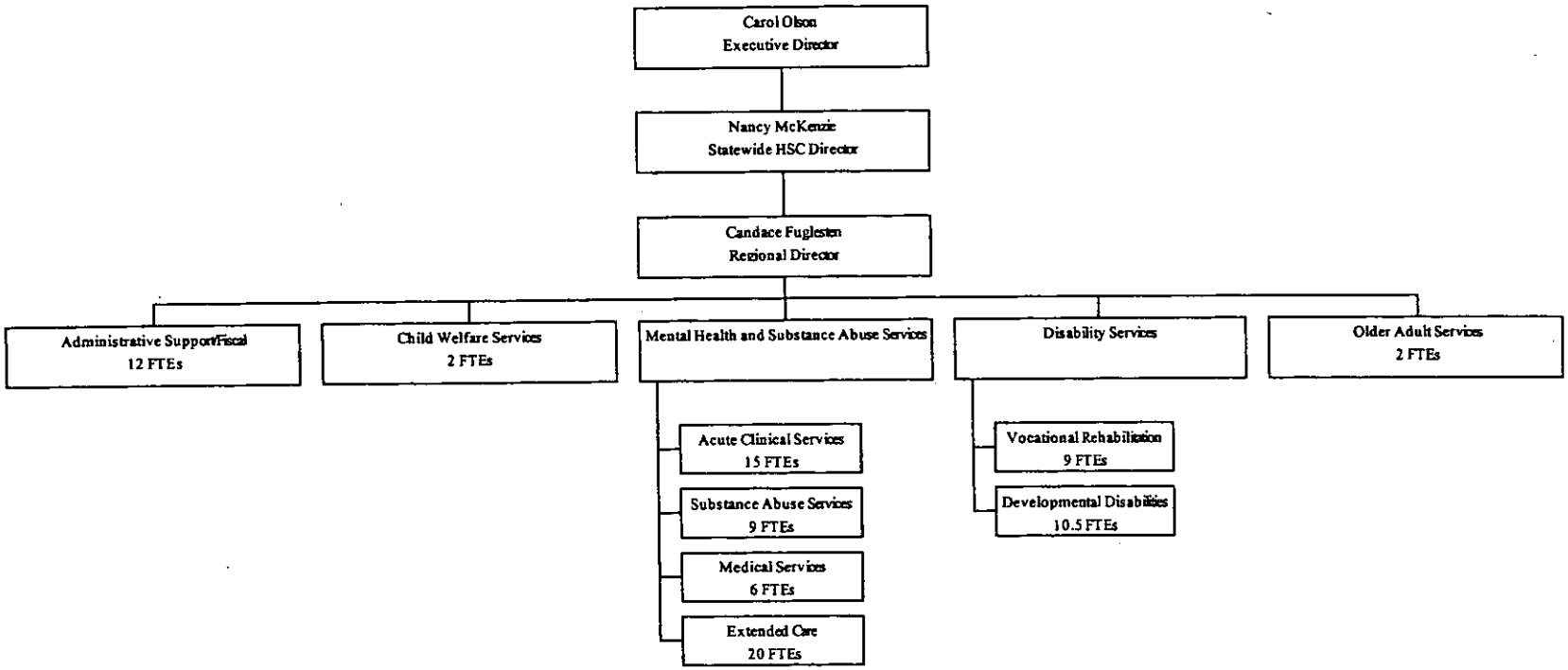
Description		Funding	2007-09 Appropriation	2009-11 Budget Recommendation	Total Changes
Flex Funds - Partnership		General Funds	$20,221	$2,306	($17,915)
Flex Funds-- $44,345		Federal Funds	$15,964	$36,407	$20,443
		Special Funds	$8,160	$5,632	($2,528)
			$44,345	$44,345	$0
Inpatient Hospitalization		General Funds	$246,457	$1,090,448	$843,991
SMI-- $392,205		Federal Funds	$156,936	$0	($156,936)
Addiction-- $698,243			$403,393	$1,090,448	$687,055
Provider Inflation-- $42,920					
Psych Social Club		General Funds	$202,346	$234,677	$32,331
Psych Social Club--$213,146		Federal Funds			$0
Provider Inflation-- $21,531			$202,346	$234,677	$32,331
Psychiatric / Psychological / Medical Services		General Funds	$26,286	$21,408	($4,878)
Psychiatric Services-- $55,692		Federal Funds	$22,333	$25,507	$3,174
Provider Inflation-- $5,926		Special Funds	$7,073	$14,703	$7,630
			$55,692	$61,618	$5,926
Residential Services		General Funds	$1,025,634	$1,486,799	$461,165
CD Residential -- $548,236		Federal Funds	$343,654	$737,218	$393,564
SMI Residential-- $1,362,270		Special Funds	$29,619	$37,171	$7,552
Supportive Living-- $226,365			$1,398,907	$2,261,188	$862,281
Provider Inflation-- $124,368					
Respite Care		General Funds	$37,667	$216,064	$178,397
Respite Care - $200,667		Federal Funds	$113,000	$0	($113,000)
Provider Inflation-- $15,397			$150,667	$216,064	$65,397

Grants Summary

Department of Human Services
Southeast Human Service Center

Description		Funding	2007-09 Appropriation	2009-11 Budget Recommendation	Total Changes
Substance Abuse Treatment and Prevention		General Funds	$10,992	$192,000	$181,008
Drug Court Contract-- $192,000		Federal Funds	$81,652		($81,652)
		Special Funds	$5,496		($5,496)
			$98,140	$192,000	$93,860
	TOTAL GRANTS		**$4,116,361**	**$6,144,428**	**$2,028,067**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
SOUTH CENTRAL HUMAN SERVICE CENTER



2007-2009 Budget
Authorized: 85.5 FTEs

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 410-76 SOUTH CENTRAL HSC								
S101		FULL-TIME EQUIVALENTS (FTEs)	87.600	85.500	0.000	2.000	0.000	87.500
32570	B	511000 Salaries - Permanent	5,864,432	6,961,538	3,158,022	274,474	3	7,236,015
32570	B	512000 Salaries-Other	6,876	10,500	3,471	(300)	0	10,200
32570	B	513000 Temporary Salaries	82,225	151,008	37,851	45,048	2	196,058
32570	B	514000 Overtime	87	0	0	0	0	0
32570	B	516000 Fringe Benefits	2,089,018	2,552,311	1,170,762	100,479	363,720	3,016,510
32570	B	521000 Travel	198,181	222,501	85,926	33,344	0	255,845
32570	B	531000 Supplies - IT Software	3,039	5,964	640	(1,864)	0	4,100
32570	B	532000 Supply/Material-Professional	43,162	40,715	5,775	1,729	0	42,444
32570	B	533000 Food and Clothing	19,277	21,896	11,438	3,152	0	25,048
32570	B	534000 Bldg, Grounds, Vehicle Supply	14,305	15,170	5,004	1,415	0	16,585
32570	B	535000 Miscellaneous Supplies	3,488	5,000	47	0	0	5,000
32570	B	536000 Office Supplies	16,796	21,029	9,492	4,525	0	25,554
32570	B	541000 Postage	24,440	33,816	13,012	(244)	0	33,572
32570	B	542000 Printing	9,720	8,950	4,309	2,550	0	11,500
32570	B	553000 Office Equip & Furniture-Under	1,062	12,000	1,676	0	0	12,000
32570	B	582000 Rentals/Leases - Bldg/Land	646,229	678,186	369,051	(1,684)	0	676,502
32570	B	591000 Repairs	7,198	16,700	4,505	3,400	0	20,100
32570	B	599110 Salary Increase	0	0	0	0	558,512	558,512
32570	B	599160 Benefit Increase	0	0	0	0	90,848	90,848
32570	B	602000 IT-Communications	91,406	125,029	52,980	(8,138)	0	116,891
32570	B	611000 Professional Development	11,834	19,125	8,377	(4,925)	0	14,200
32570	B	621000 Operating Fees and Services	326,517	142,565	106,417	(60,125)	0	82,440
32570	B	623000 Fees - Professional Services	466	0	0	2,400	0	2,400
32570	B	625000 Medical, Dental and Optical	5,827	1,900	1,312	500	0	2,400
32570	B	691000 Equipment Over $5000	24,078	0	0	0	0	0
32570	B	699000 Operating Budget Adjustment	0	0	0	29,698	0	29,698
32570	B	712000 Grants, Benefits & Claims	1,977,834	3,589,273	1,390,505	(160,363)	0	3,428,910
		Subtotal:	11,467,497	14,635,176	6,440,572	265,071	1,013,085	15,913,332
32570	F	F_7091 HSCs & Institutions - Gen Fund	5,758,243	8,005,783	3,560,561	148,801	788,746	8,943,330
32570	F	F_7092 HSCs & Institutions - Fed Fnds	4,841,510	5,860,748	2,411,491	147,572	208,033	6,216,353

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 410-76 SOUTH CENTRAL HSC							
32570 F	F_7093 HSCs & Institutions - Oth Fnds	867,744	768,645	468,520	(31,302)	16,306	753,649
	Subtotal:	11,467,497	14,635,176	6,440,572	265,071	1,013,085	15,913,332
	Subdivision Budget Total:	11,467,497	14,635,176	6,440,572	265,071	1,013,085	15,913,332
410-76 SOUTH CENTRAL HSC	**General Funds:**	5,758,243	8,005,783	3,560,561	148,801	788,746	8,943,330
	Federal Funds:	4,841,510	5,860,748	2,411,491	147,572	208,033	6,216,353
	Other Funds:	867,744	768,645	468,520	(31,302)	16,306	753,649
	SWAP Funds:	0	0	0	0	0	0
	County Funds:	0	0	0	0	0	0
	IGT Funds:	0	0	0	0	0	0
	Subdivision Funding Total:	11,467,497	14,635,176	6,440,572	265,071	1,013,085	15,913,332

South Central Human Service Center
Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2009 - 2011 Biennium

Operating Fees & Services	Amount	General	Fed/Other
Bus Transportation and Gas Vouchers for clients	35,875	19,180	16,695
Cable Television at Transitional Living Home	750	0	750
Client Record Requests to Other Agencies	800	371	429
Flexible Funding for Partnership Children and Part C Children	6,125	1,694	4,431
Freight Costs for Purchased Goods	3,050	2,329	721
Job Announcements and Yearly Civil Rights Legal Notices	10,500	9,031	1,469
Rent Assistance for Homeless clients	8,000	8,000	0
Respite Care for Families	5,000	5,000	0
Staff Licenses	6,340	3,651	2,689
Years of Service Awards	6,000	5,160	840
Total Operating Fees & Services Budget Account Code	**82,440**	**54,416**	**28,024**

Prepared by: Mark M. Anderson, Regional Human Service Center Fiscal Manager, SCHSC

South Central Human Service Center
Detail of Budget Account Code 582000
For the 2009 - 2011 Biennium Budget

1/20/2009

Rentals & Leases	Rate per Sq.Ft.	Amount	General	Fed/Other
Human Service Center Building Rent	9.95	628,502	376,387	252,115
Transitional Living Facility Rent		48,000	0	48,000
Total Rentals & Leases Budget Account Code		**676,502**	**376,387**	**300,115**

Grants Summary

Department of Human Services

South Central Human Service Center

Description	Funding	2007-2009 Appropriation	2009-2011 Budget Recommendation	Total Changes
Case Aide	General Funds		$1,344	$1,344
Partnership-- $12,480	Federal Funds	$7,800	$12,480	$4,680
Provider Inflation-- $1,344	Special Funds			$0
		$7,800	$13,824	$6,024
DD Services	Federal Funds	$40,000	$34,000	($6,000)
Experienced Parent-- $34,000		$40,000	$34,000	($6,000)
Psych Social Club	General Funds	$210,224	$232,554	$22,330
Psych Social Club--$210,224	Federal Funds	$0	$0	$0
Provider Inflation-- $22,330		$210,224	$232,554	$22,330
Residential Services	General Funds	$2,683,660	$1,890,132	($793,528)
Social Detox-- $22,000	Federal Funds	$637,981	$1,253,400	$615,419
CD Residential -- $587,400	Special Funds	$3,608	$0	($3,608)
SMI Residential-- $365,365		$3,325,249	$3,143,532	($181,717)
SMI Transitional Living--				
Semi-Structured-- $896,984				
TL facility - 14 bed -- $969,466				
Provider Inflation-- $302,317				
Respite Care	General Funds	$6,000	$5,000	($1,000)
		$6,000	$5,000	($1,000)
TOTAL GRANTS		**$3,589,273**	**$3,428,910**	**($160,363)**

Testimony
House Bill 1012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
January 22, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, I am Kate Kenna, Director of Lake Region Human Service Center (LRHSC) and Northeast Human Service Center (NEHSC) for the Department of Human Services (DHS). I am here today to provide you an overview of both centers' budget requests.

Lake Region Human Service Center

Lake Region Human Service Center provides services to Ramsey, Cavalier, Rolette, Towner, Benson, and Eddy counties. In 2007 the population estimate in the region was 40,458, or 6.3 percent of the total state population. Services are provided throughout the region with one office in Devils Lake and an outreach office in Rolla.

Caseload / Customer Base

The Lake Region HSC provided services to 2,373 individuals (excluding Vocational Rehabilitation) in Fiscal Year 2008; 1,776 adults and 572 children received services. In addition, 368 individuals received Vocational Rehabilitation services, and 136 received Older Blind services.

The poverty rate in Region III is 19.3 percent, nearly two times the state average of 10 percent. Temporary Aid to Needy Families (TANF) recipients continues to grow; currently Lake Region Human

Service Center has 852 TANF recipients – 41 percent of all TANF families in North Dakota.

Program Trends

- Difficulty recruiting qualified staff, especially in the areas of psychology, addiction, and fully qualified mental health clinicians continues. Region III remains a designated Mental Health Professional Shortage area by the National Health Service Corp, with a score of "18". This is the highest designation in North Dakota.
- Developmental Disability case management for children ages 0-3 has increased from 54 in 2007 to 65 in 2008.
- Enrollment in day supports for individuals with developmental disabilities has increased from five individuals in 2001 to 20 in 2008.
- The Lake Region HSC has experienced an increase in dually diagnosed consumers (Serious Mental Illness and Addiction). The complexity of these cases require more intensive case management and case aide services.
- Emergency/crisis calls have increased from 550 in FY 2007 to 631 in FY 2008.
- The Lake Region HSC, with 6 percent of the state's population, has nearly 17 percent of the children in foster care. This number does not include the 62 children in Native American care, which increases the percentage rate to 23 percent.
- Admissions to the State Hospital are down from 69 in FY 2007 to 58 in FY 2008. There have been substantial declines in the past few years. Lake Region Human Service Center is assisting our more challenging consumers to stay in the community by wrapping supportive services around them.

Accomplishments

- Increased efforts to screen potential North Dakota State Hospital admissions continue to be successful. Region III has no inpatient psychiatric or inpatient substance abuse alternative within the region, but state hospital diversions to community-based alternatives have increased. In the mid-1980s our regional referrals to the state hospital averaged 322 consumers per year; in the mid-1990s, the average was 207. These admissions were further reduced to just over 100 per year by the middle of the current decade. Total state hospital admissions for SFY 2007 were 69 consumers and for SFY 2008 were 58.
- The Lake Region HSC continues to work toward strengthening the quality of the community-based services we provide. We are growing our abilities to provide evidenced based services, including the UCLA Matrix Program for treating substance abuse; Trauma Focused Cognitive Behavioral Therapy, as well as Structured Psychotherapy for Adolescents under Chronic Stress for treating trauma; and other consumer friendly models including the Recovery Model and Person Centered Services. We will soon be training staff in Motivational Interviewing, as well as starting an adolescent matrix program in conjunction with a multi-agency collaboration to start an adolescent drug court.
- In another effort to strengthen community-based services Lake Region HSC expanded our full-time satellite office in Rolette County. The Rolla Outreach Office offers Developmental Disabilities case management, PATH homeless case management, Serious Mental Illness case management, Vulnerable Adult Protective Services,

mental health counseling, emergency services, and substance abuse evaluation and treatment, including the option for residential stay at our ten bed crisis residential unit.

- In an effort at quality improvement, Lake Region is one of the three pilot human service centers working with Network for the Improvement of Addiction Treatment (NIATx). This organization helps behavioral health agencies improve services by bringing to the table researched and innovative solutions to reduce no show rates, improve access, improve completion rates of consumers, reduce costs, improve staff morale, and achieve good outcomes from services provided.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / Decrease
Lake Region HSC	9,884,876	11,011,109	1,126,233
General Funds	5,304,226	6,263,550	959,324
Federal Funds	4,129,219	4,306,213	176,994
Other Funds	451,431	441,346	(10,085)
Total	9,884,876	11,011,109	1,126,233
FTE	62	62	-

- Salary and Wages related expenses increased by $795,934 and can be attributed to the following:
  - $704,783 in total funds of which $545,128 is general funds to fund the Governor's salary package for state employees.
  - $(19,212) in temporary salaries which represents a half-time temporary position.

- The remaining $110,363 is largely the result of funding legislatively approved salary increases in the current biennium into the 09-11 biennium.

- The Operating cost increased by $35,908 and is a combination of the following items:
  - An increase of $42,100 in travel related expenses. This increase is largely based on State Fleet's expected per mileage increase to $.40. This biennium that cost has been approximately $.28/mile.
  - An increase of $2,840 for data processing supplies.
  - A decrease of $9,597 in Operating Fees and Services. Of this amount, $4,250 of the decrease is in the area of Vocational Rehabilitation for the purchase of services, and $7,500 of the decrease is in the Alcohol and Drug services for purchase of services. These amounts are offset by an increase of $3,050 for the Developmental Disabilities Experienced Parent Program.

- Lake Region HSC's operating budget includes $425,580 in building rent for its two office locations. The main Devils Lake office has a projected budget of $379,980 which equates to approximately $10.42/square foot per year. The Center's Rolla Outreach office has a budget of $45,600 and is approximately $9.71/square foot per year.

- The Grants costs include an increase of $294,391. Of this amount, $85,721 is to fund the current biennium's increases into the 09-11 biennium with the remaining $208,670 representing the Governor's recommended increase for contracted providers.

The general fund request increased by $959,324 with 79% of that increase ($753,798) related to the Governor's salary package for state employees and recommended contracted provider increases. The remaining increase of $205,526 is associated largely with the current biennium salary, provider inflationary increases being carried into the new biennium, and the operating changes described above.

Northeast Human Service Center

This area of the budget includes the programs of the Northeast Human Service Center (NEHSC). The NEHSC serves the citizens of Grand Forks, Nelson, Walsh, and Pembina counties. The center is located in Grand Forks with a satellite office in Grafton and an outreach site in Cavalier.

Caseload / Customer Base

- The population in Region IV is approximately 91,000; this represents 14 percent of the state's population. Fifteen percent of the state's children, nearly 23,500, reside in our region.
- The Northeast HSC provided clinical services to 3,371 individuals in SFY 2008; 2,407 adults and 964 children received services. This represented a 10 percent increase in clients over SFY 2006. During the same two year period our addiction evaluations increased by 30 percent, and clinical intakes by 19 percent.
- Vocational Rehabilitation (VR) served 1,144 clients; 140 clients were served through the Older Blind program.

- Other residents of our counties received indirect services provided through Aging Services, Foster Grandparent Program, Child Welfare, and community education.
- Priority is placed on serving the Region's most vulnerable individuals, including those who cannot otherwise access services.

Program Trends

- The Northeast HSC has had difficulty recruiting/retaining a psychologist, community home counselors, and fully qualified mental health clinicians. We have just confirmed hiring for a vacant psychiatry opening; however, this is from within the DHS system.
- In addiction services, Northeast HSC has noted an increase in the use of prescription medication, a decrease in methamphetamine as a primary substance of use, a need for longer residential stays (which has at times created a bottleneck for new clients), and an increase in clients from County Social Services and the Department of Corrections and Rehabilitation who require additional case management and more frequent involuntary commitments.
- In Developmental Disabilities (DD), more families are struggling economically and are requesting assistance in helping meet the excess costs of having a child with a disability. Developmental Disability Case Managers (DDCM) are spending more time helping families meet basic needs such as housing, heat, diapers, food, etc. Our numbers in DD case management continue to grow each biennium.
- The Ruth Meiers Adolescent Residential Facility has experienced an increase in referrals and admissions of younger adolescents (11-12 year olds), an increase in females referred, and an increase in

youth with sexually related behavior problems. We also note there is a disproportionate number of referrals of Native American children (40 percent).

- Children and Family Services notes that there were 39 adoptions of foster care children in 2008, compared to 11 in 2007. In 2007 there were 62 family foster homes and in 2008 there are 82. The number of therapeutic foster homes also increased from 21 to 32.
- The Northeast HSC has been working with Network for the Improvement of Addiction Treatment (NIATx) to improve services to clients. We have focused on reducing wait time, increased customer satisfaction, and efficiency. This process looks at evaluating services and using a rapid change cycle in the delivery of services. We have noticed success in access for clients and a reduction of paperwork in the first two cycles.

Accomplishments

- Evidenced Based Practices have been implemented at NEHSC which include: Contingency Management in Addiction, Matrix Program, and Person Centered Treatment Planning.
- We have implemented an Adult Drug Court with funding provided during the last legislative session. In cooperation with our Court, and Department of Corrections we began seeing clients in October of 2008 and to date have 12 consumers in the program. Our Adolescent Drug Court continues and currently is serving 19 clients.
- The Northeast HSC successfully implemented a telemedicine program for psychiatric services and addiction evaluations. Region IV has telemedicine sites in Northwood, Grafton, and the Grand Forks

Correctional Center. This allows us to provide services in an efficient and timely manner.

- Admissions to the State Hospital from Region IV continue to be extremely low with 46 admissions for the period of January 1, 2008 through November 30, 2008. Region IV had 56 admissions for the same period in 2007. This is due to our diligent intake screening, coordination, and utilization of community services.
- Northeast HSC has broadened the continuum of housing available for individuals with serious mental illness in partnership with Prairie Harvest and funding received during the last legislative session. We have new community support and housing for an additional eight consumers which has resulted in preventing hospitalization and maintaining consumers in the community.
- Through the Network for Improvement of Addiction Treatment (NIATx), Northeast HSC has decreased the wait time from admission intake to time seen by a clinician by 15-20 minutes per client. We have reduced client generated paperwork eliminating two forms. We continue to identify process issues and teams to work towards continuous improvement of our service delivery.

Overview of Budget Changes

Description	2007 - 2009 Budget	2009 - 2011 Budget	Increase / Decrease
NEHSC	22,325,047	26,376,851	4,051,804
General	9,758,051	12,056,316	2,298,265
Federal	11,785,869	13,169,485	1,383,616
Other	781,127	1,151,050	369,923
FTEs	137.10	138.10	1.00

- Salaries and benefits increased by $2,166,161 and can be attributed to the following:
  - The increase in salary and fringe benefits is a result of the salary and health insurance package which adds $1,540,334 in total funds of which $1,114,357 is general fund.
  - $100,626 to fund the addition of 1.0 FTE to address requirements of the Centers for Medicare and Medicaid Services on our Developmental Disabilities programs, of which approximately half is from the general fund.
  - The cost to sustain the second year of the 2007-09 salary increases for the full 2009-11 biennium is $231,501 of which $164,132 is general fund.
  - Northeast HSC converted a contracted psychiatrist to a full time employee at the start of the 2007-09 biennium. $323,064 was added to salaries and benefits to cover the cost of the FTE; $62,544 of this was general fund.
  - The remaining $29,364 budget decrease is a combination of increases and decreases needed to sustain the pay plan of the 137.10 FTE in this area of the budget.

- Operating budget decreased by $57,786 (2%) and is a combination of the following increases and decreases expected next biennium:
  - A $62,321 increase in our rental budget is primarily for a $.70 increase in per square foot cost for Northeast HSC's main office building. The square foot cost for the Center's main office building is currently at $12.45. For the 09-11 biennium, the landlord has requested the $.70 increase to cover current and projected increases in utility and maintenance costs. The new per square foot

cost will be $13.15. The Northeast HSC also rents 658 square foot of unfinished storage space which will increase from $4.40 per square foot to $5.10 for the same reasons. In addition we pay $380/month ($9,120 a biennium) for the Outreach Office located in Cavalier.

- An $85,074 decrease in the Fees–Professional Services budget as a result of a decrease in the number of Foster Grandparents Northeast is allowed to have and compensate due to a federal reallocation.
- A $50,000 decrease in the Medical, Dental, and Optical budget based on actual expenditures. Concerns regarding increase in medication costs for clients and limited access to samples have not transpired.
- State Fleet Service's increase in the motor pool rate contributed to an increase of $15,120 in our travel budget.

- The grants budget increased by $ 1,943,434 of which $ 1,618,977 is general fund. This increase is a result of the following:
  - $967,998 is budgeted for contracted providers to reflect significant cost increases to maintain existing level of services for our residential services for adult and adolescent clients with chemical dependency and for adult clients with serious mental illness; for the operation of our psych social club for individuals with serious mental illness. $894,515 of this is general fund.
  - $613,573 is needed to fund 7% increases for providers for each year of the biennium of which $443,799 is general fund.
  - $361,863 is budgeted to meet capacity issues and meet unmet need for development of a social detox program, increasing our supported residential service by 20 client hours per week and

funding our existing utilization of psychiatric hospitalization beds at Altru Hospital. $280,663 of this budget is general fund.

The general fund request increased by $2,298,265 with 49% of that increase, $1,114,353, related to the Governor's salary package for state employees and increased health insurance costs. The remaining increase of $1,183,912 is associated with the increase in the operating changes described above.

The net change of the federal and other funds is a result of the increases above.

This concludes my testimony on the 2009 - 2011 budget requests for the Lake Region Human Service Center and Northeast Human Service Center. I would be happy to answer any questions.

Testimony
House Bill 1012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
March 4, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, this is written testimony prepared by Kate Kenna, Director of Lake Region Human Service Center (LRHSC) and Northeast Human Service Center (NEHSC) for the Department of Human Services (DHS). It is provided to give you an overview of both centers' budget requests.

Lake Region Human Service Center

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Program Trends

- Difficulty recruiting qualified staff, especially in the areas of psychology, addiction, and fully qualified mental health clinicians continues. Region III remains a designated Mental Health Professional Shortage area by the National Health Service Corp, with a score of "18". This is the highest designation in North Dakota.
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- The Lake Region HSC has experienced an increase in dually diagnosed consumers (Serious Mental Illness and Addiction). The complexity of these cases require more intensive case management and case aide services.
- Emergency/crisis calls have increased from 550 in FY 2007 to 631 in FY 2008.
- The Lake Region HSC, with 6 percent of the state's population, has nearly 17 percent of the children in foster care. This number does not include the 62 children in Native American care, which increases the percentage rate to 23 percent.
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Accomplishments

- Increased efforts to screen potential North Dakota State Hospital admissions continue to be successful. Region III has no inpatient psychiatric or inpatient substance abuse alternative within the region, but state hospital diversions to community-based alternatives have increased. In the mid-1980s our regional referrals to the state hospital averaged 322 consumers per year; in the mid-1990s, the average was 207. These admissions were further reduced to just over 100 per year by the middle of the current decade. Total state hospital admissions for SFY 2007 were 69 consumers and for SFY 2008 were 58.
- The Lake Region HSC continues to work toward strengthening the quality of the community-based services we provide. We are growing our abilities to provide evidenced based services, including the UCLA Matrix Program for treating substance abuse; Trauma Focused Cognitive Behavioral Therapy, as well as Structured Psychotherapy for Adolescents under Chronic Stress for treating trauma; and other consumer friendly models including the Recovery Model and Person Centered Services. We will soon be training staff in Motivational Interviewing, as well as starting an adolescent matrix program in conjunction with a multi-agency collaboration to start an adolescent drug court.
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evaluation and treatment, including the option for residential stay at our ten bed crisis residential unit.

- In an effort at quality improvement, Lake Region is one of the three pilot human service centers working with Network for the Improvement of Addiction Treatment (NIATx). This organization helps behavioral health agencies improve services by bringing to the table researched and innovative solutions to reduce no show rates, improve access, improve completion rates of consumers, reduce costs, improve staff morale, and achieve good outcomes from services provided.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget	House Changes	To Senate
LRHSC	9,884,876	1,126,233	11,011,109	(370,042)	10,641,067
General	5,304,226	959,324	6,263,550	(147,193)	6,116,357
Federal	4,129,219	176,994	4,306,213	(182,180)	4,124,033
Other	451,431	(10,085)	441,346	(40,669)	400,677
FTE	62	0	62	0	62

Budget Changed from Current Budget to Executive Budget:

- Salary and Wages related expenses increased by $795,934 and can be attributed to the following:
  - $704,783 in total funds of which $545,128 is general funds to fund the Governor's salary package for state employees.
  - $(19,212) in temporary salaries which represents a half-time temporary position.

- The remaining $110,363 is largely the result of funding legislatively approved salary increases in the current biennium into the 09-11 biennium.

- The Operating cost increased by $35,908 and is a combination of the following items:
  - An increase of $42,100 in travel related expenses. This increase is largely based on State Fleet's expected per mileage increase to $.40. This biennium that cost has been approximately $.28/mile.
  - An increase of $2,840 for data processing supplies.
  - A decrease of $9,597 in Operating Fees and Services. Of this amount, $4,250 of the decrease is in the area of Vocational Rehabilitation for the purchase of services, and $7,500 of the decrease is in the Alcohol and Drug services for purchase of services. These amounts are offset by an increase of $3,050 for the Developmental Disabilities Experienced Parent Program.

- Lake Region HSC's operating budget includes $425,580 in building rent for its two office locations. The main Devils Lake office has a projected budget of $379,980 which equates to approximately $10.42/square foot per year. The Center's Rolla Outreach office has a budget of $45,600 and is approximately $9.71/square foot per year.

- The Grants costs include an increase of $294,391. Of this amount, $85,721 is to fund the current biennium's increases into the 09-11 biennium with the remaining $208,670 representing the Governor's recommended increase for contracted providers.

The general fund request increased by $959,324 with 79% of that increase ($753,798) related to the Governor's salary package for state employees and recommended contracted provider increases. The remaining increase of $205,526 is associated largely with the current biennium salary, provider inflationary increases being carried into the new biennium, and the operating changes described above.

House Changes

The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for Lake Region Human Service Center is $104,767 – general funds; and $214,295 – federal and other funds for a total of $319,062.

The House reduced 50% of the department-wide travel increase. Lake Region HSC's share of this decrease is $21,170 total funds; $12,616 general fund.

The House removed $29,810 in funding to change our contracted provider's inflationary increases from the Governor's planned 7% in each year of the biennium to 6% each year, the entire $29,810 is general funds.

Northeast Human Service Center

This area of the budget includes the programs of the Northeast Human Service Center (NEHSC). The NEHSC serves the citizens of Grand Forks, Nelson, Walsh, and Pembina counties. The center is located in Grand Forks with a satellite office in Grafton and an outreach site in Cavalier.

Caseload / Customer Base

- The population in Region IV is approximately 91,000; this represents 14 percent of the state's population. Fifteen percent of the state's children, nearly 23,500, reside in our region.
- The Northeast HSC provided clinical services to 3,371 individuals in SFY 2008; 2,407 adults and 964 children received services. This represented a 10 percent increase in clients over SFY 2006. During the same two year period our addiction evaluations increased by 30 percent, and clinical intakes by 19 percent.
- Vocational Rehabilitation (VR) served 1,144 clients; 140 clients were served through the Older Blind program.
- Other residents of our counties received indirect services provided through Aging Services, Foster Grandparent Program, Child Welfare, and community education.
- Priority is placed on serving the Region's most vulnerable individuals, including those who cannot otherwise access services.

Program Trends

- The Northeast HSC has had difficulty recruiting/retaining a psychologist, community home counselors, and fully qualified mental health clinicians. We have just confirmed hiring for a vacant psychiatry opening; however, this is from within the DHS system.

- In addiction services, Northeast HSC has noted an increase in the use of prescription medication, a decrease in methamphetamine as a primary substance of use, a need for longer residential stays (which has at times created a bottleneck for new clients), and an increase in clients from County Social Services and the Department of Corrections and Rehabilitation who require additional case management and more frequent involuntary commitments.
- In Developmental Disabilities (DD), more families are struggling economically and are requesting assistance in helping meet the excess costs of having a child with a disability. Developmental Disability Case Managers (DDCM) are spending more time helping families meet basic needs such as housing, heat, diapers, food, etc. Our numbers in DD case management continue to grow each biennium.
- The Ruth Meiers Adolescent Residential Facility has experienced an increase in referrals and admissions of younger adolescents (11-12 year olds), an increase in females referred, and an increase in youth with sexually related behavior problems. We also note there is a disproportionate number of referrals of Native American children (40 percent).
- Children and Family Services notes that there were 39 adoptions of foster care children in 2008, compared to 11 in 2007. In 2007 there were 62 family foster homes and in 2008 there are 82. The number of therapeutic foster homes also increased from 21 to 32.
- The Northeast HSC has been working with Network for the Improvement of Addiction Treatment (NIATx) to improve services to clients. We have focused on reducing wait time, increased customer satisfaction, and efficiency. This process looks at evaluating services and using a rapid change cycle in the delivery of

services. We have noticed success in access for clients and a reduction of paperwork in the first two cycles.

Accomplishments

- Evidenced Based Practices have been implemented at NEHSC which include: Contingency Management in Addiction, Matrix Program, and Person Centered Treatment Planning.
- We have implemented an Adult Drug Court with funding provided during the last legislative session. In cooperation with our Court, and Department of Corrections we began seeing clients in October of 2008 and to date have 12 consumers in the program. Our Adolescent Drug Court continues and currently is serving 19 clients.
- The Northeast HSC successfully implemented a telemedicine program for psychiatric services and addiction evaluations. Region IV has telemedicine sites in Northwood, Grafton, and the Grand Forks Correctional Center. This allows us to provide services in an efficient and timely manner.
- Admissions to the State Hospital from Region IV continue to be extremely low with 46 admissions for the period of January 1, 2008 through November 30, 2008. Region IV had 56 admissions for the same period in 2007. This is due to our diligent intake screening, coordination, and utilization of community services.
- Northeast HSC has broadened the continuum of housing available for individuals with serious mental illness in partnership with Prairie Harvest and funding received during the last legislative session. We have new community support and housing for an additional eight consumers which has resulted in preventing hospitalization and maintaining consumers in the community.

- Through the Network for Improvement of Addiction Treatment (NIATx), Northeast HSC has decreased the wait time from admission intake to time seen by a clinician by 15-20 minutes per client. We have reduced client generated paperwork eliminating two forms. We continue to identify process issues and teams to work towards continuous improvement of our service delivery.

Overview of Budget Changes

Description	2007 - 2009 Budget	Increase / Decrease	2009 - 2011 Budget	House Changes	To Senate
NEHSC	22,325,047	4,051,804	26,376,851	(759,946)	25,616,905
General	9,758,051	2,298,265	12,056,316	(468,574)	11,587,742
Federal	11,785,869	1,383,616	13,169,485	(277,713)	12,891,772
Other	781,127	369,923	1,151,050	(13,659)	1,137,391
FTEs	137.10	1.00	138.10	(1.00)	137.10

Budget Changes from Current Budget to Executive Budget

- Salaries and benefits increased by $2,166,161 and can be attributed to the following:
  - The increase in salary and fringe benefits is a result of the salary and health insurance package which adds $1,540,334 in total funds of which $1,114,357 is general fund.
  - $100,626 to fund the addition of 1.0 FTE to address requirements of the Centers for Medicare and Medicaid Services on our Developmental Disabilities programs, of which approximately half is from the general fund.

- The cost to sustain the second year of the 2007-09 salary increases for the full 2009-11 biennium is $231,501 of which $164,132 is general fund.
- Northeast HSC converted a contracted psychiatrist to a full time employee at the start of the 2007-09 biennium. $323,064 was added to salaries and benefits to cover the cost of the FTE; $62,544 of this was general fund.
- The remaining $29,364 budget decrease is a combination of increases and decreases needed to sustain the pay plan of the 137.10 FTE in this area of the budget.

- Operating budget decreased by $57,786 (2%) and is a combination of the following increases and decreases expected next biennium:
  - A $62,321 increase in our rental budget is primarily for a $.70 increase in per square foot cost for Northeast HSC's main office building. The square foot cost for the Center's main office building is currently at $12.45. For the 09-11 biennium, the landlord has requested the $.70 increase to cover current and projected increases in utility and maintenance costs. The new per square foot cost will be $13.15. The Northeast HSC also rents 658 square foot of unfinished storage space which will increase from $4.40 per square foot to $5.10 for the same reasons. In addition we pay $380/month ($9,120 a biennium) for the Outreach Office located in Cavalier.
  - An $85,074 decrease in the Fees–Professional Services budget as a result of a decrease in the number of Foster Grandparents Northeast is allowed to have and compensate due to a federal reallocation.

- A $50,000 decrease in the Medical, Dental, and Optical budget based on actual expenditures. Concerns regarding increase in medication costs for clients and limited access to samples have not transpired.
- State Fleet Service's increase in the motor pool rate contributed to an increase of $15,120 in our travel budget.

- The grants budget increased by $ 1,943,434 of which $ 1,618,977 is general fund. This increase is a result of the following:
  - $967,998 is budgeted for contracted providers to reflect significant cost increases to maintain existing level of services for our residential services for adult and adolescent clients with chemical dependency and for adult clients with serious mental illness; for the operation of our psych social club for individuals with serious mental illness. $894,515 of this is general fund.
  - $613,573 is needed to fund 7% increases for providers for each year of the biennium of which $443,799 is general fund.
  - $361,863 is budgeted to meet capacity issues and meet unmet need for development of a social detox program, increasing our supported residential service by 20 client hours per week and funding our existing utilization of psychiatric hospitalization beds at Altru Hospital. $280,663 of this budget is general fund.

The general fund request increased by $2,298,265 with 49% of that increase, $1,114,353, related to the Governor's salary package for state employees and increased health insurance costs. The remaining increase of $1,183,912 is associated with the increase in the operating changes described above.

The net change of the federal and other funds is a result of the increases above.

House Changes

The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for the Northeast Human Service Center is $63,064 - general fund; and $128,994 - federal and other funds for a total of $192,058.

The House reduced 50% of the department-wide travel increase. Northeast HSC's share of this decrease is $7,225 total funds; $2,654 general fund.

The House removed $111,147 in funding and 1.0 FTE for a Developmental Disabilities case manager position to meet requirements of the Centers for Medicare and Medicaid Services on our Developmental Disabilities programs. $58,793 general fund.

The House removed $149,000 in funding for an increase of 20 hours of client service per week in our supported residential program for individuals with mental illness to meet increased demands for the service; $67,800 of general fund.

The House removed $ 140,000 in general fund for the startup and operation of a social detox service in Grand Forks.

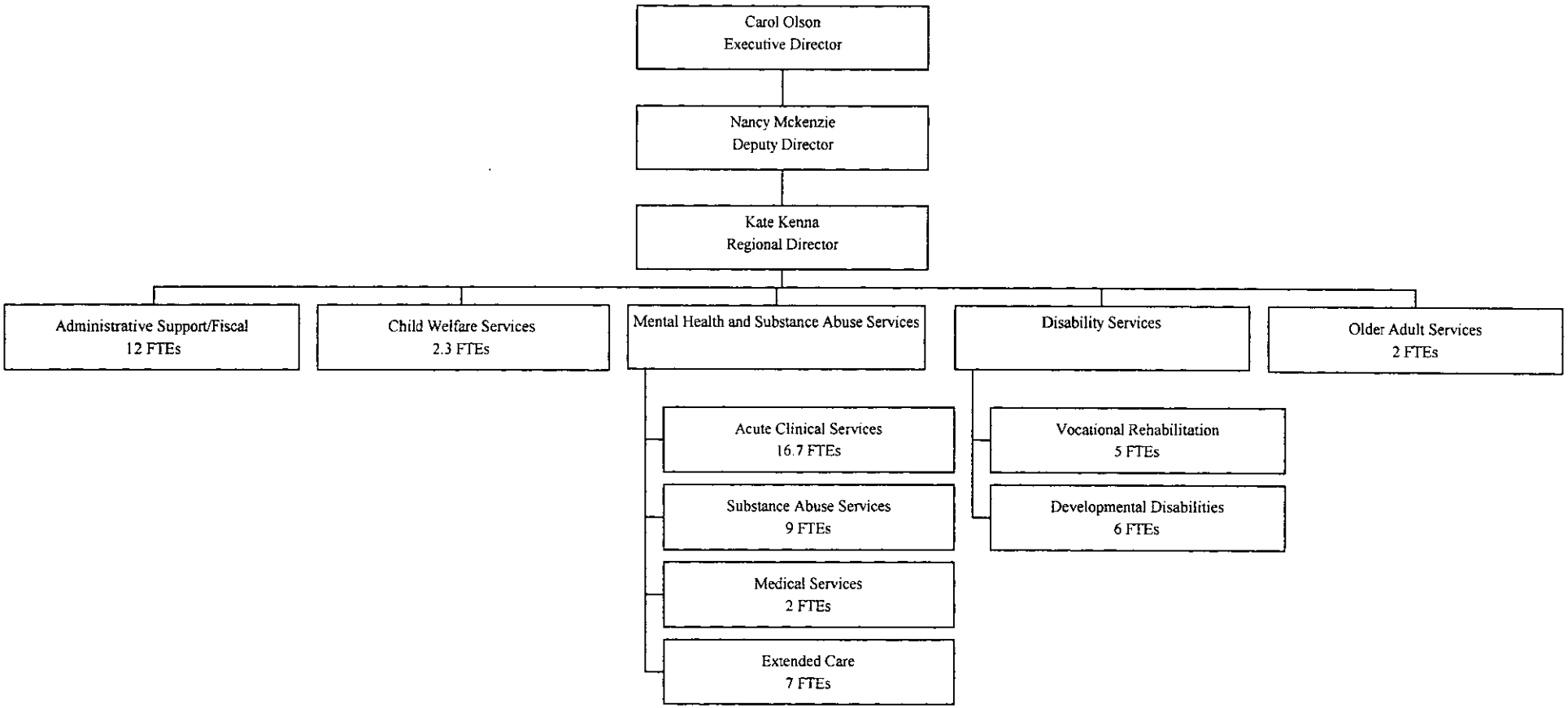
The House removed $72,863 in general fund that was intended to increase funding for our psychiatric hospitalization at Altru Hospital so

that the rate paid by the Human Service Center was consistent with the rate paid by Medical Assistance for the same service (rebasing).

The House removed $87,653 in funding to change our contracted provider's inflationary increases from the Governor's planned 7% in each year of the biennium to 6% each year; $63,400 in general fund.

This concludes testimony on the 2009 - 2011 budget requests for the Lake Region Human Service Center and Northeast Human Service Center.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
LAKE REGION HUMAN SERVICE CENTER



2007 - 2009
62.00 FTE's

Lake Region Human Service Center
Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2009 - 2011 Biennium

Operating Fees & Services	Amount	General	Fed/Other
Advertising for Crisis Line, Vacancies, & Legal Notices	10,540	6,212	4,328
Client Record Copy Fees	1,440	900	540
Freight	400	353	47
Misc Fees	1,000	71	929
Purchase of Client Services	65,393	13,606	51,787
Staff Licenses	5,340	2,501	2,839
Years of Service Awards	1,100	971	129
Total Operating Fees & Services Budget Account Code	**85,213**	**24,614**	**60,599**

Grants Summary

Department of Human Services

Lake Region Human Service Center

Description	Funding	2007-09 Appropriation	2009-11 Budget Recommendation	Total Changes
Psych-Social Club	General Funds	$152,482	$186,157	$33,675
Psych-Social Club - $168,323		$152,482	$186,157	$33,675
Provider Inflation - $17,894				
Psychiatric / Psychological / Medical Services	General Funds	$63,407	$46,341	($17,066)
Contracted Psychiatric Services - $99,916	Federal Funds	$19,743	$34,891	$15,148
	Special Funds	$16,766	$18,684	$1,918
		$99,916	$99,916	$0
Residential Services	General Funds	$507,642	$1,221,454	$713,812
CD Adult Residential $1,372,589	Federal Funds	$1,041,227	$562,658	($478,569)
SMI Residential $135,144	Special Funds	$0		$0
Children and Adolescent A&D Services $111,076		$1,548,869	$1,784,112	$235,243
Provider Inflation - $165,303				
Respite Care	General Funds		$44,235	$44,235
Respite Providers - $40,000	Federal Funds	$40,000		($40,000)
Provider Inflation - $4,235		$40,000	$44,235	$4,235
Substance Abuse Treatment and Prevention	General Funds		$21,238	$21,238
Spirit Lake Tribe $100,000	Federal Funds	$200,000	$200,000	$0
Turtle Mtn Tribe $100,000		$200,000	$221,238	$21,238
Provider Inflation - $21,238				
TOTAL GRANTS		**$2,041,267**	**$2,335,658**	**$294,391**

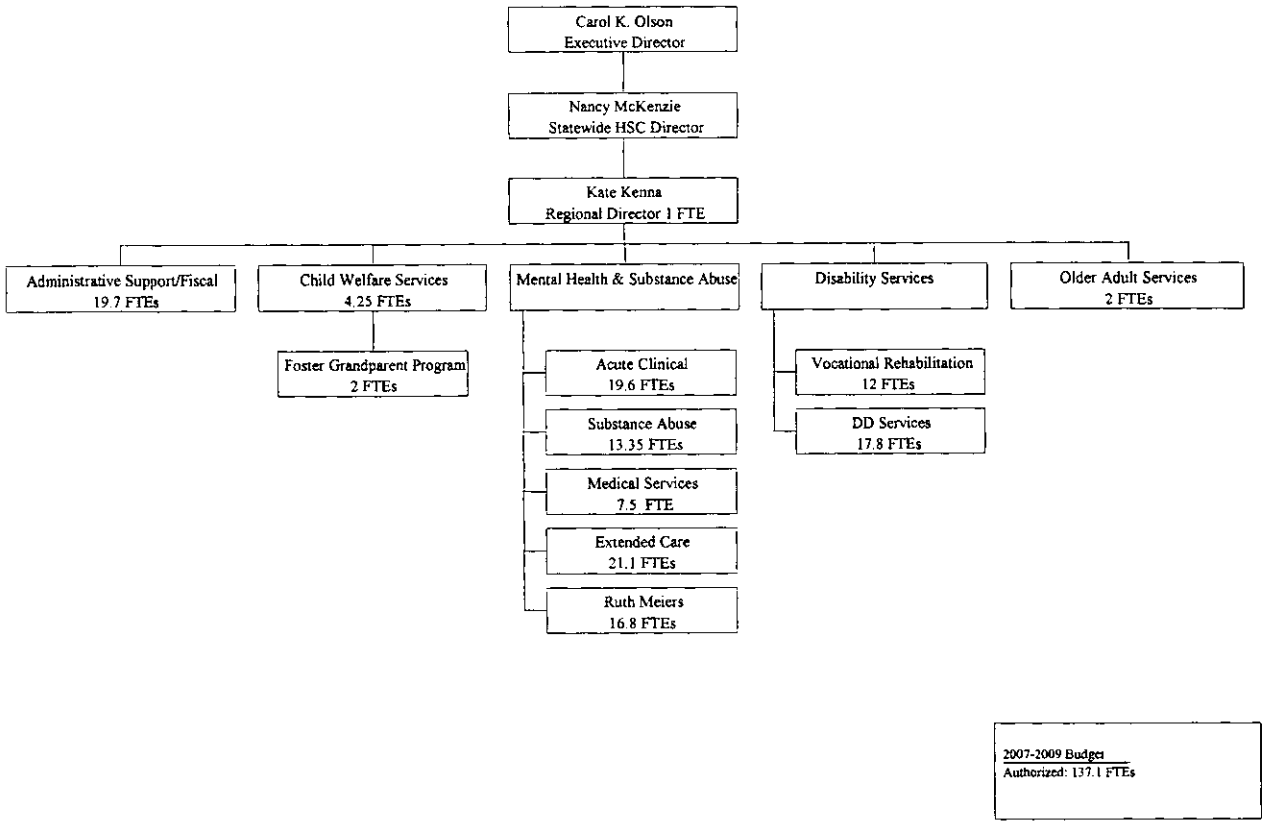
DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 410-73 LAKE REGION HSC								
S101		FULL-TIME EQUIVALENTS (FTEs)	61.250	62.000	0.000	0.000	0.000	62.000
32570	B	511000 Salaries - Permanent	4,165,770	5,008,573	2,309,141	51,635	(2)	5,060,206
32570	B	513000 Temporary Salaries	33,182	81,636	4,437	(19,212)	1	62,425
32570	B	514000 Overtime	2,080	0	0	0	0	0
32570	B	516000 Fringe Benefits	1,425,259	1,795,138	832,844	58,728	254,570	2,108,436
32570	B	521000 Travel	153,509	173,070	90,702	42,100	0	215,170
32570	B	531000 Supplies - IT Software	9,821	8,500	8,038	2,840	0	11,340
32570	B	532000 Supply/Material-Professional	47,676	44,550	14,170	(150)	0	44,400
32570	B	534000 Bldg, Grounds, Vehicle Supply	43	200	26	0	0	200
32570	B	535000 Miscellaneous Supplies	20,824	8,712	2,340	0	0	8,712
32570	B	536000 Office Supplies	19,279	28,300	17,978	0	0	28,300
32570	B	541000 Postage	27,114	24,152	8,835	150	0	24,302
32570	B	542000 Printing	6,930	8,100	4,287	0	0	8,100
32570	B	553000 Office Equip & Furniture-Under	3,719	0	0	0	0	0
32570	B	571000 Insurance	1,450	4,500	1,700	0	0	4,500
32570	B	581000 Rentals/Leases-Equip & Other	386	0	0	0	0	0
32570	B	582000 Rentals/Leases - Bldg/Land	403,305	425,640	207,706	(60)	0	425,580
32570	B	591000 Repairs	12,987	17,600	6,764	0	0	17,600
32570	B	599110 Salary Increase	0	0	0	0	386,660	386,660
32570	B	599160 Benefit Increase	0	0	0	0	63,554	63,554
32570	B	602000 IT-Communications	75,867	86,728	43,672	350	0	87,078
32570	B	611000 Professional Development	5,776	6,125	3,942	75	0	6,200
32570	B	621000 Operating Fees and Services	69,200	94,810	24,260	(9,597)	0	85,213
32570	B	623000 Fees - Professional Services	969	3,075	978	200	0	3,275
32570	B	625000 Medical, Dental and Optical	698	4,200	47	0	0	4,200
32570	B	691000 Equipment Over $5000	12,372	20,000	0	0	0	20,000
32570	B	712000 Grants, Benefits & Claims	1,683,557	2,041,267	827,962	294,391	0	2,335,658
		Subtotal:	8,181,773	9,884,876	4,409,829	421,450	704,783	11,011,109
32570	F	F_7091 HSCs & Institutions - Gen Fund	4,546,156	5,304,226	2,672,717	414,196	545,128	6,263,550
32570	F	F_7092 HSCs & Institutions - Fed Fnds	3,338,256	4,129,219	1,483,890	28,159	148,835	4,306,213
32570	F	F_7093 HSCs & Institutions - Oth Fnds	297,361	451,431	253,222	(20,905)	10,820	441,346

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class FB	Budget Account Code		Prior Biennium Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 410-73 LAKE REGION HSC								
		Subtotal:	8,181,773	9,884,876	4,409,829	421,450	704,783	11,011,109
		Subdivision Budget Total:	8,181,773	9,884,876	4,409,829	421,450	704,783	11,011,109
		General Funds:	4,546,156	5,304,226	2,672,717	414,196	545,128	6,263,550
		Federal Funds:	3,338,256	4,129,219	1,483,890	28,159	148,835	4,306,213
	410-73 LAKE REGION HSC	**Other Funds:**	297,361	451,431	253,222	(20,905)	10,820	441,346
		SWAP Funds:	0	0	0	0	0	0
		County Funds:	0	0	0	0	0	0
		IGT Funds:	0	0	0	0	0	0
		Subdivision Funding Total:	8,181,773	9,884,876	4,409,829	421,450	704,783	11,011,109

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
NORTHEAST HUMAN SERVICE CENTER



Northeast Human Service Center
Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2009 - 2011 Biennium

Operating Fees & Services	Amount	General	Fed/Other
Accreditation Fees	13,500	4,694	8,806
Advertising Services	25,900	15,281	10,619
Bank Fees	700	616	84
Bus Tickets for Clients and Foster Grandparents	29,000	7,503	21,497
Cable TV Charges for Residential Facilities	3,900	1,356	2,544
Client Assistance	104,512	29,263	75,249
Confidential Material Shredding Service	5,400	4,752	648
Crisis Line Answering Service	3,900	2,301	1,599
Employee Background Checks and Training	8,300	7,304	996
Freight	2,900	2,552	348
Nurturing Parent Classes	13,800	2,484	11,316
Orientation & Training Service for Ruth Meiers Adolescent Treatment Center	12,000	4,172	7,828
Respite Care	43,802	10,972	32,830
Staff Licenses	12,800	7,552	5,248
Tympanometer Screenings	9,100		9,100
Years of Service Awards	10,400	6,208	4,192
Total Operating Fees & Services Budget Account Code	**299,914**	**107,010**	**192,904**

Grants Summary

Department of Human Services

Northeast Human Service Center

Description	Funding	2007-09 Appropriation	2009-11 Budget Recommendation	Total Changes
Adult Protective Services	General Funds		$21,276	$21,276
Protective Services for Vulnerable Adults -- $41,826	Federal Funds	$41,826	$25,000	($16,826)
Provider Inflation -- $4,450		$41,826	$46,276	$4,450
Care Coordination	General Funds	$4,377	$48,657	$44,280
Mentoring/Tracking/Visitation -- $35,000	Federal Funds	$178,865	$154,082	($24,783)
School Social Workers -- $132,000		$183,242	$202,739	$19,497
Nurturing Parent -- $16,242				
Provider Inflation -- $19,497				
Crisis Care / Safe Beds	General Funds	$116,723	$251,469	$134,746
Crisis Beds-- SMI Adult $ 374,454	Federal Funds	$72,514	$173,386	$100,872
Provider Inflation -- $ 53,381	Special Funds	$60,983	$2,980	($58,003)
		$250,220	$427,835	$177,615
DD Services	General Funds	$0	$8,257	$8,257
Experienced Parent-- $ 77,600	Federal Funds	$77,600	$77,600	$0
Provider Inflation-- $ 8,257		$77,600	$85,857	$8,257
Detoxification	General Funds	$0	$294,896	$294,896
Social Detox.-- $ 280,000	Federal Funds	$41,074	$0	($41,074)
Provider Inflation-- $ 14,896		$41,074	$294,896	$253,822
Inpatient Hospitalization	General Funds	$118,059	$190,922	$72,863
SMI-- Altru Hospital -- $ 190,922		$118,059	$190,922	$72,863

Grants Summary

Department of Human Services
Northeast Human Service Center

Description	Funding	2007-09 Appropriation	2009-11 Budget Recommendation	Total Changes
Psych Social Club	General Funds	$190,587	$268,463	$77,876
Mental Health Association of ND -- $ 242,645		$190,587	$268,463	$77,876
Provider Inflation-- $ 25,818				
Psychiatric / Psychological / Medical Services	General Funds	$68,901	$161,970	$93,069
Psychiatric Services-- Altru Hospital $ 338,000	Federal Funds	$257,421	$170,769	($86,652)
Provider Inflation-- $ 35.962	Special Funds	$29,576	$41,223	$11,647
		$355,898	$373,962	$18,064
Residential Services	General Funds	$2,023,353	$2,951,270	$927,917
CD Residential Adult -- $ 697,806	Federal Funds	$1,217,143	$1,629,969	$412,826
CD Residential Adol -- $ 899,074	Special Funds	$55,655	$187,280	$131,625
SMI Residential-- Prairie Harvest HSF $ 1,804,052		**$3,296,151**	$4,768,519	$1,472,368
SMI Transitional Living-- Prairie Harvest HSF $ 651,016				
CD Residential Women & Children Specific - Growing Together, Inc. $ 265,259				
Provider Inflation-- $ 451,312				
Substance Abuse Treatment and Prevention	General Funds	$47,946		($47,946)
MAB Counseling Services	Federal Funds	$102,940		($102,940)
	Special Funds	$10,492		($10,492)
		$161,378	$0	($161,378)
TOTAL GRANTS		**$4,716,035**	**$6,659,469**	**$1,943,434**

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class	FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 410-74 NORTHEAST HSC								
		S101 FULL-TIME EQUIVALENTS (FTEs)	136.250	137.100	0.000	1.000	0.000	138.100
32570	B	511000 Salaries - Permanent	9,011,853	10,073,151	4,896,115	493,425	5	10,566,581
32570	B	512000 Salaries-Other	2,021	20,472	9,623	0	0	20,472
32570	B	513000 Temporary Salaries	271,865	343,082	125,245	(29,114)	0	313,968
32570	B	514000 Overtime	62,755	59,004	36,673	16,980	0	75,984
32570	B	516000 Fringe Benefits	3,354,517	3,910,029	1,887,880	144,531	570,204	4,624,764
32570	B	521000 Travel	378,992	391,946	207,054	15,120	0	407,066
32570	B	531000 Supplies - IT Software	20,072	21,000	6,173	0	0	21,000
32570	B	532000 Supply/Material-Professional	39,586	28,692	17,169	0	0	28,692
32570	B	533000 Food and Clothing	93,397	110,830	51,045	1,000	0	111,830
32570	B	534000 Bldg, Grounds, Vehicle Supply	10,041	14,584	11,485	0	0	14,584
32570	B	535000 Miscellaneous Supplies	51,563	49,700	21,283	(2,000)	0	47,700
32570	B	536000 Office Supplies	68,509	63,884	34,160	1,009	0	64,893
32570	B	541000 Postage	34,291	45,908	24,626	0	0	45,908
32570	B	542000 Printing	14,581	16,376	7,280	0	0	16,376
32570	B	551000 IT Equip under $5,000	0	7,000	6,160	2,000	0	9,000
32570	B	552000 Other Equip under $5,000	0	8,580	7,858	2,500	0	11,080
32570	B	553000 Office Equip & Furniture-Under	50,296	23,577	22,415	(5,738)	0	17,839
32570	B	561000 Utilities	37,334	42,950	20,925	0	0	42,950
32570	B	571000 Insurance	2,450	2,272	1,049	(136)	0	2,136
32570	B	581000 Rentals/Leases-Equip & Other	5,317	2,850	2,250	0	0	2,850
32570	B	582000 Rentals/Leases - Bldg/Land	1,191,308	1,219,176	614,342	62,321	0	1,281,497
32570	B	591000 Repairs	48,455	49,375	25,097	0	0	49,375
32570	B	599110 Salary Increase	0	0	0	0	833,471	833,471
32570	B	599160 Benefit Increase	0	0	0	0	136,654	136,654
32570	B	602000 IT-Communications	172,208	173,209	99,413	0	0	173,209
32570	B	611000 Professional Development	25,325	25,600	9,361	0	0	25,600
32570	B	621000 Operating Fees and Services	243,000	298,702	101,536	1,212	0	299,914
32570	B	623000 Fees - Professional Services	416,984	521,936	211,759	(85,074)	0	436,862
32570	B	625000 Medical, Dental and Optical	70,494	85,127	6,340	(50,000)	0	35,127
32570	B	712000 Grants, Benefits & Claims	4,200,073	4,716,035	2,150,589	1,943,434	0	6,659,469
32570	B	713000 Tax Dist to Government Units	11,268	0	0	0	0	0

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2009 - 2011

Class FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 410-74 NORTHEAST HSC							
	Subtotal:	19,888,555	22,325,047	10,614,905	2,511,470	1,540,334	26,376,851
32570 F	F_7091 HSCs & Institutions - Gen Fund	8,315,823	9,758,051	4,789,375	1,183,908	1,114,357	12,056,316
32570 F	F_7092 HSCs & Institutions - Fed Fnds	10,225,409	11,785,869	5,370,777	984,212	399,404	13,169,485
32570 F	F_7093 HSCs & Institutions - Oth Fnds	1,347,323	781,127	454,753	343,350	26,573	1,151,050
	Subtotal:	19,888,555	22,325,047	10,614,905	2,511,470	1,540,334	26,376,851
	Subdivision Budget Total:	19,888,555	22,325,047	10,614,905	2,511,470	1,540,334	26,376,851
	General Funds:	8,315,823	9,758,051	4,789,375	1,183,908	1,114,357	12,056,316
	Federal Funds:	10,225,409	11,785,869	5,370,777	984,212	399,404	13,169,485
410-74 NORTHEAST HSC	**Other Funds:**	1,347,323	781,127	454,753	343,350	26,573	1,151,050
	SWAP Funds:	0	0	0	0	0	0
	County Funds:	0	0	0	0	0	0
	IGT Funds:	0	0	0	0	0	0
	Subdivision Funding Total:	19,888,555	22,325,047	10,614,905	2,511,470	1,540,334	26,376,851

A

Testimony
HB 1012 - Department of Human Services
House Appropriations Committee
January 22, 2009

Chairman Pollert and members of the Human Resources Division, my name is Larry Bernhardt. I am the Director of Stark County Social Services in Dickinson and I am here today representing the ND County Social Service Director's Association and we are in support of House Bill 1012.

Counties have been a pillar in the overall public human service system since North Dakota became a state. All aspects of the human service budget, impact the citizens of our counties, therefore, we attempt to look at the needs of the whole system. We have several items we want to bring to your attention relative to HB 1012.

First of all, we are delighted that the Department of Human Services has included in their budget, dollars to raise the Medically Needy Income Level to 83% of the poverty level. This is truly a major impact on the low-income elderly and disabled of our state. Today, we have people trying to live on $500.00/month to meet their basic needs of shelter, food, utilities, clothing, transportation, etc., because any income over $500.00 must go towards their medical costs before Medicaid can pay anything. This change will allow the single individual to keep $720.00/month for their living needs and a couple will be allowed to keep $969/month for their needs. I speak for the elderly and disabled in ND when I say thank you to the Department, the Governor, and the Legislature for making an adjustment to these Medically Needy Income Levels. It is long overdue and will change the lives of many North Dakotans.

Second, a major concern for the County Social Service Agencies is the need for a comprehensive Eligibility Computer System to determine eligibility for the Medicaid Program, Supplemental Nutritional Assistance Program (Food Stamps), Temporary Assistance to Needy Families Program (TANF), Low Income Home Energy Assistance Program (LIHEAP), Foster Care Payments Program and Child Care Assistance Program.

Today, Eligibility Workers must enter data in four different computer systems – NATL, TECS, VISION, and CCWIPS – in order to determine eligibility and authorize benefits for these Programs. There is a definite need to develop one computer system that works across Program lines. The Department of Human Services had developed an OAR for an Eligibility System Replacement with a total cost of $ 18,632,280 ($9,316,140 would be General Funds) to develop that system. However, this OAR has not been included in the Department's budget by OMB or the Governor's Office. Recognizing that the MMIS Replacement Project completion has now been delayed to May, 2010, we believe that it would be next to impossible to start the process for the Eligibility Computer Systems prior to May, 2010 – however it is crucial that we start that process. We are hoping that you will take a look at the OAR, get a revision in costs to allow for a beginning of that process in the upcoming biennium, and include that in the Department's budget so that work can begin. It should be noted that once the new MMIS System is up and running, Eligibility Workers will have to enter data into that system as well, so they will then have 5 systems to work in. The 200+ Eligibility Workers in this state are counting on you to help them continue to do the good job they do, by providing a computer system that will make the work possible as we move forward with continuous program changes, more complex policies, and an expectation to meet quality performance standards. We need to start that process in June, 2010.

Third, we ask the Committee to take note of the loss of funding for Counties in the area of Targeted Case Management. Maggie Anderson, Medicaid Director, mentioned in her testimony that CMS (Centers for Medicaid and Medicare Services) has issued a policy to terminate the payment of Targeted Case Management for Child Welfare Services that would have gone into effect in April, 2008 – however a moratorium was put in place so that billings could continue until April, 2009. When hat moratorium ends in April, 2009, counties will no longer be able to bill for the costs for child welfare case management and we will lose about $1,588,731 in reimbursement as a result. We obviously are very concerned about that loss and the impact it may have on the delivery of Child Welfare Services in North Dakota.

Fourth, we need to invest more in prevention and intervention services in the Child Welfare System and the following OAR's, which did not get into the Department's Budget are excellent ways to do that. Those OAR's are:

$ 102,400 (all General Funds)	**Increase Safety Permanency Funds**
$ 934,742 (all General Funds)	**Increase Parent Aid Services**

Both of these OAR's are very important and we would ask the Committee to include them in the Department's Budget. The increase for Safety Permanency Funds would allow Counties some flexibility to meet the immediate needs of families so that children would no longer be at risk of child abuse/neglect or have to be placed in out of home care. The increase in Parent Aid Services would allow for all counties to have access to funds to offer Parent Aid Services and would allow for the expansion of the service in some counties. This service works directly with families to provide parenting education, household management, strategies to deal with difficult child behaviors, and support to families so that children can stay in their family home or be reunited with their family after having been placed in out of home care. We need to invest more in prevention and intervention services in the Child Welfare System and these are both excellent ways to do that.

Finally, we as County Social Service Agencies have several other concerns. Those being 1.) the reimbursement to Indian Counties for the costs of providing Economic Assistance on reservation and trust lands, 2.) a better reimbursement to counties for the provision of child welfare services, and 3.) increases in provision of prevention and intervention services for child welfare in North Dakota. However, all three of these issues will be coming forward in individual bills in the Legislative process and we would hope that you will support those efforts when they reach your Committee.

Chairman Pollert and members of the Committee, thank you for the opportunity to provide testimony on HB 1012 and I would be happy to attempt to address any questions you may have.

B

County Social Service Agency Activities

(State wide numbers)

Supplemental Nutrition Assistance Program	22,800	households
Temporary Assistance to Needy Families (TANF)	2,388	households
Child Care Assistance Payments	2,448	households
Heating Assistance (LIHEAP)	12,037	households
Medicaid	56,686	recipients
Adoption Subsidy Payments	912	children
Foster Care Payments (2007 CY)	2,152	children
Child Abuse/Neglect	4,011	assessments
Home and Community Based Services (HCBS)	3,388	clients
Child Care Licensing	3,461	licensing studies

Prepared by:

Larry Bernhardt

January 22, 2009

A

Department of Human Services
Breakdown of "County" Funds
House Appropriations Human Resources Division
2009 - 2011

Description	Amount
Information Technology - "capped"	1,584,396
Economic Assistance Policy	315,354
Long Term Care - SPED	836,938
Children and Family Services	
Foster Care and Adoption	13,178,991
Countywide Cost Allocation	263,033
North Central Human Service Center	
Shelter Care	100,000
Total County Funds	16,278,712

Compensation for MI Case Management Positions ND and Clay County, MN

North Dakota HRMS Classification and Pay Scale:

CLASS	CLASS TITLE	GRADE	MIN	MAX
4080	MI Case Manager I	9	$2384	$3974
4081	MI Case Manager II	10	$2588	$4314

Lakeland Mental Health Information-Chris Kotschevar, Lakeland HR Source
218-736-6987

MI Case Manager 1 Equivalent: Monthly Salary Range for BA with no experience
$2448 – $3617

MI Case Manager II Equivalent: Monthly Salary Range for BA & 2 Years of Experience
$2586 - $3617

Distinction in the two systems is that in MN an employee receives each January a cost of living adjustment and then on their employment anniversary date they move one step with steps varying between 4-6%. They also have health insurance and other benefits.

Testimony
HB 1012 - Department of Human Services
Senate Appropriations Committee
March 4, 2009

Chairman Holmberg and members of the Senate Appropriations Committee, my name is Larry Bernhardt. I am the Director of Stark County Social Services in Dickinson and I am here today representing the ND County Social Service Director's Association and we are in support of House Bill 1012.

Counties have been a pillar in the overall public human service system since North Dakota became a state. All aspects of the human service budget, impact the citizens of our counties, therefore, we attempt to look at the needs of the whole system. We have several items we want to bring to your attention relative to HB 1012.

First of all, we are delighted that the Department of Human Services had included in their budget, dollars to raise the Medically Needy Income Level to 83% of the poverty level. This is truly a major impact on the low-income elderly and disabled of our state. Today, we have people trying to live on $500.00/month to meet their basic needs of shelter, food, utilities, clothing, transportation, etc., because any income over $500.00 must go towards their medical costs before Medicaid can pay anything. This change will allow the single individual to keep $720.00/month for their living needs and a couple will be allowed to keep $969/month for their needs. I speak for the elderly and disabled in ND when I say thank you to the Department, the Governor, and the Legislature for making an adjustment to these Medically Needy Income Levels. It is long overdue and will change the lives of many North Dakotans. However, the House has decreased the funding for this change to reflect income levels of only 75% of the federal poverty level. We are asking the Senate to replace those funds and return the level to the 83% of the poverty level.

Second, a major concern for the County Social Service Agencies is the need for a comprehensive Eligibility Computer System to determine eligibility for the Medicaid Program, Supplemental Nutritional Assistance Program (Food Stamps), Temporary

Assistance to Needy Families Program (TANF), Low Income Home Energy Assistance Program (LIHEAP), Foster Care Payments Program and Child Care Assistance Program. Today, Eligibility Workers must enter data in four different computer systems – NATL, TECS, VISION, and CCWIPS – in order to determine eligibility and authorize benefits for these Programs. It should be noted that once the new MMIS System is up and running, Eligibility Workers will have to enter data into that system as well, so they will then have 5 systems to work in. There is a definite need to develop one computer system that works across Program lines. The Department of Human Services had developed an OAR for an Eligibility System Replacement with a total cost of $ 18,632,280 ($9,316,140 would be General Funds) to develop that system. However, this OAR was not included in the Department's budget by OMB or the Governor's Office. Recognizing that the MMIS Replacement Project completion has now been delayed to May, 2010, we believe that it would be next to impossible to start the process for the Eligibility Computer Systems prior to May, 2010 – however it is crucial that we start that process. The House did ask DHS to develop an amendment to consider starting the process in the next biennium and determined that only $685,000 would be needed to start the process in the next biennium. (Half of those funds would be general funds and the other half would be federal funds) The 200+ Eligibility Workers in this state are counting on you to help them continue to do the good job they do, by providing a computer system that will make the work possible as we move forward with continuous program changes, more complex policies, and an expectation to meet quality performance standards. We need to start that process in June, 2010.

Third, we need to invest more in prevention and intervention services in the Child Welfare System and the following OAR, which did not get into the Department's Budget, is an excellent way to do that. That OAR is:

$ 934,742 (all General Funds) Increase Parent Aid Services

This OAR is very important and we would ask the Committee to include it in the Department's Budget. The increase in Parent Aid Services would allow for all counties to

have access to funds to offer Parent Aid Services and would allow for the expansion of the service in some counties. This service works directly with families to provide parenting education, household management, strategies to deal with difficult child behaviors, and support to families so that children can stay in their family home or be reunited with their family after having been placed in out of home care. We need to invest more in prevention and intervention services in the Child Welfare System and this is an excellent way to do that.

Finally, we as County Social Service Agencies have several other concerns. Those being 1.) the reimbursement to Indian Counties for the costs of providing Economic Assistance on reservation and trust lands, 2.) assistance in the costs of Foster Care and Subsidized Adoption, and 3.) increases in provision of prevention and intervention services for child welfare in North Dakota. However, all three of these issues will be coming forward in individual bills in the Legislative process and we would hope that you will support those efforts when they reach your Committee.

Chairman Holmberg, the following gives you some sense of the numbers of clients being served by County Social Service Agencies across the state:

County Social Service Agency Activities

(State Wide Numbers)

Supplemental Nutrition Assistance Program	**22,800**	**households**
Temporary Assistance to Needy Families (TANF)	**2,388**	**households**
Child Care Assistance Payments	**2,448**	**households**
Heating Assistance (LIHEAP)	**12,037**	**households**
Medicaid	**56,686**	**recipients**
Adoption Subsidy Payments	**912**	**children**
Foster Care Payments (2007 CY)	**2,152**	**children**
Child Abuse/Neglect	**4,011**	**assessments**
Home and Community Based Services (HCBS)	**3,388**	**clients**
Child Care Licensing	**3,461**	**licensing studies**

Chairman Holmberg, we would hope that your Committee would look favorably upon making the following changes to HB 1012:

** **Medically Needy: Replace the funding for the medically needy to reflect income levels of 83% of the Federal Poverty Level**

General	Other	Total
$ 376, 947	$642, 379	$1,019,326

** **Economic Assistance Computer System: Provide funding to begin the planning process, including $100,000 for temporary salaries, $85,000 for assistance from county staff, and $500,000 for contract services**

General	Other	Total
$342,500	$342,500	$685,000

** **Increase Parent Aid Services: Provide funding in order to expand Parent Aid Services to all counties in ND and expand the program in some counties.**

General	Other	Total
$934,742	-0-	$934,742

Chairman Holmberg and members of the Committee, thank you for the opportunity to provide testimony on HB 1012 and I would be happy to attempt to address any questions you may have.

House Bill 1012 – Department of Human Services
House Appropriations - Human Resources Division
Representative Pollert, Chairman
January 14, 2009

Chairman Pollert, members of the House Appropriations Human Resources Committee, I am Alex C. Schweitzer, Superintendent of the North Dakota State Hospital and North Dakota Developmental Center of the Department of Human Services (One Center). I am here today to provide you with an overview of the North Dakota State Hospital and North Dakota Developmental Center for the Department of Human Services.

North Dakota State Hospital Programs:

The North Dakota State Hospital provides short-term inpatient and long-term residential psychiatric, forensic and chemical addiction services for adults. Within this group of adult patients are inmates referred to the Tompkins Rehabilitation and Corrections Center by the Department of Corrections and Rehabilitation for residential addiction services.

The State Hospital provides inpatient services for children and adolescents with serious emotional disorders and substance abuse problems. The Jamestown School system provides educational services to the child and adolescent population on the grounds of the State Hospital.

The above-mentioned patients are considered to be the traditional patient population of the Hospital.

The Hospital also provides inpatient evaluation and treatment services for sexually dangerous individuals. This group of patients are housed and treated in the secure services unit of the Hospital.

The Hospital provides psychiatric, medical and x-ray services under a contract with the James River Correctional Center.

North Dakota State Hospital Census:

The State Hospital operates 307 beds.

The Hospital utilizes ninety (90) of these beds to provide addiction services to offenders in the Tompkins Rehabilitation and Correction Center, comprised of the 60 male and 30 female offenders.

The Hospital utilizes one hundred thirty-two (132) beds for inpatient and residential psychiatric services where the Hospital treats adults, children and adolescents with serious and persistent mental illness, serious emotional disorders and chemical addiction. Inpatient and residential services have been highly occupied for the past three years, with occupancy often running between 95-100%. The Hospital increased the capacity of inpatient and residential services by eight (8) beds in the 05 - 07 biennium to deal with the increased occupancy. In addition, the Hospital increased capacity by four (4) beds in the current biennium to meet the demand for patients. The Hospital during the past biennium was staffed for 85% occupancy in the nursing department.

The primary reasons for the high occupancy are the admission of first time patients, increased acuity from community admissions, a number of chronic patients needing residential settings and the increased need for treatment of patients with complex medical and psychiatric issues.

The Tompkins Rehabilitation and Corrections Center and the Inpatient and Residential Psychiatric Service admissions and average daily census data is outlined in Attachments A (1) & A (2).

The Hospital operates 85 beds in the sex offender unit, and we have current occupancy of 59 patients. The Hospital also operates a Transitional Living Home on the campus for sex offenders in the late stages of their commitment to the program. We can house two offenders at a time in this unit.

The current number of sex offenders in the program is outlined in Attachment B.

In summary, the Executive Budget recommendation for the State Hospital is for a total capacity of 307 patients. The breakdown by program includes; 90 beds in the Tompkins Rehabilitation and Corrections Center with 60 men and 30 women, 85 beds in the Secure Services Unit (sex offender program) and 132 beds in inpatient and residential psychiatric services.

Major Program Changes/Trends:

- The Hospital is experiencing high occupancy and higher acuity in the traditional services program for adults for the past three years.

- The Hospital transitioned 16 serious mentally ill patients to a residential long-term care program at the Sheyenne Care Center in Valley City to best meet their needs and increase capacity at the State Hospital.

- During the current biennium the Hospital opened a fourth sex offender unit with an additional 20 beds and 17 FTEs. The Sex Offender Program should be able to meet capacity needs for the foreseeable future with the current 85 beds and the Transitional Living Program.

- The Hospital did not follow through with the construction of a building addition (the fifth unit) to the GM Building for the sex offender program as authorized during the 2007 legislative session. The additional space was not needed because of the slowing of referrals, the emergence of the outpatient sex offender treatment program and discharges from the inpatient program.

Overview of Budget Changes:

Traditional Services:

Description	2007-2009 Budget	2009-2011 Budget	Increase/ Decrease
Institutions	52,235,044	59,596,627	7,361,583
General Funds	36,423,429	40,066,332	3,642,903
Federal Funds	4,467,669	4,394,303	(73,366)
Other Funds	11,343,946	15,135,992	3,792,046
Total	52,235,044	59,596,627	7,361,583
FTE	381.06	387.06	6.00

Budget Changes from Current Budget to Executive Budget:

- The increase in General Funds is the result of the Executive Budget recommendation for the state employee's salaries and benefit package.

- Federal Funds decrease by $73,366 because of the reduction in Federal Participation.

- Other Funds increase by $3,792,046 because of increased Medicare payments in Pharmacy Part D and Inpatient Part A.

- Salary and benefit increase of $4,306,134 total funds, with general funds increase of $3,333,913, federal funds increase of $419,419

and other funds increase of $552,802 to cover the Executive Budget recommendation for employee salary increase of 5% and 5% and benefit increases (increase in health insurance).

- The cost to continue year two of the 2007-2009 biennium salary increases into the 2009-2011 biennium is $657,917 with General Funds of $599,752.

- The Executive Budget recommendation contains an under funding of salaries of $988,683 and a decrease of $82,141 in other salaries because of decreased utilization of shift differential.

- Operating costs increase of $1,995,383 is due to high patient occupancy and acuity and increased utilization of medications and medical services/supplies. In addition the Hospital is experiencing cost increases in medications, medical services/supplies and utilities.

- The extraordinary repairs increase includes; major extraordinary repairs of $320,000 for resurfacing campus streets and parking lots, $75,000 for campus flooring replacement, $75,000 for asbestos abatement, $106,000 to replace siding and windows in the Transitional Living Houses, $1,146,500 for plumbing work, $360,000 for electrical service work, $95,000 for roofing repair, $25,000 for ADA improvements, and $1,028,517 for heating and cooling upgrades for a total of $3,231,017.

- The net increase in the Executive Budget recommendation for extraordinary repairs is $1,897,517.

- Equipment over $5,000 in the Executive Budget recommendation is $246,220. The net increase for equipment over $5,000 in the Executive Budget recommendation is $123,720.

- Bond payment of $437,729 and this is the final bond payment for the North Dakota State Hospital. The net decrease for bond payments in the Executive Budget recommendation is $28,662.

- The 2009 - 2011 Executive Budget recommendation contains a request for 6 FTEs. These FTEs are for the Inpatient Psychiatric Unit where we are experiencing higher occupancy and higher acuity.

Secure Services:

Description	2007-2009 Budget	2009-2011 Budget	Increase/ Decrease
Institutions	14,491,287	10,404,900	(4,086,387)
General Funds	14,331,656	10,371,601	(3,960,055)
Federal Funds	-	-	-
Other Funds	159,631	33,299	(126,332)
Total	14,491,287	10,404,900	(4,086,387)
FTE	85.45	85.45	-

Budget Changes from Current Budget to Executive Budget:

- The decrease in general funds in the Executive Budget recommendation for secure services is primarily the result of not building the fifth unit and the completion of the safety and security upgrades.

- Other funds decrease of $126,332 is the result of a smaller number of patients having third party payers or private funds for payment.

- Salary and benefit increase of $838,694 total funds, with general funds increase of $837,522 and other funds of $1,172 to cover the Executive Budget recommendation for the employee salary increase of 5% and 5% and benefit increases (increase in health insurance).

- The cost to continue year two of the 2007-2009 biennium salary increase into the 2009-2011 biennium is $123,486 with General Funds of $122,726.

- The Executive Budget recommendation contains a salary under funding of $368,091.

- Operating costs increase in the Executive Budget recommendation by $258,493 because of medication, medical services and utilities increases.

- The Executive Budget recommendation contains a decrease in capital improvements of $3,100,000 as the fifth unit was not built.

- The Executive Budget recommendation contains a decrease of $1,820,303 in extraordinary repairs for the completion of safety and security upgrades in the sex offender unit during the current biennium.

- Total FTEs remain the same in the Executive Budget recommendation as the Current Budget.

North Dakota Developmental Center Programs:

The Developmental Center provides services for individuals with developmental disabilities. The program includes residential services, work and day activity services, clinical and medical services and evaluation and consultation services.

Residential Services at the Developmental Center includes:

- Secure Services Program – this unit is for individuals with developmentally disabilities who have sex offending behaviors and for other individuals from the campus that require a more secure living environment. These individuals require long-term care.

- Medical Program – for individuals with developmental disabilities who are totally dependent on staff to complete daily cares and have medical concerns that require nursing staff accessibility 24 hours

per day. Also, in this area are a small number of individuals diagnosed with profound mental retardation and dual sensory disabilities (vision and hearing). These individuals require long-term care.

- Behavioral Care Program – these individuals with developmental disabilities present with psychiatric diagnoses and significant challenging behaviors. Some of these individuals may also have less severe medical needs.

- Youth Services Program - these young people between the ages of 16 - 25 have difficulty finding programming and housing in the community. The Center will provide short-term services to these individuals until a community placement can be found. This service will be added in early 2009.

- Independent Supported Living Arrangement Program - the Developmental Center is placing and supporting with staff three individuals with sexual health issues in a transitional living facility on the campus to prepare them for community living. They will be discharged from the Developmental Center when they make the transition. This service will be added in early 2009.

- The Developmental Center continues its efforts on an outreach program to assist the community with Consultation, Assistance, Resources, Evaluations and Services (CARES Team) in order to

prevent admissions, readmissions and also assist in transitioning people from the Developmental Center. In 2008 the CARES Team went statewide.

North Dakota Developmental Center (NDDC) Census:

See Attachment C, for the census data at the Center for the period of 1997 through 2008. The Executive Budget recommendation is built for a census of 115 individuals at the Center.

Major Program Changes/Trends:

- The One Center (NDSH/NDDC) shares ten (10) senior and middle management positions.

- The Community Transition task force is working on reducing the population of the Developmental Center with appropriate placements into community settings.

- The Center has added two transitional programs (one for youth and one for individuals with sexual health issues) and enhanced the CARES function to support people in community settings, prevent admissions, to reduce readmissions, and support transition to the community. In respect to the CARES function, the Center is adding (4) four behavioral analysts to carry out the statewide duties. The addition of the two transitional programs, the enhancement of the

CARES function and adding of the behavioral analysts is being absorbed in the current budget and no request for additional dollars is in the Executive Budget recommendation.

Developmental Center:

Description	2007-2009 Budget	2009-2011 Budget	Increase/ Decrease
Institutions	48,221,619	54,015,265	5,793,646
General Funds	14,840,379	16,854,593	2,014,214
Federal Funds	29,378,634	33,003,559	3,624,925
Other Funds	4,002,606	4,157,113	154,507
Total	48,221,619	54,015,265	5,793,646
FTE	445.54	445.54	-

Budget Changes from Current Budget to Executive Budget:

- The increase in General Funds is for the Executive Budget recommendation for the state employee's salary and benefit package.

- The Federal Funds increase is for the state employee's salary and benefit package and a Medicaid settlement.

- The Other Funds increase is for the state employee's salary and benefit package.

- Salary and benefit increase of $4,450,939 total funds, with general funds increase of $1,544,418, federal funds increase of $2,752,054, and other funds increase of $154,467 to cover the Executive Budget recommendation for the employee salary increase of 5% and 5% and benefit increases (increase in health insurance).

- The cost to continue year two of the 2007-2009 biennium salary increase into the 2009-2011 biennium is $606,365 with General Funds of $228,054.

- The Executive Budget recommendation contains a decrease of $46,040 in temporary salaries because of the reduction of one FTE in the dietary department.

- Operating costs increase of $16,127 is due to increases in medications and utilities, but mitigated by decreases in other areas of the operating budget.

- The Executive Budget recommendation for extraordinary repairs at the Center is for $712,675, which is a decrease of $185,525 from the current budget. Extraordinary repairs include; roofing repairs of $215,000, Powerhouse repairs and upgrades of $364,100, flooring and counter top replacement of $65,575, sidewalks and parking lots repairs of $20,000, campus door replacement of $36,000 and painting projects of $12,000.

- Equipment over $5,000 in the Executive Budget recommendation is $75,000. This is a net decrease of $17,640 from the current budget.

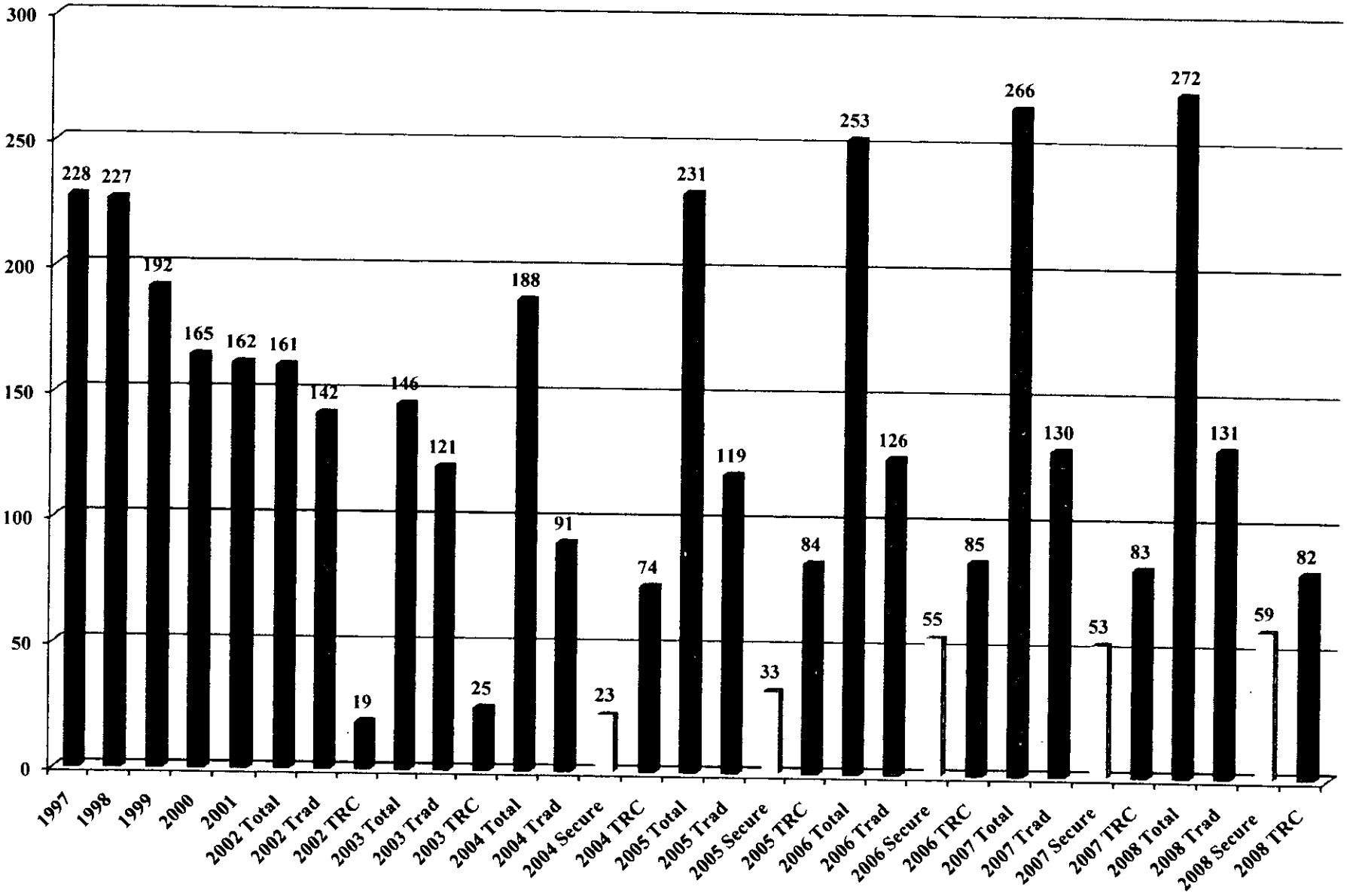
- Bond payment of $501,657 and this is the final bond payment for the North Dakota Developmental Center. The net decrease for bond payments in the Executive Budget recommendation is $32,848.

- The total Executive Budget recommendation for extraordinary repairs, bond payments and equipment at the Center is $1,289,332.

- No increase in FTEs at the Developmental Center for this biennial period.

Thank you. I would be happy to answer any questions about the budget request for the North Dakota State Hospital and North Dakota Developmental Center.

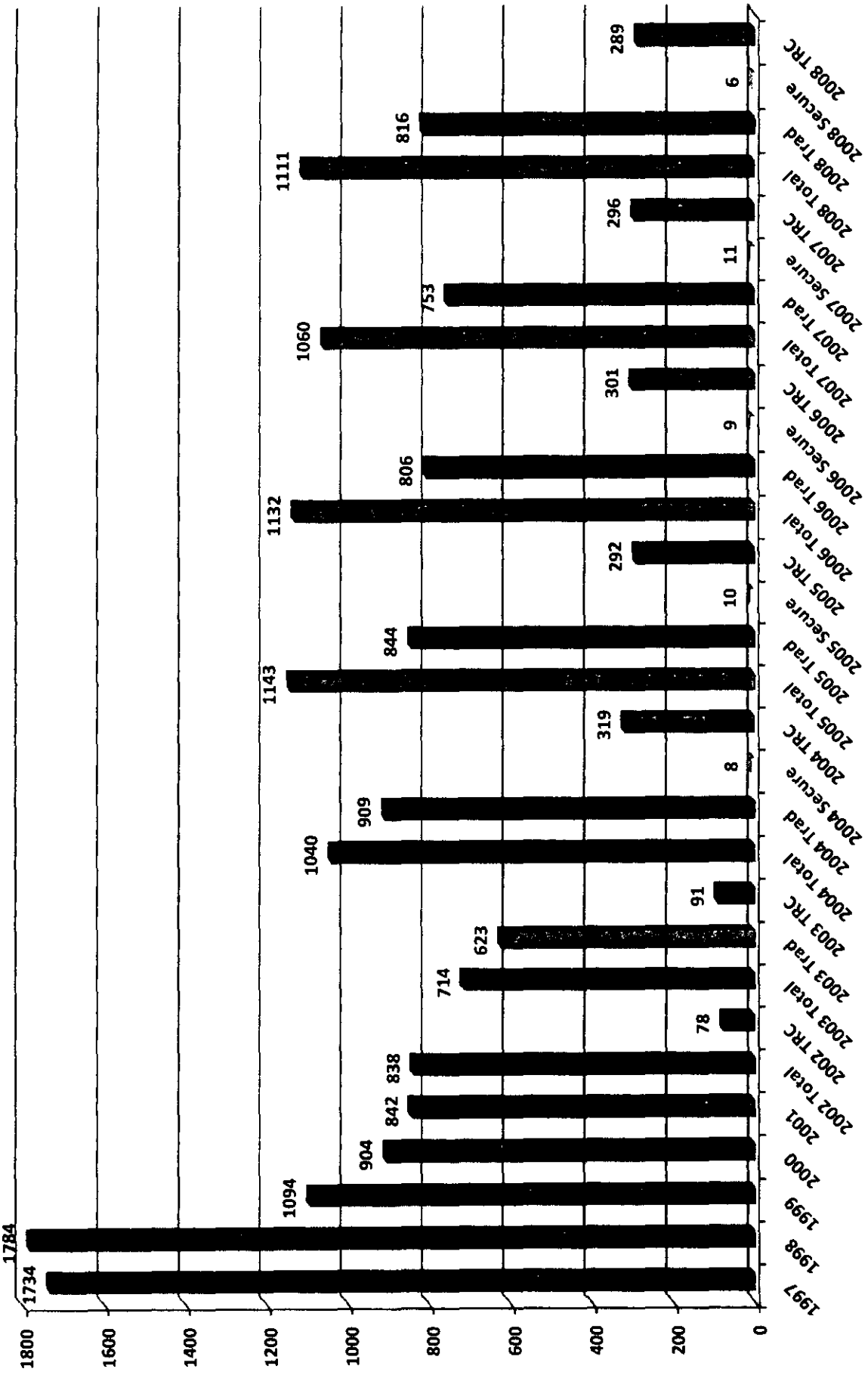
NDSH AVERAGE DAILY POPULATION



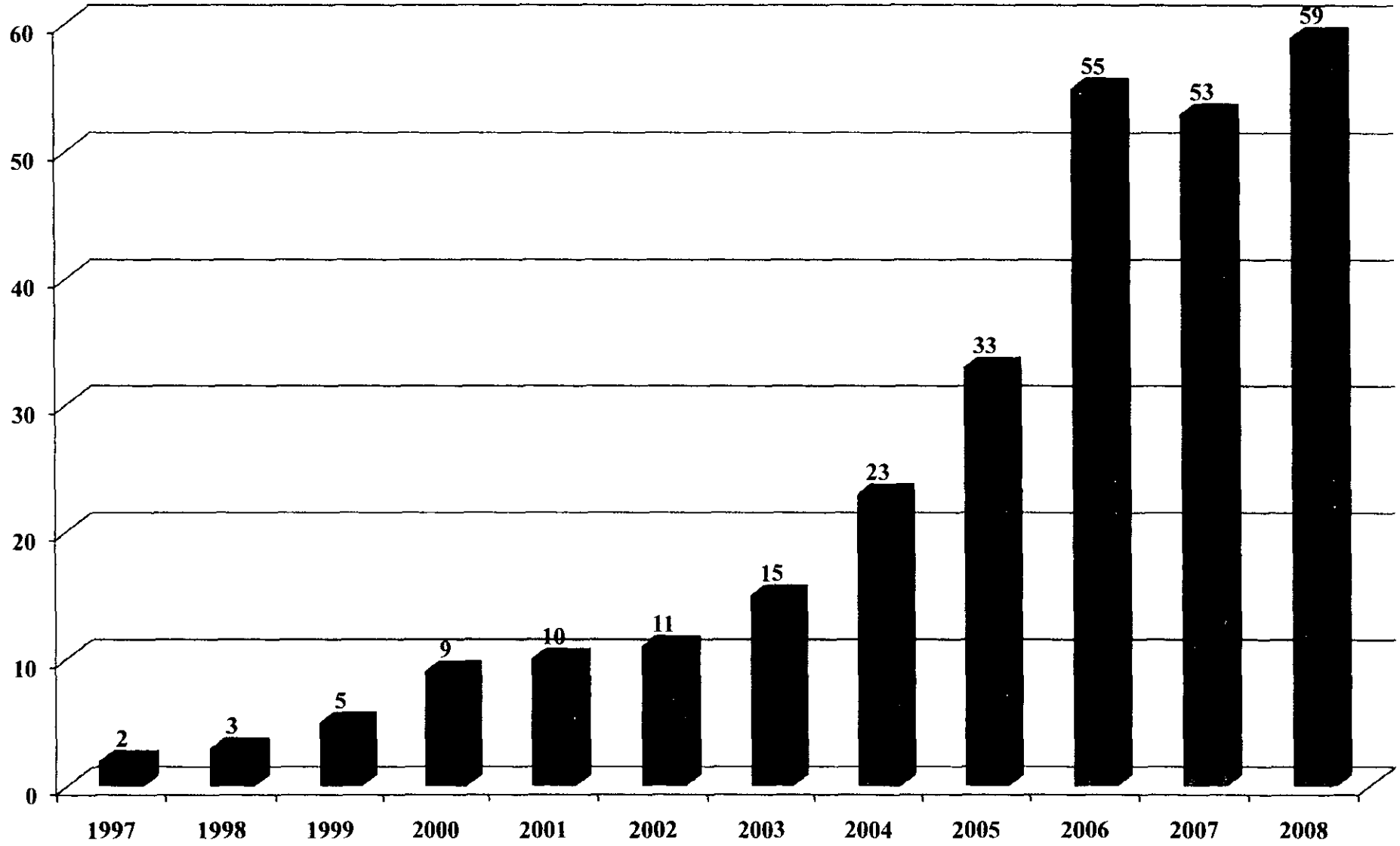
Attachment A (1)

Attachment A (2)

NDSH TOTAL ADMISSIONS

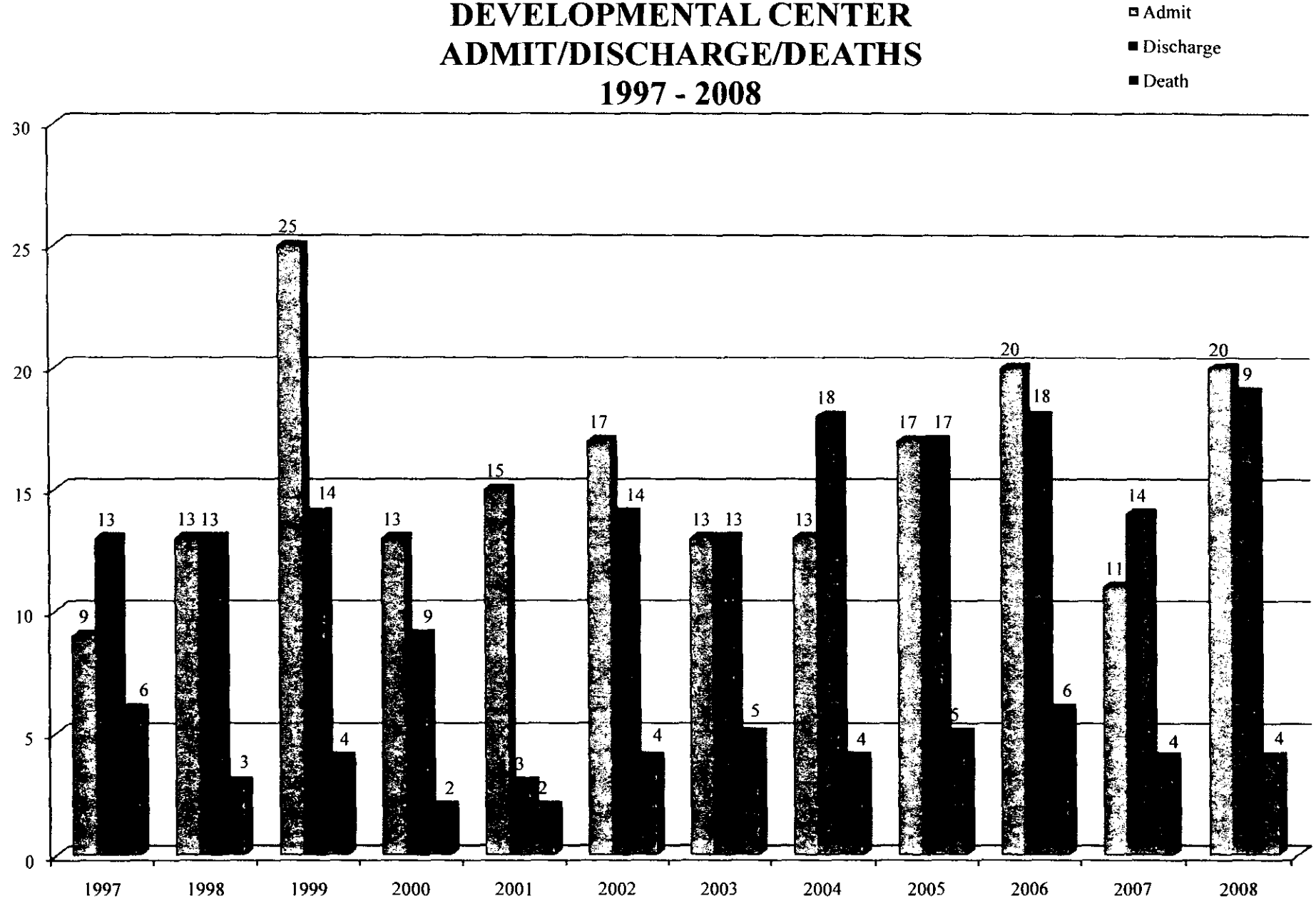


NDSH SEX OFFENDER PROGRAM CENSUS
1997 - 2008



Attachment B

DEVELOPMENTAL CENTER
ADMIT/DISCHARGE/DEATHS
1997 - 2008



Attachment C

Community Capacity Issues with Two Components – Inpatient and Outpatient

The Inpatient component addresses the capacity issues faced by the State Hospital and local hospitals:

- The State Hospital is staffed for 85% occupancy, while the actual occupancy has averaged between 90% - 100% during the same time frame. This is being primarily managed by staff caring for more patients than is considered acceptable staff-to-patient ratios. This, coupled with increased occupancy and increased acuity, creates issues with adequately meeting the needs of patients. The Hospital is also using double shifts, on-call staff and limited overtime when occupancy is running near 100% for a significant period of time. The additional 5 FTE will address this issue - $424,084.

- Also included in the inpatient component is funding to provide a higher rate of payment to the regional hospitals (Trinity, Altru, Meritcare, MedCenter One, and St. Alexius) when Human Service Center clients require short term stabilization. This rate change would be consistent with the rate paid by Medicaid at the newly rebased amount - $1,349,464.

The Outpatient component provides funding to enhance community supports in order to serve clients in the community rather than admitting to inpatient care at the State Hospital or local hospitals.

- To reach this goal, a crisis bed residential program is being proposed in Minot, along with a 16 bed residential facility in Dickinson - $1,910,387. Funding is also proposed to enhance existing community supports in Grand Forks - $289,000 and adds 5 FTE to deal with the growing capacity issues - $542,044.

The inpatient and outpatient components are linked, with the goal being to keep NDSH capacity under 100% while providing adequate staff coverage, and to maintain more clients in their home communities.

NORTH DAKOTA STATE HOSPITAL
TOMPKINS PROGRAM

DESCRIPTION	2007-09 Biennium	2009-11 Biennium
FTEs	43.75	43.75
General Funds	$ 186,236	$ -
Federal Funds	$ 39,258	$ -
Other Funds	$ 4,139,203	$ 4,239,484
TOTAL TOMPKINS COSTS--->	**$ 4,364,697**	**$ 4,239,484**

Overhead Costs - Dept. 9515	$ 157,329	$ 524,551
TOTAL DOCR PAYMENT--->	**$ 4,522,026**	**$ 4,764,035**

NORTH DAKOTA STATE HOSPITAL
CAPITAL IMPROVEMENTS AND EXTRAORDINARY REPAIRS
TRADITIONAL SERVICES
2009-11 BUDGET

PRIORITY	PROJECT	2009-11 Base Budget	2011-13	2013-15
1	Resurface streets and parking lots	$ 300,000	$ 100,000	$ 50,000
2	Replace 1981 Detroit Stoker coal feeders for coal boiler	$ 270,000		
3	Overhaul and replace worn equipment on coal boiler rotating grate system	$ 200,000		
4	Handicapped accessible entry and bathroom for Protection and Advocacy office space in Chapel	$ 25,000		
5	Replace coal boiler rotating grate hydraulic drive system	$ 95,517		
6	Replace most of the Lahaug sanitary sewer system	$ 250,000		
7	Replace aging water line to JRCC kitchen, ET and Amusement Hall	$ 175,000		
8	Siding and windows for TL houses	$ 106,000		
9	Replace flooring throughout the campus	$ 75,000	$ 50,000	$ 50,000
10	Rewiring and updating electrical equipment in New Horizons Building	$ 150,000		
11	Replace the sub-panel in the New Horizons Building	$ 150,000		
12	Replace obsolete ash tower unloading system for coal boiler	$ 198,000		
13	Half of Heating Plant roof repaired in 2007-09 - remainder of roof repair.	$ 45,000		
14	Overhaul Chillers (must be done every 5 years) one each biennium	$ 15,000	$ 15,000	$ 15,000
15	Repipe roof drains in several buildings	$ 150,000		
16	Rewiring TL Houses	$ 25,000		
17	Camera all sewer lines	$ 50,000		
18	Topographical survey of water mains and sewers	$ 50,000		
19	Replace coal boiler steam stop and header isolation valves	$ 21,000		
20	Coal boiler safety valve overhaul/replacement	$ 10,000		
21	Replace coal boiler ash handling system combining tube	$ 4,000		
22	Replacement and/or repair of parts for ash handling system	$ 35,000		
23	High and low pressure steam line systems valve replacement in Heating Plant	$ 35,000		
24	Replace coal boiler feed water inlet regulating valve	$ 10,000		
25	Install water cooling and recycling system on coal boiler's water cooled bearings	$ 35,000		
26	Install Back-up Heat Exchanger in the Lahaug Building	$ 20,000		
27	Replace obsolete sprinkler heads on one floor of the Lahaug Building	$ 20,000		
28	Pump House Valves	$ 15,000		
29	Backup water supply system with Jamestown	$ 250,000		
30	Ventilation for Motor Control Center at the Heating Plant	$ 35,000		
31	Install chilled water coils in areas of New Horizons not currently air conditioned	$ 50,000		
32	Asbestos Abatement throughout the campus	$ 75,000	$ 50,000	$ 50,000

NORTH DAKOTA STATE HOSPITAL
CAPITAL IMPROVEMENTS AND EXTRAORDINARY REPAIRS
TRADITIONAL SERVICES
2009-11 BUDGET

PRIORITY	PROJECT	2009-11 Base Budget	2011-13	2013-15
33	Replace water line and add second water line to JRCC Administration Building	$ 75,000		
34	Repaint two chiller sump tanks	$ 23,500		
35	Roof repairs - Maintenance schedule for all buildings	$ 50,000	$ 50,000	$ 50,000
36	Repair sidewalks throughout the campus	$ 20,000	$ 10,000	$ 10,000
37	Replace two main water shut off valves	$ 18,000	$ 18,000	$ 18,000
38	Replace 2 fire hydrants	$ 20,000	$ 20,000	$ 20,000
39	Repairing two manholes per biennium	$ 5,000	$ 5,000	$ 5,000
40	Repair leaking basement windows in the Lahaug Building	$ 75,000		
41	Replace Emergency Generator - Phase 3		$ 1,160,000	
42	New Security Lights		$ 150,000	
43	Lahaug Building roof replacement		$ 400,000	
44	Repaint exterior of water tower		$ 200,000	
45	Tuckpoint Administration Building		$ 100,000	
46	Cost to bring Employees' Building up to code		$ 2,099,332	
47	Replace roof on Employees' Building		$ 100,000	
48	Cost to bring 16 West Building up to code and use two floors for patient care		$ 2,976,302	
49	Replace the fire alarm system in the Lahaug Building		$ 250,000	
50	Replace analog-pneumatic controls on boiler #1 with digital controls		$ 103,302	
51	Build concrete slab and walls below ash tower outside Heating Plant		$ 70,000	
52	Coal boiler water side tube testing		$ 20,000	
53	Coal boiler refractory repair		$ 36,000	
54	Modify heating plant overhead door to accommodate parking of Trackmobile during winter months		$ 25,000	
55	Replace the windows in the south end of the Chapel		$ 10,000	
56	Paint Ash Tower - Heating Plant		$ 25,000	
57	Replace siding on implement shed		$ 40,000	
58	New Heating System for GM Building			$ 1,500,000
59	Purchase a new fuel oil pump to replace obsolete pumps #1 and #2 on boilers at Heating Plant			$ 30,500
60	Replace current atomizing system on oil/gas boiler with air atomization			$ 50,000
61	Remove underground fuel oil tank no longer in service for Heating Plant			$ 20,000
62	Engineering costs to design new coal unloading system			$ 140,000
	Purchase 2 stage air compressor for ash system at Heating Plant			$ 6,000
	TOTALS--->	**$ 3,231,017**	**$ 8,082,936**	**$ 2,014,500**
	EQUIPMENT OVER $5,000			
1	Cutter for Print Shop	**$ 6,000**		
2	Microscope for Lab	**$ 5,000**		
3	POC Coaguchek Meter for Lab	**$ 6,000**		

NORTH DAKOTA STATE HOSPITAL
CAPITAL IMPROVEMENTS AND EXTRAORDINARY REPAIRS
TRADITIONAL SERVICES
2009-11 BUDGET

PRIORITY	PROJECT	2009-11 Base Budget	2011-13	2013-15
4	Computer Radiography connected to Jamestown Hospital	$ 50,000		
5	800 lb. Sit to Stand Lift/Scale	$ 9,500		
6	600 lb. Full Body Lift/Scale	$ 5,020		
7	Hi-Lo Table for Physical Therapy	$ 5,000		
8	Refrigerator for Lab - Must keep constant temperature	$ 5,000		
9	Photo ID/Badge System	$ 11,000		
10	Skidsteer	$ 25,000		
11	Riding Lawn Mower	$ 19,400		
12	2 Tugs for Nutrition Services @$8,000	$ 16,000		
13	Copier for Lahaug Building	$ 12,500		
14	Copier for Tompkins Building	$ 12,500		
15	Tug for Central Receiving	$ 8,000		
16	Copier for Lab and Pharmacy to share	$ 12,500		
17	Duct Installed Air Purifier for Lahaug Basement	$ 37,800		
	TOTAL EQUIPMENT OVER $5,000--->	$ 246,220		
	TOTAL CAP IMPR & EXTRAORDINARY REPAIRS	$ 3,477,237	$ 8,082,936	$ 2,014,500
	OTHER CAPITAL PAYMENTS			
	Bond Payments	$ 437,729		

House Bill 1012 – Department of Human Services
Senate Appropriations Committee
Senator Holmberg, Chairman
March 4, 2009

Chairman Holmberg, members of the Senate Appropriations Committee, I am Alex C. Schweitzer, Superintendent of the North Dakota State Hospital and North Dakota Developmental Center of the Department of Human Services (One Center). I am here today to provide you with an overview of the North Dakota State Hospital and North Dakota Developmental Center of the Department of Human Services.

North Dakota State Hospital Programs:

The North Dakota State Hospital provides short-term inpatient and long-term residential psychiatric, forensic and chemical addiction services for adults. Within this group of adults are patients referred to the Tompkins Rehabilitation and Corrections Center by the Department of Corrections and Rehabilitation for residential addiction services.

The State Hospital provides inpatient services for children and adolescents with serious emotional disorders and substance abuse problems. The Jamestown Public School System provides educational services to the child and adolescent population on the grounds of the State Hospital.

The above-mentioned patients are considered to be the traditional patient population of the Hospital.

The Hospital also provides inpatient evaluation and treatment services for sexually dangerous individuals. This group of patients are housed and treated in the secure services unit of the Hospital.

The Hospital provides psychiatric, medical and x-ray services under an agreement with the James River Correctional Center.

North Dakota State Hospital Census:

The State Hospital operates 307 beds.

The Hospital utilizes ninety (90) of these beds to provide addiction services to patients in the Tompkins Rehabilitation and Corrections Center, comprised of 60 male and 30 female patients.

The Hospital utilizes one hundred thirty-two (132) beds for inpatient and residential psychiatric services where the Hospital treats adults, children and adolescents with serious and persistent mental illness, serious emotional disorders and chemical addiction. Inpatient and residential services have been highly occupied for the past three years, with occupancy often running between 95% - 100% and occasionally exceeding 100%. The Hospital increased the capacity of inpatient and residential services by eight (8) beds in the 05 – 07 biennium to deal with the increased occupancy. In addition, the Hospital increased capacity by four (4) beds in the current biennium to meet the increased demand. The Hospital during the past biennium was staffed for 85% occupancy in the nursing department.

The major reasons for the high occupancy are the admission of first time patients, increased acuity from community admissions, chronic patients awaiting referral to residential settings and the increased need for treatment of patients with complex medical and psychiatric issues.

The Tompkins Rehabilitation and Corrections Center and the Inpatient Psychiatric Service admissions and average daily census data is outlined in Attachments A (1) & (2) based on a census year of July 1st to June 30th.

The Hospital operates 85 beds for sexually dangerous individuals, and at the end of 2008 we had an occupancy of 59 patients. The Hospital also operates a Transitional Living Home on the campus for two sexually dangerous individuals in the late stages of their commitment to the program.

The census data for the sexually dangerous individuals population is outlined in Attachment B.

In summary, the Executive Budget recommendation for the North Dakota State Hospital is for a total capacity of 307 patients. The breakdown by program includes; 90 beds in the Tompkins Rehabilitation and Corrections Center with 60 men and 30 women, 85 beds in the Secure Services Unit and 132 beds for inpatient psychiatric services.

Major Program Changes/Trends:

- The Hospital is experiencing high occupancy and higher acuity in the traditional services program for adults for the past three years.

- The Hospital transitioned 16 serious and persistent mentally ill patients to a residential long-term care program at the Sheyenne Care Center in Valley City to best meet their needs and increase capacity at the State Hospital.

- During the current biennium the Hospital opened a fourth sex offender unit with an additional 20 beds and 17 FTEs. The Sex Offender Program should be able to meet capacity needs for the foreseeable future with the current 85 beds and the Transitional Living Program.

- The Hospital did not follow through with the construction of a building addition (the fifth unit) to the GM Building for the sex offender program as authorized during the 2007 legislative session. The additional space was not needed because of the slowing of referrals, the emergence of the outpatient sex offender treatment program and discharges from the inpatient program.

Overview of Budget Changes in Traditional Services:

Description	2007 - 2009 Budget	Increase/ Decrease	2009 - 2011 Budget	House Changes	To Senate
Institutions	52,235,044	7,361,583	59,596,627	(3,089,601)	56,507,026
General Funds	36,423,429	3,642,903	40,066,332	(2,037,161)	38,029,171
Federal Funds	4,467,669	(73,366)	4,394,303	(231,311)	4,162,992
Other Funds	11,343,946	3,792,046	15,135,992	(821,129)	14,314,863
Total	52,235,044	7,361,583	59,596,627	(3,089,601)	56,507,026
FTE	381.06	6.00	387.06	(6.00)	381.06

Budget Changes from Current Budget to Executive Budget:

- The increase in General Funds is the result of the Executive Budget recommendation for the state employee's salaries and benefit package.

- Federal Funds decrease by $73,366 because of the reduction in Federal Participation.

- Other Funds increase by $3,792,046 because of increased Medicare payments in Pharmacy Part D and Inpatient Part A.

- Salary and benefit increase of $4,306,134 total funds, with general funds increase of $3,333,913, federal funds increase of $419,419 and other funds increase of $552,802 to cover the Executive Budget recommendation for employee salary increase of 5% and 5% and benefit increases (increase in health insurance).

- The cost to continue year two of the 2007-2009 biennium salary increases into the 2009-2011 biennium is $657,917 with General Funds of $599,752.

- The Executive Budget recommendation contains an under funding of salaries of $988,683 and a decrease of $82,141 in other salaries because of decreased utilization of shift differential.

- Operating costs increase of $1,995,383 is due to high patient occupancy and acuity and increased utilization of medications and medical services/supplies. In addition the Hospital is experiencing cost increases in medications, medical services/supplies and utilities.

- The extraordinary repairs increase includes; major extraordinary repairs of $320,000 for resurfacing campus streets and parking lots, $75,000 for campus flooring replacement, $75,000 for asbestos abatement, $106,000 to replace siding and windows in the Transitional Living Houses, $1,146,500 for plumbing work, $360,000 for electrical service work, $95,000 for roofing repair, $25,000 for ADA improvements, and $1,028,517 for heating and cooling upgrades for a total of $3,231,017. The net increase in the Executive Budget recommendation for extraordinary repairs is $1,897,517.

- Equipment over $5,000 in the Executive Budget recommendation is $246,220. The net increase for equipment over $5,000 in the Executive Budget recommendation is $123,720.

- Bond payment of $437,729 and this is the final bond payment for the North Dakota State Hospital. The net decrease for bond payments in the Executive Budget recommendation is $28,662.

- The 2009 - 2011 Executive Budget recommendation contains a request for 6 FTEs. These FTEs are for the Inpatient Psychiatric Unit where we are experiencing higher occupancy and higher acuity.

House Changes:

The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $1,556,650, with $511,140 in general funds, $231,282 in federal funds and $814,228 in other funds. This is in addition to the underfund contained in the Executive Budget of $988,683.

The House reduced 50% of the department-wide travel increase. The North Dakota State Hospital's Traditional Services share of this decrease is $16,136, with $9,206 in general funds, $29 in federal funds and $6,901 in other funds.

The House reduced the State Hospital's extraordinary repairs by $1,000,000 – all general funds.

The House removed 6 FTEs from the executive budget that were added because of capacity issues at the State Hospital. The Hospital made a request during House testimony to remove one of these six FTEs. Reduction of $516,815 – all general funds.

Overview of Budget Changes in Secure Services:

Description	2007 - 2009 Budget	Increase/ Decrease	2009 – 2011 Budget	House Changes	To Senate
Institutions	14,491,287	(4,086,387)	10,404,900	-	10,404,900
General Funds	14,331,656	(3,960,055)	10,371,601	-	10,371,601
Federal Funds	-	-	-	-	-
Other Funds	159,631	(126,332)	33,299		33,299
Total	14,491,287	(4,086,387)	10,404,900	-	10,404,900
FTE	85.45	-	85.45	-	85.45

Budget Changes from Current Budget to Executive Budget:

- The decrease in general funds in the Executive Budget recommendation for secure services is primarily the result of not building the fifth unit and the completion of the safety and security upgrades.

- Other funds decrease of $126,332 is the result of a smaller number of patients having third party payers or private funds for payment.

- Salary and benefit increase of $838,694 total funds, with general funds increase of $837,522 and other funds of $1,172 to cover the Executive Budget recommendation for the employee salary increase of 5% and 5% and benefit increases (increase in health insurance).

- The cost to continue year two of the 2007-2009 biennium salary increase into the 2009-2011 biennium is $123,486, with General Funds of $122,726.

- The Executive Budget recommendation contains a salary underfunding of $368,091.

- Operating costs increase in the Executive Budget recommendation by $258,493 because of medication, medical services and utilities increases.

- The Executive Budget recommendation contains a decrease in capital improvements of $3,100,000 as the fifth unit was not built.

- The Executive Budget recommendation contains a decrease of $1,820,303 in extraordinary repairs for the completion of safety and security upgrades in the sex offender unit during the current biennium.

- Total FTEs remain the same in the Executive Budget recommendation as the Current Budget.

North Dakota Developmental Center Programs:

The Developmental Center provides services for individuals with developmental disabilities. The program includes residential services, work and day activity services, clinical and medical services and evaluation and consultation services.

Residential Services at the Developmental Center includes:

- Secure Services Program – this unit is for individuals with developmentally disabilities who have sex offending behaviors and for other individuals from the campus that require a more secure living environment. These individuals require long-term care.

- Medical Program – for individuals with developmental disabilities who are totally dependent on staff to complete daily cares and have medical concerns that require nursing staff accessibility 24 hours per day. Also, in this area are a small number of individuals diagnosed with profound mental retardation and dual sensory disabilities (vision and hearing). These individuals require long-term care.

- Behavioral Care Program – these individuals with developmental disabilities present with psychiatric diagnoses and significant challenging behaviors. Some of these individuals may also have less severe medical needs.

- Youth Services Program - these young people between the ages of 16 - 25 have difficulty finding housing and services in the community. The Center provides short-term services to these individuals until a community placement can be found.

- Independent Supported Living Arrangement Program - the Developmental Center is placing and supporting with staff three individuals with sexual health issues in a transitional living facility on the campus to prepare them for community living. They will be discharged from the Developmental Center when they make the transition.

- The Developmental Center continues its efforts on an outreach program to assist the community with Consultation, Assistance, Resources, Evaluations and Services (CARES Team) in order to prevent admissions, readmissions and also assist in transitioning people from the Developmental Center. In 2008 the CARES Team went statewide.

North Dakota Developmental Center (NDDC) Census:

See Attachment C, for the census data at the Center for the period of 1997 through 2008. The Executive Budget recommendation is built for a census of 115 individuals at the Center.

Major Program Changes/Trends:

- The One Center (NDSH/NDDC) shares ten (10) senior and middle management positions.

- The Community Transition task force is working on reducing the population of the Developmental Center with appropriate placements into community settings.

- The Center has added two transitional programs (one for youth and one for adults) to assist in the transition of individuals to community settings.

- In addition, the CARES function has been enhanced to support people in community settings and to prevent admissions and readmissions to the Center. The Center is adding (4) four behavioral analysts to carry out the statewide duties. The addition of the two transitional programs, the enhancement of the CARES function and adding of the behavioral analysts is being absorbed in the current budget and no request for additional dollars is in the Executive Budget recommendation.

Overview of Budget Changes – North Developmental Center:

Description	2007 – 2009 Budget	Increase/ Decrease	2009 – 2011 Budget	House Changes	To Senate
Institutions	48,221,619	5,793,646	54,015,265	(1,025,546)	52,989,719
General Funds	14,840,379	2,014,214	16,854,593	(437,518)	16,417,075
Federal Funds	29,378,634	3,624,925	33,003,559	(531,518)	32,472,041
Other Funds	4,002,606	154,507	4,157,113	(56,510)	4,100,603
Total	48,221,619	5,793,646	54,015,265	(1,025,546)	52,989,719
FTE	445.54	-	445.54	-	445.54

Budget Changes from Current Budget to Executive Budget:

- The increase in General Funds is for the Executive Budget recommendation for the state employee's salary and benefit package.

- The Federal Funds increase is for the state employee's salary and benefit package and a Medicaid settlement.

- The Other Funds increase is for the state employee's salary and benefit package.

- Salary and benefit increase of $4,450,939 total funds, with general funds increase of $1,544,418, federal funds increase of $2,752,054, and other funds increase of $154,467 to cover the Executive Budget recommendation for the employee salary increase of 5% and 5% and benefit increases (increase in health insurance).

- The cost to continue year two of the 2007-2009 biennium salary increase into the 2009-2011 biennium is $606,365 with General Funds of $228,054.

- The Executive Budget recommendation contains a decrease of $46,040 in temporary salaries because of the reduction of one FTE in the dietary department.

- Operating costs increase of $16,127 is due to increases in medications and utilities, but mitigated by decreases in other areas of the operating budget.

- The Executive Budget recommendation for extraordinary repairs at the Center is for $712,675, which is a decrease of $185,525 from the current budget. Extraordinary repairs include; roofing repairs of $215,000, Powerhouse repairs and upgrades of $364,100, flooring and counter top replacement of $65,575, sidewalks and parking lots repairs of $20,000, campus door replacement of $36,000 and painting projects of $12,000.

- Equipment over $5,000 in the Executive Budget recommendation is $75,000. This is a net decrease of $17,640 from the current budget.

- Bond payment of $501,657 and this is the final bond payment for the North Dakota Developmental Center. The net decrease for bond payments in the Executive Budget recommendation is $32,848.

- The total Executive Budget recommendation for extraordinary repairs, bond payments and equipment at the Center is $1,289,332.

- No increase in FTEs at the Developmental Center for this biennial period.

House Changes:

The House underfunding of salaries for anticipated savings from vacant positions and employee turnover for this area of the budget is $875,170, with $287,370 in general funds, $531,385 in federal funds and $56,415 in other funds.

The House reduced 50% of the department-wide travel increase. The North Dakota Developmental Center's share of this decrease is $376, with $148 in general funds, $133 in federal funds and $95 in other funds.

The House in addition reduced the executive budget request for extraordinary repairs at the North Developmental Center by $150,000.

The House added an amendment requiring a screening prior to admission or readmission to the North Dakota Developmental Center.

Thank you. I would be happy to answer any questions about the budget request for the North Dakota State Hospital and North Dakota Developmental Center.

Memorandum

To: Senator Holmberg, Chairman – Senate Appropriations Committee

From: Alex C. Schweitzer, Superintendent – DHS Institutions

Date: March 11, 2009

The attached reports are presented to the Senate Appropriations Committee at the request of Senator Mathern.

Attached reports include;

(1. Average Length of Stay at the North Dakota State Hospital (Fiscal 2008).

(2. Occupancy levels compared to Baseline nursing staffing levels at the North Dakota State Hospital for calendar years 2006, 2007 and 2008.

If you have any questions or need any more information, please feel free to contact me.

3-11-09

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Average Length of Stay
North Dakota State Hospital
Fiscal 2008
March 11, 2009

Average Length of Stay:

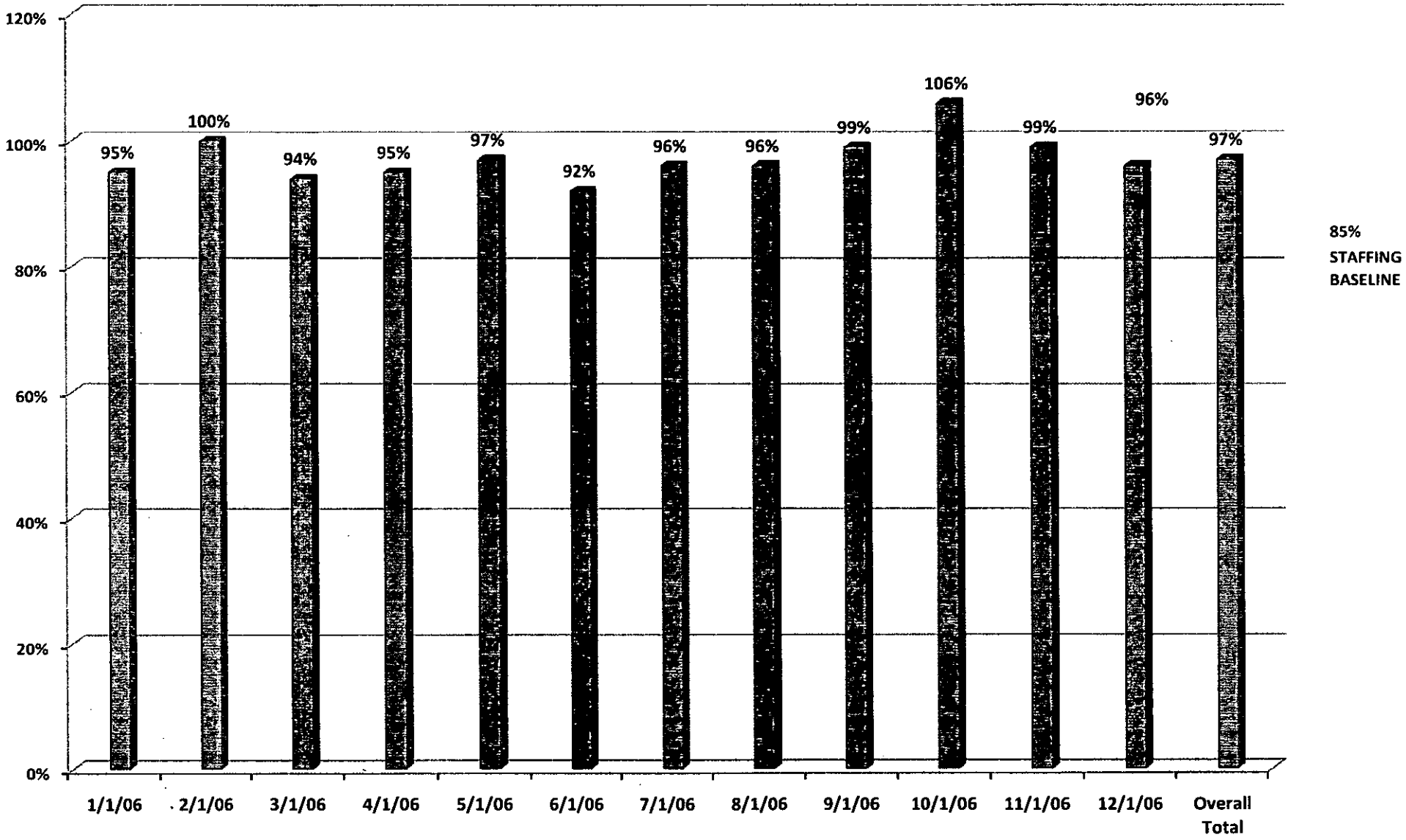
Traditional Services (Inpatient): Average Length of Stay = 75.5 days

Traditional Services (Transitional): Average Length of Stay = 247.2 days

Prepared by;

Alex C. Schweitzer
Superintendent
DHS Institutions

NDSH ADULT 2006 INPATIENT
TRADITIONAL OCCUPANCY



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North Dakota State Hospital 09 - 11 Extraordinary Repairs
March 25, 2009

Summary:

Governor's Budget Request:	$3,231,017
House Reductions:	$1,000,000
To the Senate:	$2,231,017

Detail:

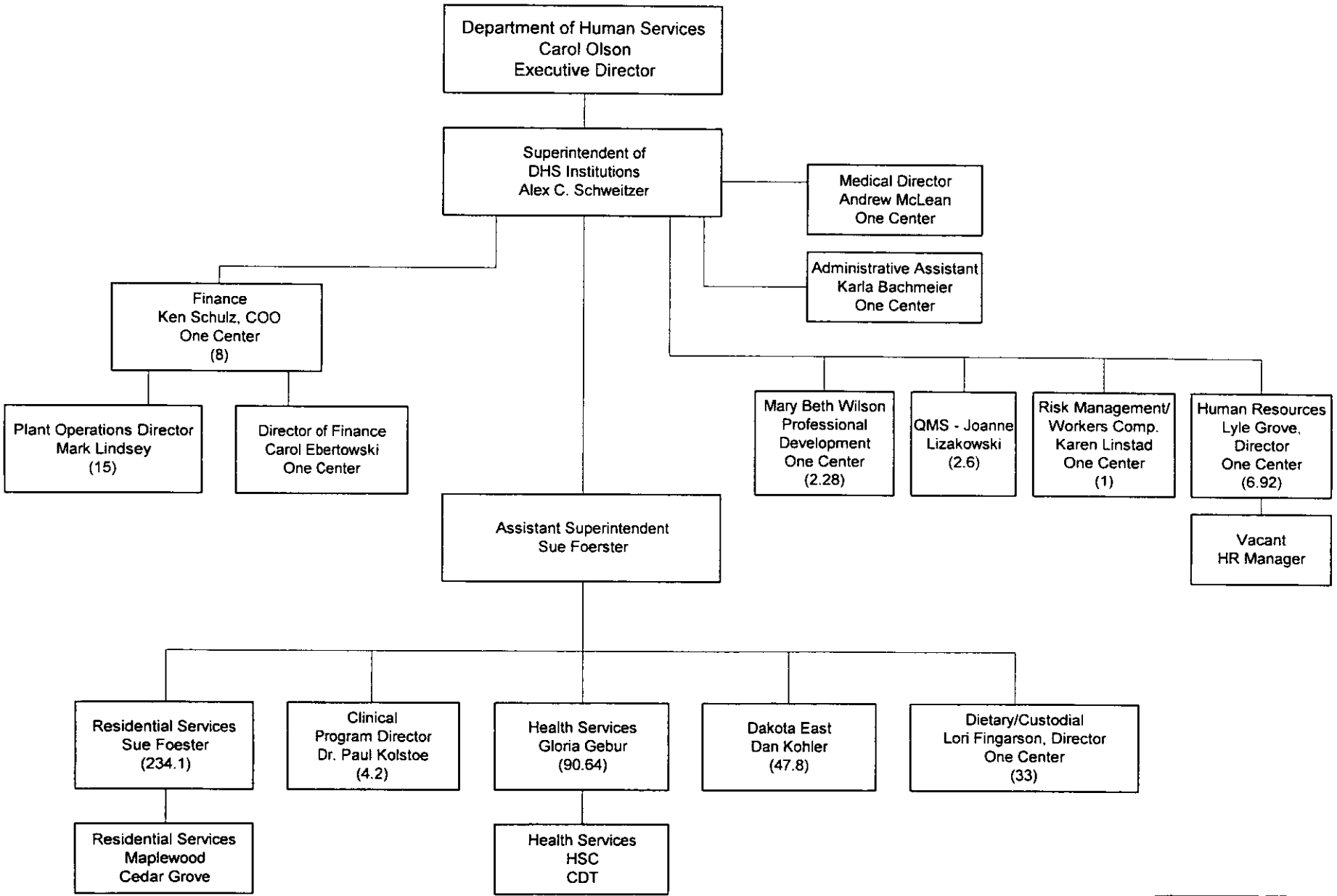
Funds for Projects after House Reductions:

Priority:	Project:	Cost:
1	Resurface streets and parking lot	$300,000
2	Replace 1981 coal feeders for coal boiler	$270,000
3	Replace worn rotating grate system on coal boiler	$200,000
4	Handicap Accessible entry/bathroom – P&A office	$ 25,000
5	Replace grate hydraulic system on coal boiler	$ 95,517
6	Replace most of LaHaug sanitary sewer system	$250,000
7	Replace aging water line to JRCC facilities	$175,000
8	Siding and windows for TL Homes	$106,000
9	Replace flooring throughout campus	$ 75,000
10	Rewiring electrical equipment in NH Building	$150,000
11	Replace sub-panel in NH Building	$150,000
12	Replace obsolete ash tower unloading system for Coal boiler	$198,000
13	Repair the remainder of heating plant roof	$ 45,000
14	Overhaul chillers (must be done every 5 years)	$ 15,000
15	Repipe roof drains in several buildings	$150,000
16	Rewiring TL Homes	$ 25,000

Projects not able to complete in 09 – 11 because of House Reductions:

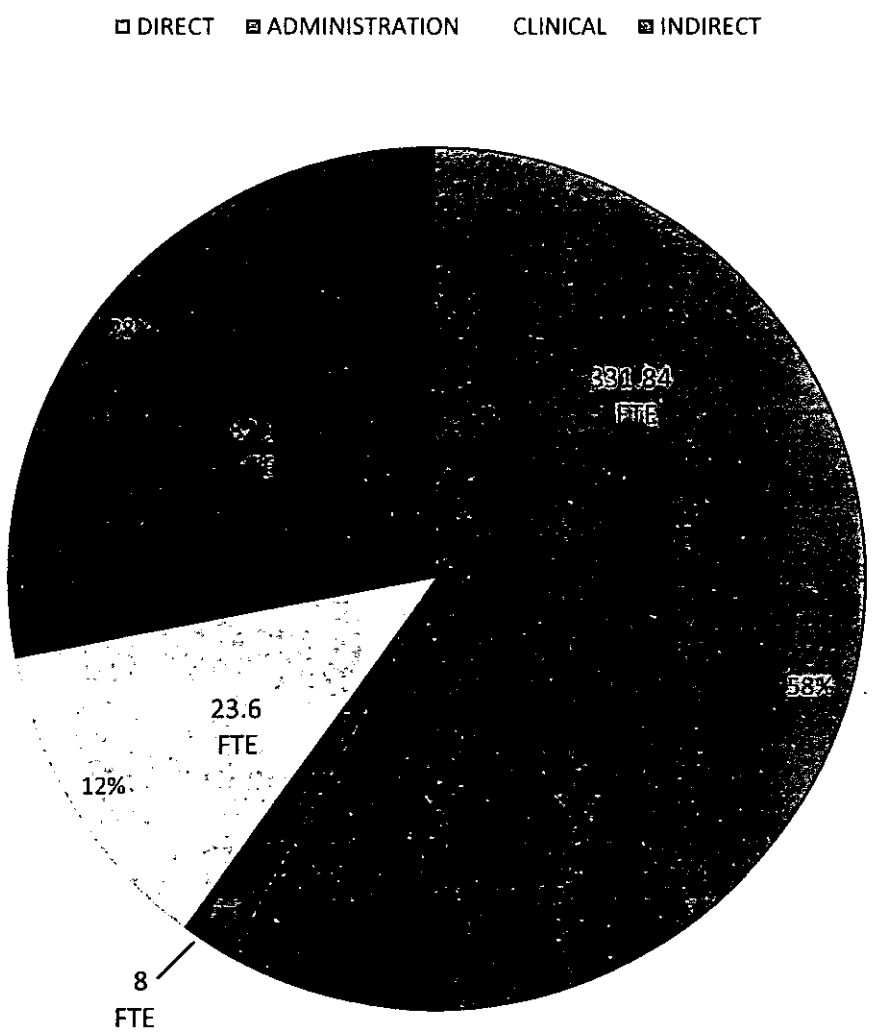
17	Camera all sewer lines	$ 50,000
18	Topographical survey of water mains and sewer	$ 50,000
19	Replace coal boiler steam stop and header valves	$ 21,000
20	Coal boiler safety valve overhaul/replacement	$ 10,000
21	Replace coal boiler ash handling system tube	$ 4,000
22	Replacement and/or repair parts – ash handling System	$ 35,000
23	Valve replacement of pressure steam lines	$ 35,000

North Dakota Developmental Center
January 2009



Total FTEs 445.54

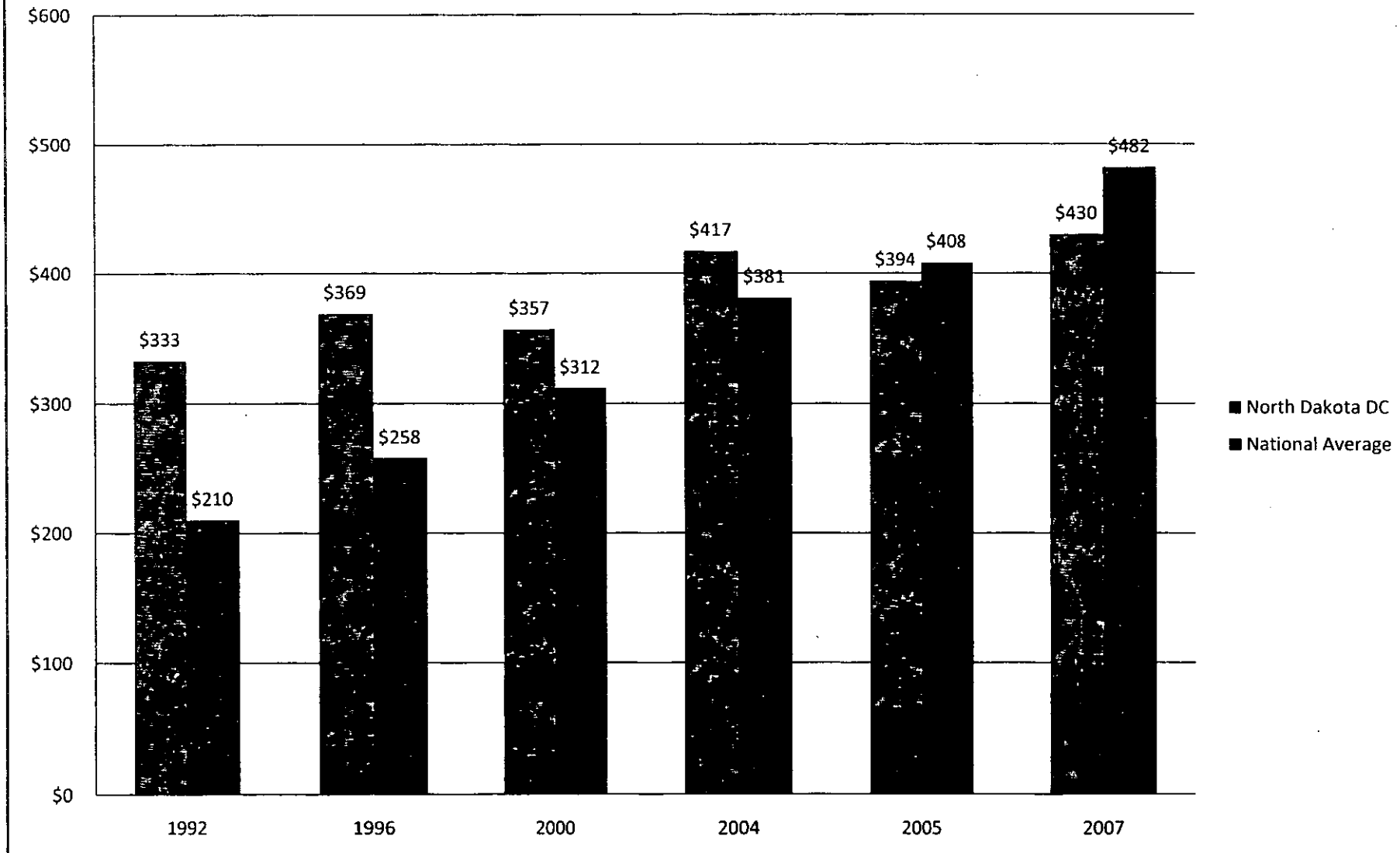
ND Developmental Center
2009-2011



MA Daily Rate	$578.02
Capital/Other	65.40
Total	$643.42

Daily Rate
$578.02/per day

North Dakota Developmental Center & National Average Daily Cost 1992 to 2007



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NORTH DAKOTA DEVELOPMENTAL CENTER
CAPITAL IMPROVEMENTS AND EXTRAORDINARY REPAIRS
FINAL

Priority	PROJECT	2009-11	2011-13	2013-2015
1	Maple Wood – this roof is the same age as Cedar Grove and has some of the same problems.	135,000		
2	Replace or repair doors --- campus-wide	36,000	10,000	10,000
3	Power House - Repairs & maintenance to motors and absorbers; In 2009 run Edy tests on tubes for absorbers #1 & #2, replace softeners, combustion air heater replacement, seal hose and tune up cooling towers, replace motor for #3 boiler fans;	58,400		
4	Powerhouse-In 2010 retube & overhaul #2 absorber	38,000		
5	There are a few areas of the chill water piping system that are direct buried. There have been a few leaks in this system in the past 10 years. This project should coincide with the steam line replacement, as the two systems are located in the same term	50,000	50,000	50,000
6	Grate Replacement Coal Boiler	55,000		
7	Repairs on air handlers, ductwork, univent heaters, coils, air handler motors and dampers on campus. We have done some repairs with the energy upgrade project but there is still a lot of equipment on campus that could need repairs in the upcoming years.	25,000	25,000	25,000
8	There are a few areas of the steam distribution system that are direct buried. There have been leaks in this system in the past and the section of the piping needs to be replaced.	70,000	50,000	50,000
9	Prairie View – this roof is over 20 years old and has passed its life expectancy. There are a few leaks in the tunnel area of the building.	80,000		
10	Concrete Repairs: This is an area that needs ongoing attention. With frost heaves and general wear there should be a rotation of sidewalk replacement to keep them in good condition.	10,000	5,000	5,000
11	Preventive maintenance and repairs on parking lots.	10,000	10,000	10,000
12	There are many areas of campus that need flooring replacement. Carpeting and linoleum.	55,575	40,000	40,000
13	The kitchen and laundry rooms of New Horizons, Maplewood and Cedar Grove are in bad shape. The counter tops are chipped, cracked and many of the cabinets have swelled do to water damage.	10,000	5,000	5,000
14	Repair cracks and eliminate water leaks in tunnels	25,000	25,000	25,000

NORTH DAKOTA DEVELOPMENTAL CENTER
CAPITAL IMPROVEMENTS AND EXTRAORDINARY REPAIRS
FINAL

Priority	PROJECT	2009-11	2011-13	2013-2015
15	Replacement of work out traps, pumps and other heating system components on campus. We have done some repairs with the energy upgrade project but there is still a lot of equipment on campus that could need repairs in the upcoming years.	15,000	15,000	15,000
16	Paint requests across campus	12,000	12,000	12,000
17	Airheater #3 boiler	10,000		
18	Water Softener & motor-boiler	17,700		
	Greenhouse: New building is needed		75,000	-
	Overhaul of chillers required every 5 years		19,000	
	Sprinkler system MW, CG, PTOT, HSC		505,295	
	Fire alarm MW, CG, PTOT, Sunset, Laundry, Shop		35,000	
	Refinish AES Flooring		5,500	
	TOTALS--->	**$ 712,675**	**$ 886,795**	**$ 247,000**
	OTHER CAPITAL PAYMENTS			
	Bond Payments	$ 501,657		
	EQUIPMENT OVER $5,000			
	Mower (Plant Services)		20,000	
	Hospital Beds (Campus-Wide)	50,000		
	Mechanical Lifts (PT - Campus-Wide)	25,000		
		$ 75,000	$ 20,000	
		$ 1,289,332	$ 906,795	$ 247,000

DEPARTMENT OF HUMAN SERVICES

Summary by Subdivision and Bgt_Acct with Funding Sources

2009 - 2011

Class	FB	Budget Account Code	Prior Bien Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 430-00 DEVELOPMENTAL CENTER								
		S101 FULL-TIME EQUIVALENTS (FTEs)	449.540	445.540	0.000	0.000	0.000	445.540
32570	B	511000 Salaries - Permanent	22,519,155	24,861,033	12,014,232	1,404,351	(1)	26,265,383
32570	B	512000 Salaries-Other	279,051	194,054	141,520	59,842	0	253,896
32570	B	513000 Temporary Salaries	267,060	235,712	228,262	(46,040)	(2)	189,670
32570	B	514000 Overtime	75,316	97,889	75,154	42,511	0	140,400
32570	B	516000 Fringe Benefits	9,960,377	12,106,920	5,587,086	124,429	1,911,350	14,142,699
32570	B	521000 Travel	363,763	348,073	200,502	783	0	348,856
32570	B	531000 Supplies - IT Software	33,890	21,215	13,974	10,400	0	31,615
32570	B	532000 Supply/Material-Professional	45,952	54,261	20,196	5,078	0	59,339
32570	B	533000 Food and Clothing	1,184,097	1,217,099	551,204	(11,498)	0	1,205,601
32570	B	534000 Bldg, Grounds, Vehicle Supply	335,321	300,960	185,910	(13,207)	0	287,753
32570	B	535000 Miscellaneous Supplies	184,171	176,843	103,757	(9,694)	0	167,149
32570	B	536000 Office Supplies	137,225	128,712	67,658	(24,806)	0	103,906
32570	B	541000 Postage	17,362	25,000	10,049	(4,050)	0	20,950
32570	B	542000 Printing	12,811	15,777	8,434	952	0	16,729
32570	B	552000 Other Equip under $5,000	17,343	22,500	11,431	(22,500)	0	0
32570	B	553000 Office Equip & Furniture-Under	1,176	300	300	(200)	0	100
32570	B	561000 Utilities	2,164,916	2,075,507	1,112,368	13,000	0	2,088,507
32570	B	571000 Insurance	77,085	109,700	23,934	200	0	109,900
32570	B	581000 Rentals/Leases-Equip & Other	39,236	57,416	24,863	(14,000)	0	43,416
32570	B	582000 Rentals/Leases - Bldg/Land	80	100	90	100	0	200
32570	B	591000 Repairs	548,922	340,425	222,281	(26,167)	0	314,258
32570	B	599110 Salary Increase	0	0	0	0	2,175,115	2,175,115
32570	B	599160 Benefit Increase	0	0	0	0	364,477	364,477
32570	B	602000 IT-Communications	247,542	202,480	119,357	28,098	0	230,578
32570	B	603000 IT Contractual Services and Re	4,470	0	0	0	0	0
32570	B	611000 Professional Development	21,891	35,604	16,043	5,292	0	40,896
32570	B	621000 Operating Fees and Services	2,950,279	2,288,676	1,171,584	48,638	0	2,337,314
32570	B	623000 Fees - Professional Services	257,580	263,341	75,409	(6,750)	0	256,591
32570	B	625000 Medical, Dental and Optical	1,326,374	1,516,677	739,968	13,958	0	1,530,635
32570	B	683000 Other Capital Payments	581,586	534,505	253,811	(32,848)	0	501,657
32570	B	684000 Extraordinary Repairs	627	898,200	295,257	(185,525)	0	712,675

DEPARTMENT OF HUMAN SERVICES

Summary by Subdivision and Bgt_Acct with Funding Sources

2009 - 2011

Class	FB	Budget Account Code		Prior Blen Exp 2005-2007	Current Budget 2007-2009	Year 1	Total Changes	Exec Salary Recmndtn	To the House 2009-2011
Subdivision: 430-00 DEVELOPMENTAL CENTER									
32570	B	691000	Equipment Over $5000	45,713	92,640	12,768	(17,640)	0	75,000
			Subtotal:	43,700,371	48,221,619	23,287,402	1,342,707	4,450,939	54,015,265
32570	F	F_7091	HSCs & Institutions - Gen Fund	14,845,695	14,840,379	13,593,549	469,796	1,544,418	16,854,593
32570	F	F_7092	HSCs & Institutions - Fed Fnds	26,099,572	29,378,634	9,691,870	872,871	2,752,054	33,003,559
32570	F	F_7093	HSCs & Institutions - Oth Fnds	2,755,104	4,002,606	1,983	40	154,467	4,157,113
			Subtotal:	43,700,371	48,221,619	23,287,402	1,342,707	4,450,939	54,015,265
			Subdivision Budget Total:	43,700,371	48,221,619	23,287,402	1,342,707	4,450,939	54,015,265
			General Funds:	14,845,695	14,840,379	13,593,549	469,796	1,544,418	16,854,593
			Federal Funds:	26,099,572	29,378,634	9,691,870	872,871	2,752,054	33,003,559
430-00 DEVELOPMENTAL CENTER			**Other Funds:**	2,755,104	4,002,606	1,983	40	154,467	4,157,113
			SWAP Funds:	0	0	0	0	0	0
			County Funds:	0	0	0	0	0	0
			IGT Funds:	0	0	0	0	0	0
			Subdivision Funding Total:	43,700,371	48,221,619	23,287,402	1,342,707	4,450,939	54,015,265
		S101	FULL-TIME EQUIVALENTS (FTEs)	2,058.430	2,223.380	0.000	14.000	0.000	2,237.380
			Report Budget Total:	1,577,361,589	1,909,297,261	869,660,844	323,226,108	29,563,592	2,262,086,961
			General Funds:	478,362,900	595,736,533	295,549,803	106,826,422	18,949,591	721,512,546
			Federal Funds:	1,017,286,161	1,212,943,782	535,605,888	212,003,691	9,644,246	1,434,591,719
			Other Funds:	44,987,988	54,247,813	14,748,601	(2,708,754)	969,755	52,508,814
			SWAP Funds:	21,447,894	27,527,920	15,080,863	6,667,250	0	34,195,170
			County Funds:	12,076,646	18,315,616	8,412,890	(2,036,904)	0	16,278,712
			IGT Funds:	3,200,000	525,597	262,799	2,474,403	0	3,000,000
			Report Funding Total:	1,577,361,589	1,909,297,261	869,660,844	323,226,108	29,563,592	2,262,086,961

ND Developmental Center

Detail of Budget Account Code 621000 - Operating Fees & Services

Operating Fees & Services	Amount	General	Federal/Other
Assessment	2,129,750	683,650	$ 1,446,100
Advertising	16,500	5,297	$ 11,204
Pest Extermination	7,500	2,408	$ 5,093
Freight & Express	29,000	9,309	$ 19,691
Miscellaneous Fees	36,128	11,597	$ 24,531
Licenses and Taxes	65,000	20,865	$ 44,135
Years of Service Awards	26,000	8,346	$ 17,654
Background Checks	27,436	8,807	$ 18,629
	-	-	-
	-	-	-
	-	-	-
Total Operating Fees & Services Budget Account Code	$ 2,337,314	$ 750,278	$ 1,587,036

For 1012 from ARC of ND, Tim Mathern 3.19.09

25-04-05. Qualifications for admission to state facility. ~~Temporary~~ Screening required prior to admissions or readmission – Educational or related services without charge for persons twenty-one years of age and under.

2. ~~The superintendent~~ No person may ~~admit~~ be admitted or readmitted to the developmental center at westwood park, Grafton, unless it is first established that the person cannot be appropriately served through community-based programs and services in the person's home community, or as close thereto as possible. If admission is sought because programs or services are not then available in the person's home community, the programs and services necessary to allow for education or related services to be provided in the student's home community must be identified, and a plan to develop those programs and services shall be created and fully implemented by the appropriate agency no later than the next school year. ~~temporarily for the purposes of observation, without commitment,~~ Any person recommended for admission may not be admitted unless that person has undergone a screening process at the developmental center, with the involvement of local and regional staff, to determine whether the admission or readmission is appropriate. Length of stay criteria may be established under rules as the department of human services may adopt, but no person may remain ~~, any~~. Any person who is suspected of being able to benefit from the services offered at the center, may be screened to ascertain whether or not that person is actually a proper case for care, treatment, and training ~~in~~ at the ~~state facility~~ developmental center. If in the opinion of the interdisciplinary team the person temporarily ~~admitted to the developmental center at westwood part, Grafton~~ screened under this subsection is a proper subject for institutional care, treatment, and training at the developmental center, that person may remain as a voluntary resident at ~~such~~ the center at the discretion of the superintendent on a temporary basis only until the community based services required by this section are in place, if all other conditions for admission required by this section are met.

North Dakota Developmental Center 09 -11 Extraordinary Repairs
March 25, 2009

Summary:

Governor's Budget Request:	$712,675
House Reductions:	$150,000
To the Senate:	$562,675

Detail:

Funds for projects after House Reductions:

Priority:	Project:	Cost:
1	Maplewood Roof Repair	$135,000
2	Campus wide repair of doors	$ 36,000
3	Repairs in the powerhouse	$ 58,400
4	Powerhouse – retube and overhaul absorber	$ 38,000
5	Repair of Chill water piping system	$ 50,000
6	Grate replacement on coal boiler	$ 55,000
7	Repair on air handlers, ductwork and heater coils	$ 25,000
8	Repair of steam distribution system	$ 70,000
9	Replace Praireview roof	$ 80,000
10	Concrete Repairs	$ 10,000

Projects not able to complete in 09 – 11 because of House Reductions:

11	Preventive maintenance and repairs on parking lots	$ 10,000
12	Flooring replacement	$ 55,575
13	Repair of individual suite kitchen areas	$ 10,000
14	Repair cracks and eliminate water leaks in tunnels	$ 25,000
15	Work on heating system	$ 15,000
16	Paint requests across campus	$ 12,000
17	Airheater #3 boiler	$ 10,000
18	Water softener and motor-boiler	$ 17,700

Page Two: Extraordinary Repairs at State Hospital

Priority:	Project:	Cost:
24	Replace coal boiler feed water inlet regulating valve	$ 10,000
25	Install water cooling system on coal boiler	$ 35,000
26	Install back-up heat exchanger in LaHaug Bldg.	$ 20,000
27	Replace obsolete sprinkler heads	$ 20,000
28	Pump House Valves	$ 15,000
29	Backup water supply system with City	$250,000
30	Ventilation for Heating Plant	$ 35,000
31	Install chilled water cools for air conditioning	$ 50,000
32	Campus asbestos abatement	$ 75,000
33	Replace water line/add second line to JRRC Administration Building	$ 75,000
34	Repaint two chiller sump tanks	$ 23,500
35	Roof Repairs – Maintenance schedule	$ 50,000
36	Repair sidewalks throughout campus	$ 20,000
37	Replace two main water shut off valves	$ 18,000
38	Replace two fire hydrants	$ 20,000
39	Repairing two manholes per biennium	$ 5,000
40	Repair leaking basement windows in LaHaug	$ 75,000

CLOSING THE NORTH DAKOTA DEVELOPMENTAL CENTER: ISSUES, IMPLICATIONS, GUIDELINES

David Braddock, Ph.D.
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March 7, 2006

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CLOSING THE NORTH DAKOTA DEVELOPMENTAL CENTER: ISSUES, IMPLICATIONS, GUIDELINES

PURPOSE AND FOCUS OF THE PAPER

This paper has been prepared at the request of the Arc-Upper Valley Board of Directors. It is intended to stimulate discussion and further study by the Arc and other interested parties in North Dakota on the possible closure of the North Dakota Developmental Center at Grafton (hereafter "Grafton").

The primary focus of the paper is to identify and discuss 10 key issues, expressed as questions, associated with the potential closure of Grafton, North Dakota's remaining mental retardation and developmental disabilities (MR/DD) institution. The implications of closing Grafton are considered in light of other states' experiences in closing state-operated MR/DD institutions and in light of relevant research. The paper addresses the following ten questions:

1. How did state-operated institutions for persons with mental retardation and developmental disabilities evolve nationally?

2. What are residential and community services trends in North Dakota today and in two groups of "comparison states"?

3. How many states have closed state MR/DD institutions and how many are planning to do so in the near future?

4. What are today's institutional costs per resident in North Dakota and, based on previous trends, what can these costs be estimated to be in future years?

5. How well do persons with MR/DD typically adjust to relocation from institutions to community living environments?

6. How do parents of individuals relocated from state institutions to community settings respond to this process of change?

7. How might cost savings be achieved in North Dakota if Grafton were to be closed in the near future?

8. Should the State of North Dakota anticipate a need for increased appropriations associated with Grafton's closure, to cover the temporary "dual costs"?

9. What are some of the alternate uses to which a closed Grafton facility might be put?

10. What can North Dakota learn from the extensive experience of other states in planning and implementing institutional closures?

Question #1: How did state-operated institutions for persons with mental retardation and developmental disabilities (MR/DD) evolve nationally?

The first state-operated MR/DD institutions were opened in the Northeastern U.S. in the 1850s. They were developed to provide a temporary residential placement for individuals who, after a relatively brief period of education and training in these facilities, returned to community life. Early success at several schools led to the opening of additional state-operated MR/DD institutions across the U.S. (Braddock & Parish, 2003). The first state MR/DD institution in North Dakota was opened as the State Institute for Feeble-Minded in Grafton in 1904. In addition, the San Haven facility, opened originally as a tuberculosis hospital in 1922, was converted to MR/DD use in 1973, and closed in 1987 (Braddock & Hemp, 2004).

As the country industrialized and urbanized, state institution populations expanded much faster than facilities' capacities to provide appropriate training and educational services. By 1930, more than 100,000 persons with mental retardation were institutionalized across the U.S., and most residents received minimal custodial care. This trend toward custodial care and "warehousing" of persons with mental retardation increased after the Second World War and throughout the 1950s. Media exposés about deficient conditions were commonplace (Blatt & Kaplan, 1974).

In 1967, the nation's institutional census peaked at 195,000 residents in 240 state mental retardation facilities. Since 1968, the number of individuals with mental retardation served in state institutions has declined every year and, on average, four percent annually for 37 consecutive years. In 2004, the residential census of the nation's state institutions was 41,214 persons. If present trends continue, there will be fewer than 20,000 residents in state institutions in 10 years (2016). Costs for residential care, however, are climbing rapidly. Based on previous trends, in 10 years they are projected to reach an average of approximately $193,000 for each resident per annum ($530/day), in constant 2004 dollars. The per diem cost in the Grafton facility in 2004 was $392/day and $143,000 annually (Braddock, Hemp, Rizzolo, Coulter, Haffer, & Thompson, 2005).

Current trends promoting community services in the mental retardation field evolved out of the parent movement in the 1950s and 1960s. At that time, parents began insisting upon both a higher quality of institutional care and greater opportunities for community living. Federal legislation was enacted in 1963 (Pub. L. 88-156 and Pub. L. 88-164) that authorized the establishment of an initial, but incomplete, network of community centers and services across the country (Braddock, 1987). Segregating individuals with MR/DD in large, often remote institutions and providing substandard care became prominent civil rights issues in the 1970s and 1980s. Class action lawsuits (e.g., *Wyatt v. Stickney* in Alabama, *Ricci v. Okin* in Massachusetts, *New York State Arc v. Carey, Association for Retarded Citizens of North Dakota v. Olson*) were filed and such litigation continues in Federal District Courts throughout the U.S. (Braddock, 1998). By 1980, however, many states had begun implementing community services initiatives involving the development and funding of

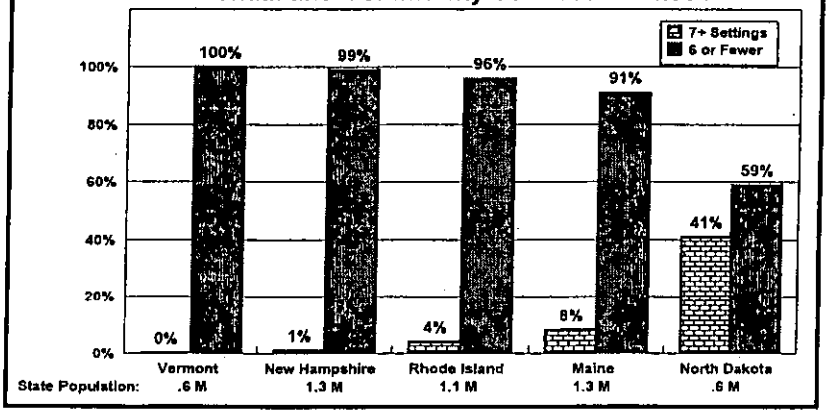
small group homes, supervised apartments, in-home family support programs, and supported employment.

Question #2: What are residential and community services trends in North Dakota today and in two groups of "comparison states"?

Today, institutional settings are being replaced by smaller, more individualized community placements and family support services. There are now more than 140,000 supervised living settings in the U.S. for six or fewer residents with MR/DD (Prouty, Smith, & Lakin, 2005). The total residential population of these small living environments was approximately 335,000 and this figure represented 68% of all out-of-home residential placements in 2004. In contrast, 86% of all persons with mental retardation in out-of-home residential placements nationally were living in large, 16 beds or more, publicly and privately-operated institutions in 1977 (Braddock et al., 2005).

North Dakota, however, significantly lags the dominant national trend in this regard. The State ranked 39th in 2004 in the percentage of persons with MR/DD living in smaller (six person or fewer), family-scale out-of-home environments, and 44th in the proportion of its total spending allocated to six-person or fewer settings. ***Figure 1*** compares North Dakota to four New England states with roughly the same state general population as North Dakota (Braddock et al., 2005).

Figure 1
Percentage of Total State Spending for 6-Person or Fewer Residential and Community Services: FY 2004



Another analytically useful comparison group of states includes South Dakota (.8 million population), Wyoming (.5 million), Montana (.9 million), and Idaho (1.4 million). Each of these "mountain west/plains states," like North Dakota, has one remaining institution. The 2004 MR/DD institutional censuses were 90 (MT), 92 (WY), 94 (ID) and 176 (SD), compared to 146 in North Dakota. Although South Dakota's census in 2004 was larger than North Dakota's, all four of these states had lower institutional utilization per capita rates (per 100,000 of the state general population).

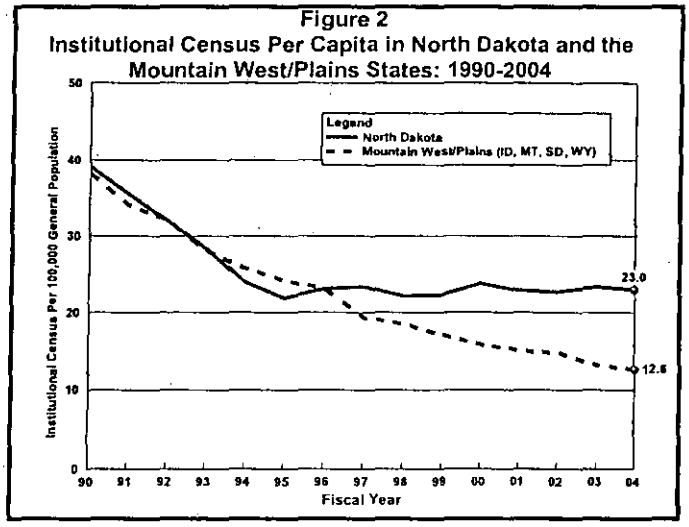


Figure 2 illustrates how the MR/DD institutional utilization per capita (of the state general population) for the four mountain west/plains comparison states began diverging from North Dakota in 1996. In 2004, North Dakota's institutional utilization exceeded the aggregate of the four comparison states by 83% (23.0 vs. 12.6). Moreover, South Dakota, Wyoming, Montana, and Idaho each committed a considerably larger share of total MR/DD spending to six-person or fewer residential and community services (70-77%) compared to only 59% in North Dakota. North Dakota's utilization rate for state-operated institutional care has been stable for the past 12 years, through 2006.

Question #3: How many states have closed state MR/DD institutions and how many are planning to do so in the near future?

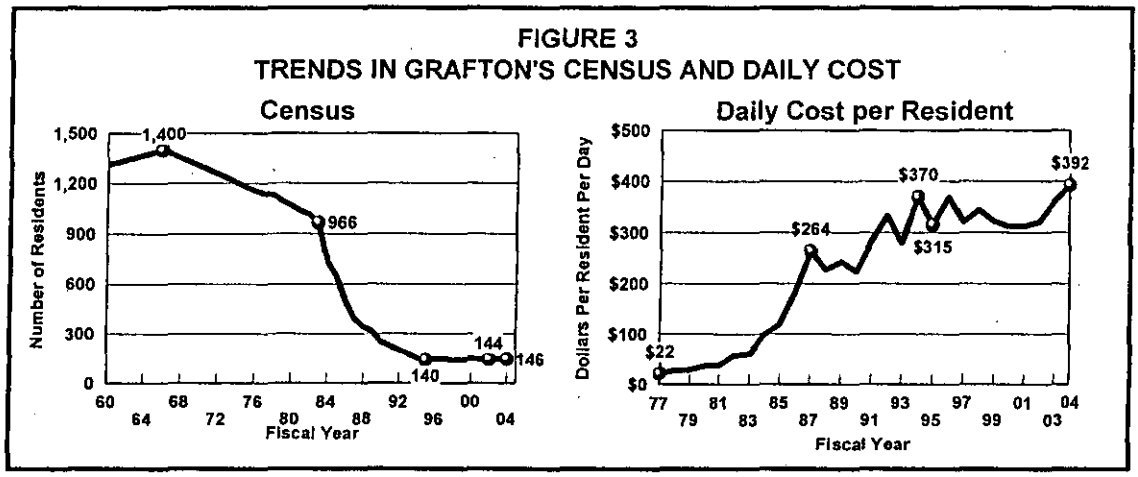
Since 1970, on a national basis, 39 states have closed, or are planning to close, 139 state-operated MR/DD institutions (*Appendix I*). This is more than one-half the 240

institutions that existed in 1970. (The average institutional census in 1970 was about 800 persons, compared to an average of 206 residents for the 200 facilities open in 2004.)

Sixty of the 139 completed and in-progress closures have occurred in the past 10 years. In January 1991, New Hampshire closed the Laconia State School and became the first contemporary American state to operate an institution-free service delivery system. The District of Columbia, Vermont, Rhode Island, New Mexico, West Virginia, Hawaii, and Maine became institution-free from 1991 to 1999. Michigan has closed 12 state institutions and in 2004, its only remaining facility, Mt. Pleasant, had a census of 162 persons. Minnesota has only one "institutional" program for persons with MR/DD. This is an intensive behavioral treatment program for seven consumers, located in a state psychiatric hospital.

Providing community-based services for persons with MR/DD and their families has gained considerable public support in recent years. Between 1977 and 2004, the annual growth of total community spending in the United States averaged 10% per year, after adjusting for inflation. Total state institution spending, however, actually declined 1% annually during 1977-04, and the average annual census of residents in institutions dropped by five percent per year.

The census of Grafton and San Haven in North Dakota (***Figure 3***) declined by an average of two percent per year from 1966 to 1983, one-half of the U.S. institutional rate over that period. Following the implementation of the consent decree in *Association for Retarded Citizens of North Dakota v. Olson* (1982), the North Dakota institutional census dropped by 15% per year from 1983 to 1995, from 966 to 140 persons. San Haven closed in 1987. In the past 12 years, through early 2006, there has been essentially no further decline in Grafton's institutional population. In fact, it has increased slightly since 1995.



Question #4: What are today's institutional costs per resident in North Dakota and, based on previous trends, what can these costs be estimated to be in future years?

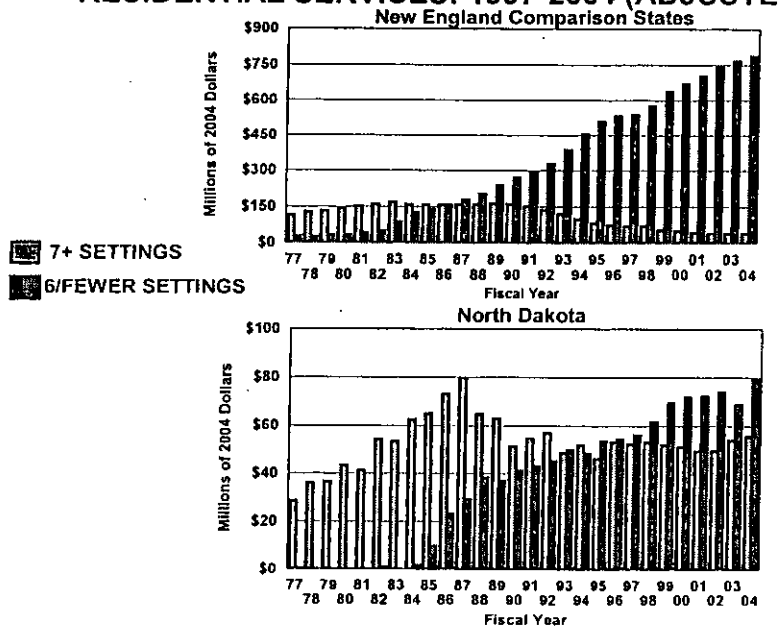
If present trends continue, an average of $193,000 per year, or $530 per day in constant 2004 dollars, is expected to be spent in the year 2016 for each institutional resident in the United States. From 1977 to 2004, average per diems grew nearly nine-fold, from $45/day to $400/day, and in 2004 per diems exceeded $500/day in 15 states, $400/day in 21 states, and $300/day in 35 states (Braddock et al., 2005).

Since 1995, the cost for each Grafton resident has advanced from $315 to $392 per day (***Figure 3***). The average cost of care in North Dakota's institution is now over $143,000 per year for each resident. Absent a decision to close Grafton, and given the stability of the Grafton census, the Grafton per diem for fiscal year 2016 in constant 2004 dollars may well surpass $600/day for approximately 146 residents. This amounts to $219,000 per year per resident, or $32.0 million per annum for the Grafton facility in 10 years.

An equally significant fiscal consequence of continuing to commit increasingly larger sums of money to institutional operations lies in the fact that, given current spending trends for Grafton, fewer "new" funds would be available to initiate additional or higher quality community services for consumers and families in the State. However, the New England

states of Maine, New Hampshire, Rhode Island and Vermont have all closed their remaining state MR/DD institutions, reallocated institutional funding, and greatly expanded their community services for thousands more individuals with MR/DD and their families (***Figure 4***). In contrast, North Dakota has continued to dedicate funding to persons in Grafton and to larger group living arrangements for seven or more persons. The New England states' decisions to close their MR/DD institutions lead to the development of a range of community housing and supported work options that subsequently received widespread political support (e.g., Covert, Macintosh & Shumway, 1994).

FIGURE 4
SPENDING FOR SIX PERSON OR FEWER RESIDENTIAL SERVICES: 1997-2004 (ADJUSTED)



Question #5: How well do persons with MR/DD typically adjust to relocation from institutions to community living environments?

Larson and Lakin (1989) of the University of Minnesota published a comprehensive review of research on changes in adaptive behavior associated with residents moving from state mental retardation institutions to smaller community living arrangements. Over 50

studies published between 1976 and 1988 were initially identified. After screening them according to six quality standards, 18 studies were subsequently analyzed. Results of the analysis indicated that institutions were "consistently less effective than community-based settings in promoting growth, particularly among individuals diagnosed as severely or profoundly retarded" (p. 330). The 18 studies reviewed involved 1,358 participants. The studies were conducted in 13 different states from all regions of the country. The authors concluded:

> ...it must be recognized that based on a substantial and remarkably consistent body of research, placing people from institutions into small, community-based facilities is a predictable way of increasing their capacity to adapt to the community and culture (p. 331).

In California, Brown, Fullerton, Conroy, & Hayden (2001) evaluated the well-being of more than 2,000 individuals with developmental disabilities who left state-operated California developmental centers from 1993 to 2001. The researchers assessed each individual at the state institution prior to the move, and, during 1994-2001, visited all 2,170 relocated individuals in their new homes in the community.

Data collected included measures of independence, behavioral challenges, choice-making, friendships, integration, person-centered planning, health, service intensity, earnings, and both consumer and family satisfaction. Brown et al. (2001) found that those relocated, compared to their lives in an institution in 1994, experienced improvement in "integrative activities," individualized treatment," "progress toward individual goals," "opportunities for choice-making," "reduced challenging behavior," and "perceived quality of life." Families were reported to be "unexpectedly and overwhelmingly happy with community living, even those who formerly opposed the change" (p. 3).

Brown et al. (2001) acknowledged that individuals relocated lost some of those gains between 2000 and 2001, stating that a plausible explanation was that "low salaries and high turnover rates translate into poorly motivated and poorly trained staff" in the community, an issue confirmed by family members who stressed the "poor quality and the short tenure of direct care staff" (p. 50). The State of California spent only 55% of the previous institutional cost per person, compared to community spending levels in New Hampshire, Pennsylvania, and Connecticut ranging from 80% to 86% of their states' institutional costs (Brown et al., 2001; Conroy, 1996).

Many people with levels of impairment once believed to be manageable only in institutional settings now live satisfactorily in community settings. This includes individuals with health problems (Gaylord, Abery, Cady, Simunds, & Palsbo, 2005; Hayden, Kim, & DePaepe, 2005; Larson, Anderson, & Doljanac, in press) and with challenging behaviors (Hanson, Wiesler, & Lakin, 2002; Kim, Larson, & Lakin, 2001; Stancliffe, Hayden, Larson, & Lakin, 2002). Undeniably, anecdotal reports of instances in which community placements did not work out are occasionally cited by proponents of continuing institutionalization of persons with MR/DD. However, the institutionalization of persons who have committed no wrong against society can only be justified by demonstrating clear benefits accruing to these persons from living in an institution. *Research literature noted above clearly indicates that state institutions do not provide a superior level of care for people with mental retardation.*

Question #6: How do parents of individuals relocated from state institutions to community settings respond to this process of change?

Families often initially oppose the transfer of their relatives from institutions to community settings, but after transfer occurs, the great majority of parents become strong

supporters of community placement (Heller, Bond, & Braddock, 1988). Since the late 1970s several studies have addressed the reactions of parents of institutionalized persons to the community placement of their relative with mental retardation. The studies demonstrated that, after community placement, parents consistently reported lower levels of satisfaction with the earlier institutional placement and higher levels of satisfaction with community placement (Brown et al., 2001; Larson & Lakin, 1991).

Initial family dissatisfaction with closure often bears little relationship to family attitudes toward closure a year later. The relative's medical status and the family's worry over "transfer trauma" have often both played significant roles initially upon the announcement of the closure, but not in determining longer-term parent reactions. The primary variables affecting both parent satisfaction with closure and parent stress levels is the family's current appraisal of the quality of the new community placement. Frequent staff consultation with the family members during the closure process was related to higher parent satisfaction with closure one year later (Heller et al., 1988).

Given that some families might resist institutional closure and the relocation of their relative, it is important to assure families that increased consumer health and adjustment problems are now uncommon during and following institutional closures. This is due to implementing the relocation process with sensitivity to the consumer's needs and preferences and involving families directly in the process. The literature on family reaction to institutional closure and relocation may be summed up as follows:

> ...the clearest message in these studies is that the overwhelming majority of parents become satisfied with community settings once their son or daughter has moved from the institution, despite general predisposition to the contrary (Larson & Lakin, 1991, p. 36).

Question #7: How might cost savings be achieved in North Dakota if Grafton were to be closed in the near future?

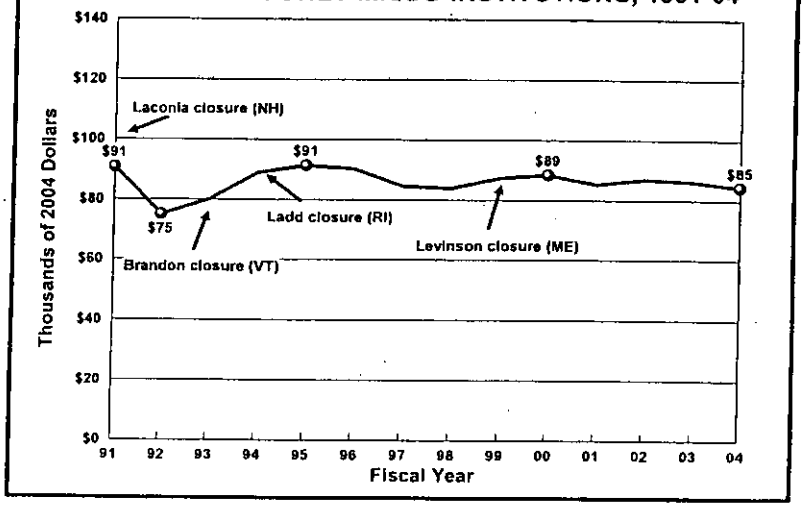
The closure of a state institution can generate savings for state government over time because it: 1) eliminates the high fixed cost of operating a state-owned facility, usually built for many more residents than live there at the time of closure; 2) shifts some fiscal responsibilities from state government tax revenues to federal Supplemental Security Income (SSI) and, in some cases, to local government sources; 3) increases the likelihood that individuals will engage in productive employment in a local community because they now live there; 4) utilizes less costly social, educational, religious, and recreational resources in the community rather than the relatively expensive, specialized services provided in the institution; and, 5) by renting/leasing residences it avoids the expensive institutional capital construction and remodeling costs necessary for most older institutions to remain open and certified for receipt of federal reimbursement (Braddock, 1991a, 1991b).

In a relevant study of closure costs and savings, the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) retained the services of an independent consulting firm to study the cost implications of its decision to close multiple mental retardation institutions. The study, authored by the Grant-Thornton accounting firm, concluded that the average post-closure per diem operating costs for each client "were approximately 9% lower than the pre-closure costs" (New York OMRDD, 1990). The study found that closure had little effect on state employee levels. Conversion of a state school campus to an alternate use such as a prison or juvenile facility provided substantial new employment opportunities and absorbed much of the economic impact of the state institution closure.

Another perspective on pre- and post-closure costs is afforded by the four New England states (Maine, New Hampshire, Rhode Island, and Vermont). These states, upon the closures of their last remaining institutions during 1991-99, became "institution-free"--like North Dakota would with the closure of Grafton. New Hampshire closed Laconia in 1991, Vermont closed Brandon in 1993, Rhode Island closed Ladd in 1994, and Maine closed Levinson in 1999 (Braddock et al., 2005).

An analysis of pre- and post-closure costs per residential recipient across 1991-2004 was completed. From the dates of the first closure (Laconia in 1991) through 2004, in inflation-adjusted terms, annual spending per statewide residential recipient in the four New England states declined from $91,000 to $85,000 (***Figure 5***). In addition, the number of aggregate MR/DD recipients served in the four states increased by 44% from 1991 to 2004. The number of recipients post-closure increased by 76% in New Hampshire, 50% in Rhode Island, 41% in Vermont and 30% in Maine.

FIGURE 5
AVERAGE ANNUAL RESIDENTIAL SERVICES SPENDING FOR MR/DD RECIPIENTS IN FOUR NEW ENGLAND STATES CLOSING THEIR ONLY MR/DD INSTITUTIONS, 1991-04



Question #8: ***Should the State of North Dakota anticipate a short-term need for increased appropriations associated with Grafton's closure, to cover the temporary "dual costs"?***

Without specific knowledge as to how a closure process might be implemented in North Dakota, including the nature of the phase-down of the physical plant and the duration

of the closure's implementation, it is difficult to provide an accurate estimate of "dual" costs associated with the closure. However, the state should anticipate some temporary dual costs. Assuming closure takes three years to implement (i.e., 2007-09), and that approximately 50 residents move to the community each of the three years, "dual" costs were estimated to be $3.1 million in the first year, $5.7 million in the second year, and $1.9 million in the third year. These estimates, totaling $10.7 million for the three year implementation period are based on the following two additional assumptions:

- The annual cost per relocated consumer in the new community settings in FY 2007 was assumed to be equivalent to the projected per diem cost at Grafton in FY 2007. This assumption permitted community direct support staff wages in 2007, the first year of closure implementation, to be comparable with Grafton's wages. Community direct support staff wage costs for FYs 2008 and 2009 were projected to increase at the average annual rate of increase in Grafton's per diem rates during FYs 1977-04 (2.6% per year on an inflation-adjusted basis).[1]
- Consumer per diems for those residents remaining at Grafton during the closure process will increase significantly in the second and third years, due to fixed costs being spread over fewer residents. We estimated the increased Grafton per diem rates based on the average increases in per diems in the New England comparison states to be 17% in year one, 51% in year two and 57% in year three.

However, as noted in the previous discussion for ***Question 7***, average inflation-adjusted statewide costs per resident receiving services in the consolidated four New England comparison states actually declined from 1995 to 2004. This was due to the fact that additional community recipients with lower average support needs were able to be served as well. North Dakota may experience a similar trend in average overall community costs in the long-term as well.

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[1] Some studies, however, have indicated that community costs for individuals with MRDD who had comparable needs were only 55-86% of those in institutions (Brown et al., 2002; Conroy, 1996). These lower community cost estimates were not used to generate the community per diem estimates in favor of emphasizing the conservative assumption of equalizing FY 2007 direct support staff wages in community settings with Grafton's projected FY 2007 staffing costs.

Question #9: What are some of the alternate uses to which a closed Grafton facility might be put?

Alternate uses possible for the Grafton physical plant depend upon the facility's proximity to projected population growth areas, the adaptability of the facility to alternate public or private use (e.g., prison, factory, state or industrial warehouse, etc.), and other factors. ***Table 1*** presents a summary of the various alternate uses for 130 developmental disabilities institutional closures in the U.S. See ***Appendix I*** for additional detail on each of the facilities that closed.

TABLE 1: ALTERNATE USES FOR INSTITUTIONAL CLOSURES IN THE U.S.

Alternate Use	Number[1]	Alternate Use	Number[1]
Corrections (including federal corrections)	22	New MR facilities	2
DD or other state/local administrative offices	15	Unoccupied (asbestos)	2
Alternate use not yet known	9	Private institutions	2
Universities/junior colleges	9	Historic preservation	1
Property vacant	9	Housing	1
Various community uses	6	Public health infirmary	1
Community DD programs	5	Retirement program	1
To be sold (including realty, public auction)	5	Reverting to U.S. Department of Defense	1
Commercial uses	4	Veterans' medical center	1
MI facilities	4	Water survey office	1
Demolished	3	Women's prison	1
Juvenile facilities	3	Undetermined	29

[1]Total is 137--7 institutions had two alternate uses

The four New England closures demonstrate the range of possible alternate uses displayed in ***Table 1***. The Laconia State School in New Hampshire was quickly reopened in 1991 as the Lakes Region Adult Correctional Facility. The town of Laconia (population 16,411) is 30 miles from Concord (population, 40,687). Brandon Center in Vermont, closed in 1993, is near Rutland (population 17,292) which is 85 miles from Colonie, New York (population 79,258). The closed facility is currently under development as a manufacturing site, with both private and state ownership.

The Ladd Center in Rhode Island, closed in 1994, was located in Exeter (population

6,045), 13 miles from Warwick (population 85,808) and was also proximal to Providence, a large city. A $6.4 million state fire academy and new state police headquarters is being developed on the Ladd Center site. The Elizabeth Levinson Center in Maine closed as a state institution in 1999 and now operates as a state-run short-term residential and health program for medically fragile children. Levinson, in Bangor (population 31,473) is 129 miles from Portland (population 64,249). Like North Dakota, the institutions in New Hampshire and Vermont were located in small towns, somewhat distant from a larger city. Grafton, a town of 4,516, is located 38 miles from Grand Forks.

Question #10: What can North Dakota learn from the extensive experience of other states in planning and implementing institutional closures?

In 1983, Illinois successfully relocated the 820 residents of the Dixon State School within a single calendar year. More than 90% of the parents were satisfied with the closure process and outcomes. Resident friendship patterns were kept intact by moving small groups of individuals together and by closing down one residential unit at a time (Braddock, Heller, & Zashin, 1983; Heller, Factor, & Braddock, 1986).

Guidelines based on state experiences in MR/DD institutional closures are summarized in ***Appendix II.*** They are presented from five perspectives: 1) general guidelines; 2) the individuals with developmental disabilities who are being relocated; 3) their families; 4) the community programs receiving residents from the closing facility; and 5) the staff of the closing facility. The guidelines were revised from Braddock et al. (1983) and Heller, et al. (1986).

CONCLUSION

In three previous analyses of the structure, financing and quality assurance of residential and community services in North Dakota, Braddock & Hemp (2004, 2000) and Braddock, Hemp, & Rizzolo (2002) suggested service and funding priorities for the State. For example, it was noted that North Dakota had fared better than most states fiscally in the recent national economic downturn during 2003-2005, and North Dakota was one of 10 states with the strongest financial outlook for fiscal year 2005. Priority needs for MR/DD services identified in the most recent North Dakota study included: 1) continuing the expansion of the Medicaid Home and Community-Based Services (HCBS) Waiver; 2) reducing reliance on Intermediate Care Facility/Mental Retardation (ICF/MR) programs for 16+ person public and private institutional facilities; 3) increasing family support, supported employment and supported living; and, 4) enhancing direct support staff wages and benefits (Braddock & Hemp, 2004, p. 50).

Nationwide, there are over nine times more individuals with mental retardation and developmental disabilities living in supervised out-of-home community settings than in state-operated institutions. The number of families and persons with disabilities benefiting from community services and supports nationally is growing as well. State-operated institutions are being closed in many states across the country and few families prefer such programs. Thus, given the trends outlined in this paper, the long-term future of services to persons with mental retardation and developmental disabilities in North Dakota is in community settings.

It therefore seems appropriate for North Dakotans to seriously consider expanding community residential services and support programs for people with MR/DD and their families, and subsequently closing the North Dakota Developmental Center at Grafton.

However, if Grafton is slated for closure, the implementation of that closure needs to be planned and executed in a manner sensitive to the needs of Grafton's consumers and their families and considerate of the employees of the facility as well. As previously noted, suggested guidelines specifically addressing closure implementation issues are presented in ***Appendix II.***

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APPENDIX I
COMPLETED AND IN-PROGRESS CLOSURES OF STATE-OPERATED 16+ INSTITUTIONS IN THE U.S. (139 CLOSURES IN 39 STATES)

State	Institution	Year Built/ Became MR	Original Use	# Residents, Closure Announcement	Year of Closure	Alternate Use
Alabama	Brewer-Bayside	1964	MR Facility	67	2003	Corrections
	Glenn Ireland	1966	MR Facility	20	1996	To be sold
	Tarwater	1976	MR Facility	74	2003	Corrections
	Wallace	1970	MR Facility	80	2003	Corrections
Alaska	Harborview	1964	MR Facility	45	1997	Community Programs
Arizona	Phoenix	1974	MR Facility	46	1988	Commercial
	Tucson	1972	MR Facility	13	1997	Outreach Offices
California	Agnews	1855/1966	MI Facility	411	2007	Undetermined
	Camarillo	1935	MR Facility	497	1998	University
	DeWitt	1942/1947	Army Hospital	819	1972	Placer County Recreation
	Modesto Unit	1943/1948	Army Hospital	1,394	1969	Modesto Co. Comm. College
	Napa	1875/1967	Asylum for MR/MI	30	2001	MI Use Only
	Stockton	1852	Asylum for MI	414	1996	University
Colorado	Pueblo	1935	MI/MR Facility	163	1989	Pueblo Regional Center
Connecticut	John Dempsey Center	1964	MR Facility		1998	Administrative Offices
	Mansfield	1906/1917	Epileptic Colony	146	1993	Corrections/U. of Connecticut
	New Haven	1964	MR Facility	56	1994	Job Corps
	Seaside	1961	MR Facility		1996	Administrative/Storage
	Waterbury	1963/1972	Convent	40	1989	Administrative Offices
DC	Forest Haven	1925	MR Facility	1,000	1991	Private Rehab/PH Infirmary
Florida	Community of Landmark	1965	MR Facility	256	2005	Revert to Dade County social programs
	Gulf Coast Center	1960	MR Facility	306	2010	Undetermined
	Orlando	1928/1959	TB Hospital	1,000	1984	Demolished, land to school, county
	Tallahassee	1928/1967	TB Hospital	350	1983	Unoccupied; asbestos
Georgia	Bainbridge	1967	WW II Air Force School	129	2001	Corrections
	Brook Run	1969	MR Facility	364	1997	Undetermined
	Georgia Regional-Augusta			438	2004	Undetermined
	Gracewood School/Hospital			93	2004	Undetermined
	Rivers' Crossing	1969	MR Facility	37	1994	Undetermined
Hawaii	Kula Hospital (privatized)	1984			1999	
	Waimano	1921	MR Facility	96	1999	Art Center for PWD
Illinois	Adler	1967	MI/MR Facility	16	1982	Water Survey Offices
	Bowen	1965	MR Facility	105	1982	Corrections
	Dixon	1918	MR Facility	820	1987	Corrections/New MR Facility
	Galesburg	1950/1969	Army Hospital	350	1985	Head Start/Community Programs
	Lincoln	1877	MR Facility	153	2004	Vacant*
	Meyer	1966/1970	MI Facility	53	1993	Women's Prison
	Singer	1966	MI Facility	45	2004	Undetermined
Indiana	Central State	1848	MI/MR Facility	83	1994	Undetermined
	Ft. Wayne	1879	MR Facility	120	2007	To be demolished
	Muscatatuck	1920	MR Facility	287	2005	Undetermined
	New Castle	1907	Epileptic Village	200	1998	Corrections
	Northern Indiana	1943	MR Facility	53	1998	Undetermined
Kansas	Norton	1926/1963	TB Hospital	60	1988	Corrections
	Winfield	1888	MR Facility	250	1998	Undetermined
Kentucky	Frankfort	1860	MR Facility	650	1972	Demolition
	Outwood	1922/1962	TB Hospital	80	1983	Demolition/New Campus
Maine	Aroostook	1972			1995	
	Levinson	1971			1999	
	Pineland	1908	MR Facility	265	1996	Undetermined
Maryland	Victor Cullen	1908/1974	TB Hospital	79	1991	Private Juvenile Facility
	Great Oaks	1970	MR Regional Center	273	1997	Private Senior Retire. Community
	Henryton	1928/1962	TB Hospital	312	1985	Undetermined
	Highland Health	1870/1972	General Hospital	88	1989	Sold to Johns Hopkins University
Massachusetts	Belchertown	1922	MR Facility	297	1992	Vacant
	John T. Berry	1900/1963	TB Sanitarium	101	1995	Undetermined
	Paul A. Dever	1940/1946	P.O.W. Camp	294	2001	Undetermined
	Fernald	1848	MR Facility	274	2007	Undetermined
Michigan	Alpine	1937/1959	TB Hospital	200	1981	Notsego County Offices
	Caro	1914			1998	
	Coldwater	1874/1939	Orphanage	113	1987	Corrections
	Fort Custer	1942/1956	Army Hospital	1,000	1972	Back to U.S. Dept. of Defense
	Hillcrest	1905/1961	TB Hospital	350	1982	Demolition
	Macomb-Oakland	1967/1970	CDA	100	1989	Reverted to Community Dev.
	Muskegon	1969	MR Facility	157	1992	Vacant
	Newberry	1896/1941	MI Facility	39	1992	Vacant
	Northville	1952/1972	MI/MR Facility	180	1983	Revert to MI Use
	Oakdale	1895	MR Facility	100	1991	Vacant/County Negotiating
	Plymouth	1960	MR Facility	837	1984	County/State Offices
	Southgate	1977	MR Facility	55	2002	Undetermined

APPENDIX I (CONTINUED)

State	Institution	Year Built/ Became MR	Original Use	# Residents, Closure Announcement	Year of Closure	Alternate Use
Minnesota	Brainerd	1958			1999	
	Faribault	1879	MR Facility	501	1998	Portion used by Corrections
	Fergus Falls	1888/1969	Asylum for MI	38	2000	Regional MH Center
	Moose Lake	1938/1970	Psychiatric Hosp	34	1993	Corrections
	Owatonna	1895/1947	Orphanage	250	1970	Abuse
	Rochester	1879/1972	MI Facility	150	1982	Federal Corrections
	St. Peter	1968			1996	
	Willmar	1973			1996	
Missouri	Bellefontaine	1924	MR Facility	341	2005	Undetermined
Montana	Eastmont	1969/1979	Residential School	29	2003	Nursing Facility
New Hampshire	Laconia	1903	MR Facility	4	1991	Corrections
New Jersey	Edison	1975/1981	Corrections	70	1988	Sold at public auction
	Johnstone	1955	MR Facility	239	1992	Corrections
	North Princeton	1898/1975	Epileptic Colony	512	1998	Undetermined
New Mexico	Fort Stanton	1964	Army Apache Outpost/TB H	145	1995	Skilled Nursing/Respite
	Los Lunas	1929	MR Facility	252	1997	Community Based Program MR/DD
	Villa Solano	1964/1967	Missile Base	82	1982	Housing
New York	J.N. Adam	1912/1967	TB Hospital	180	1993	Undetermined
	Bronx	1977	MR Facility	217	1992	Plans Not Final
	Craig	1896/1935	Epilepsy Hospital	120	1988	Corrections
	Gouverneur	1962	MR Facility	N/A	1978	Leased site
	O.D. Heck	1972	MR Facility	274	1999	Administrative Offices; non-profit use
	Letchworth	1911	MR Facility	704	1996	Undetermined
	Long Island	1965	MR Facility	682	1993	Undetermined
	Manhattan	1919/1972	Warehouse	197	1991	OMRDD Office
	Newark	1878	Custodial Asylum	325	1991	Community College
	Rome	1825/1894	County Poorhouse	638	1989	Corrections
	Sampson	1860/1961	Naval Base	695	1971	Office of Mental Health
	Staten Island	1942/1952	Army Hospital	692	1987	OMRDD & Community College
	Sunmount	1922/1965	TB Hospital	503	2004	OMRDD Specialty Units
	Syracuse	1851/1972	MR Facility	409	1997	Undetermined
	Valatie	1971	MR Facility	N/A	1974	Private Holdings and ICFs/MR
	Westchester	1932/1979	MI Facility	195	1988	Office of MH
	Wilton	1960	MR Facility	370	1995	Sold to private industry
North Dakota	San Haven	1922/1973	TB Hospital	86	1987	Vacant
Ohio	Apple Creek	1931	MR Facility	178	2006	Undetermined
	Broadview	1930/1967	TB Hospital	178	1992	City Administration Building/Retirement
	Cleveland	1855/1963	MI Facility	149	1988	Vacant/Negot. with City of Cleveland
	Orient	1898	MR Facility	800	1984	Corrections
	Springview	1910/1975	TB Hospital	86	2005	Undetermined
Oklahoma	Hissom	1967	MR Facility	451	1994	Corrections/Educational
Oregon	Columbia Park	1929/1963	TB Hospital	304	1977	College
	Eastern Oregon	1929/1963	TB Hospital	240	1984	Corrections/Opened New MR Facility
	Fairview	1907	MR Facility	327	2000	Light commercial/housing
Pennsylvania	Altoona	1975	MR Facility	90	2005	Undetermined
	Cresson	1912/1964	TB Hospital	155	1982	Corrections
	Embreeville	1880/1972	County Poorhouse	152	1998	Undetermined
	Hollidaysburg	1974	MR Facility	60	1976	Revert to MI Use
	Laurelton	1920	MR Facility	192	1998	Undetermined
	Marcy Center	1915/1974	TB Hospital	152	1982	Vacant
	Pennhurst Center	1908	MR Facility	179	1988	Veterans' Medical Center
	Philadelphia	1983	MI/MR Facility	60	1989	Vacant
	Western	1962		133	1999	
	Woodhaven	1974	MR Facility	N/A	1985	Became private institution
Rhode Island	Dix Building	1945/1982	WPA	80	1989	Corrections
	Ladd Center	1907	MR Facility	292	1994	Undetermined
South Carolina	Clyde Street	1973	Home for unwed mothers	20	1995	Administrative Offices
	Live Oak	1987	Nursing home	50	1999	To be sold
South Dakota	Custer	1964	TB Hospital	76	1996	Boot camp for delinquent boys
Tennessee	Winston	1979			1998	
Texas	Forth Worth	1976	MR Facility	339	1995	Undetermined
	Travis	1934	MR Facility	585	1997	Undetermined
Vermont	Brandon	1915	MR Facility	26	1993	For Sale, Local Realty
Washington	Interlake School	1946/1967	Geriatric MI	123	1995	Other State Agency
West Virginia	Colin Anderson	1920s	MR Facility	85	1998	Possible Juvenile Corrections
	Greenbrier	1801/1974	Women's College	56	1994	Community College
	Spencer	1893	MI/MR Facility	150	1989	Vacant/Possible Corrections
	Weston	1864/1985	MI/MR Facility	99	1988	Revert to MI Use
Wisconsin	Northern Wisconsin Ctr.	1897	MR Facility	173	2005	Intensive Treatment/Dental

*Four 10-bed "grouphomes" to be built on the Lincoln, Illinois site, to be named "Lincoln Estates."

Source: Braddock, Hemp, & Rizzolo, Coleman Institute and Department of Psychiatry, University of Colorado, 2005.

APPENDIX II
SUGGESTED PRELIMINARY GUIDELINES FOR INSTITUTIONAL CLOSURES

Institutional closure affects "sending" facility staff (staff at the institution that is closing), the "receiving" community staff and their agencies, and, of course, the individuals with disabilities and their families who are most affected. These guidelines were primarily adapted from closures at the Dixon and Galesburg Centers in Illinois (Braddock, Heller, & Zashin, 1983; Heller, Factor, & Braddock, 1986)

There are five sections in the Guidelines:

I. General Guidelines
II. Individuals Moving from the Institution
III. Families and Guardians
IV. Community Programs
V. Personnel of the Closing Facility

I. GENERAL GUIDELINES

1. Evaluate the Closure Systematically and Longitudinally

Develop a plan to evaluate (study) the closure of Grafton, first from the standpoints of the residents and their families but also from the standpoint of the impacted staff and the local community in which Grafton is situated. Use this evaluative information to help increase the likelihood of positive long-term impacts on consumers, employees, and communities. Announce the study at the same time the closure is announced. It should continue for at least two years after the last resident is moved to the community.

2. Seek Out Knowledge From Other States' Experiences with Institutional Closure

Many states have a great deal of experience with closing institutions for people with MR/DD. Seek out that experience if you choose to close Grafton.

II. GUIDELINES FOR INDIVIDUALS MOVING FROM THE INSTITUTION

1. Minimize Resident Transfer Trauma by Implementing an "Anticipatory Coping Strategy"

- Close Down Institutional Cottages or Units One at a Time;
- Keep Resident Groups and Friends Intact;
- Minimize Internal Transfer of Residents and Staff in the Closing Facility;

- Conduct Preparatory Programs for Consumers. This should include site visits to the new residential settings, as desired by the individuals, and in respect to any support needed based on their level of functioning; and,
- Involve Consumers Personally in Choosing Their Roommate(s) and Their New Community Home and Support Network.

2. Transfer Staff with Those Moving From the Institution

Determine whether institutional staff can be employed at community programs with individuals with developmental disabilities who know them and who are relocating to those programs.

3. Adopt a Relocation Assessment Process with an Appeal Mechanism

- Level One: Identification of an Alternative Plan

  The sending facility and state agency staff recommend a receiving program in the community for each resident based on service and support needs, preferences of the individual and/or the legally responsible persons, and availability of community resources.

- Level Two: Development of an Individual Services Plan

  A service plan is developed by the receiving program staff in collaboration with the sending facility staff. Minimizing internal transfers at the sending facility will improve the quality of information transmitted, as staff most familiar with the individuals moving would be available to provide the necessary input into the plans. The community agency staff has the final discretion in writing the plan.

- Level Three: Conference with Legally Responsible Person

  Prior to relocation, a meeting is offered at the community program with the legally responsible family member or guardian, if desired, to review with the community program staff the individual service plan. Closing facility staff may also participate in the meeting.

- Level Four: Appeal Process Available to Legally Responsible Person

  The legally responsible parent or guardian can object to the transfer plan if he or she believes it does not meet the individual's habilitation, support or medical needs. An appeal process is a necessary "relief mechanism."

III. FAMILY AND GUARDIAN GUIDELINES

1. Consultation with Closing Facility's Parents' Association

If a closure is decided upon, the state agency should promptly request permission to address the facility's parents' association. Meetings should be held, as necessary, to explain the closure process and to deal with problems that might arise during the relocation process. It is wise to acknowledge upfront to parents at both the sending facility, and to the community programs, that the relocations may temporarily disrupt routines at the institution and the community programs and in the lives of the individuals being relocated and their families. Every attempt to minimize this disruption should be made.

The state agency representative should convey to parents her or his willingness to work out solutions. It is also important for community program parents to be engaged to help provide a receptive environment for the relocated individuals and their families.

2. Involve Parents Who Have Been Through the Process

Parents involved in a successful institutional closure from a nearby state with such experience may be invited to the initial closure discussions with state agency representatives and with the closing facility parents' association. This can help reduce family anxiety and build support for the positive opportunities that a well-planned relocation can bring to their relatives.

3. Family/Guardian Notification

Individualized notification of families and guardians can serve to reduce anxiety and build support for individuals' planned relocations. Immediately upon the announcement of closure or phase-down, notification letters are sent to family members or guardians providing the following information.

- A rationale for the closure;
- The approximate time-frame;
- Anticipated positive aspects of the change;
- Types of community programs that will be available;
- Family and guardian options for alternative community programs;
- Reaffirmation of the state's commitment to serve the individual throughout relocation;
- Description of the four-level relocation assessment process--what will happen next; and,

- Name and phone number of a contact person designated by the state agency.

  Follow-up is continued through telephone contact reiterating essential information that was in the letter of notification and soliciting family or guardian participation in the individual's relocation to the community program.

4. Encourage Family Involvement

The following six steps can be employed to involve the families meaningfully in the process:

- Hold Informational Sessions at the Sending Facility

  Invite families to informational sessions at the sending (closing) facility. Representatives of the receiving community programs should also make presentations about their programs for the families.

- Open House at Community Programs

  Most community agencies operate a range of residential, day, work, and other support services. Invite families to an open-house at each receiving agency so that they have access to the appropriate information about the programs their family member is likely to be involved in.

- Parents at the Receiving Community Agencies. Contact families at the sending institution to offer assistance, inviting them for individualized or small group visits.

- Set Up a Family Buddy System at the Community Agency

  This system connects community agency families with the new families before, during and after the relocation.

- Family and Guardians Should be Present During the Actual Relocation if Desired

- The Community Agency Should Contact Families and Guardians to Inform Them When the Relocation is Scheduled and Invite Them to be Present. (The community agency parent buddy should also be present if possible.)

IV. COMMUNITY PROGRAMS RECEIVING RESIDENTS FROM THE CLOSING FACILITY

1. Develop Consistent Entry Criteria

Develop systematic criteria for accepting residents at each receiving program and communicate these clearly with sending facilities and family/guardians. Encourage pre-placement visits to the receiving programs by staff, consumers with disabilities, and families to enable them to evaluate the program's appropriateness.

2. Provide Staff Training

Prepare incumbent staff and personally orient new staff to the consumers who will be moving in. Often the persons coming from closing facilities are lower functioning, medically fragile, or have challenging behaviors. Without sufficient training, staff may lack the specific knowledge and skills to properly support some of the individuals moving.

3. Involve Receiving Programs in Planning

Once closure has been scheduled, involve receiving program representatives early in the planning process and keep them involved and well-informed.

4. Establish Mental Health Back-Up Supports

Mental health back-up supports to community residences should take the form of a troubleshooting group of trained and experienced professionals drawn from the state facility and community agencies. A "behavioral unit" at one of the community programs or at a state mental health center could function as a temporary placement until appropriate, permanent back-up programs are established in the community and/or state mental health center.

5. Develop Public Relations and Education Programs for Communities

Community providers and state agency personnel can enlist community support by attending meetings with persons and groups in the receiving communities. These meetings could be held at churches, schools, or informally with immediate neighbors, to educate and reassure.

6. Establish Relationships with Local Resources

Some new community residences may need to establish relationships with such local resources as the fire department, health providers, and public safety offices. Specific recommendations for local resources include the following topics:

- Testing, counseling and behavioral support for community mental health providers;
- Updated treatment and medication training for physicians and hospitals on topics such as challenging behavior, seizures, and motor problems;

- Dental monitoring and treatment techniques for neighborhood dentists; and,
- General orientation to developmental disabilities for firemen, police, recreation facilities.

7. Provide Financial Incentives for Community Residential Development

Community placements will be greatly facilitated by financial incentives for community programs. The Medicaid Home and Community-Based Services (HCBS) Waiver has been used successfully in most states.

8. Facilitate Development of Needed Support Services in the Community

Closure affords the opportunity for the development of necessary community services "infrastructure." For example, expanded supported living and supported employment programs for individuals moving from the institution will be needed.

V. PERSONNEL GUIDELINES

1. Plan Ahead Beginning Early in the Process

Develop a plan for future staffing patterns as individuals are relocated, conduct surveys of employee desires for transfer, and determine clear personnel policies early in the closure process. Do not promise employees what cannot be delivered.

2. Terminate One Unit at a Time and Minimize Internal Transfers

Close down one unit, wing, ward, or cottage at a time when possible and determine the schedule ahead of time, not during implementation. Closing down one component at a time keeps groups of individuals with developmental disabilities and familiar staff together, and can also result in increased administrative efficiency and cost savings.

3. Minimize Employee "Bumping"

"Bumping" (whereby staff working elsewhere in a state agency have more seniority and can replace less senior employees) should be avoided or at least minimized during the closure process. Bumping destroys program continuity in the closing facility at precisely the moment individuals being relocated need it most, with a deleterious effect on individuals who have developed interdependent relationships with staff over a long period of time.

4. Establish Employee Counseling Service

Establish an employee counseling and job placement service at the closing facility as soon as the closure is announced and becomes evident to staff. This service

would include individual counseling, workshop training, job relocation and transfer planning, job fairs, resume writing, and retirement planning.

5. Conduct Early and Continuing Briefings for Staff

Have a representative of the state agency or the state's personnel department present comprehensive briefings to facility staff when closure is announced. The briefings should announce the initiation of the employee counseling service, and fully discuss employee rights, benefits, and realistic expectations concerning layoffs, employee transfers, and retirement.

6. Develop an Open Door Policy

Develop clear lines of communication between management and all levels of staff at the closing facility.

7. Establish Liaison with Other Departments and Facilities

Establish positive working relationships with the other major employers in the closing facility's community, and in neighboring municipalities.

8. Adopt as Many Staff Incentives as Possible

Consider using one or more of the following incentives for staff in the closing facility:

- Early Retirement Inducements
- Staff Retraining

  In particular, develop staff retraining programs for community-based services employment.

- Extended Health Coverage

  Temporarily extend health insurance benefits for laid-off workers and their families throughout the first year if the workers remain unemployed.

- Adopt a Priority Interviewing Policy at Community Agencies

  Implement a priority for community agencies to interview staff from the closing facility, but give the community agency complete latitude to judge an employee's potential for working at the agency.

- Payment of Moving Expenses

Consider paying a pre-designated sum of money for moving expenses for employees transferring to MR/DD community agencies or to other MR/DD-related employment in North Dakota that is beyond 30 miles from Grafton.

9. Develop/Distribute Newsletter

Develop a periodic newsletter, perhaps monthly, and distribute it to staff at the closing facility and at the community agencies receiving individuals from the closing institution. A newsletter is useful in dispelling rumors and improving communication between the supervisory staff at the closing facility and employees affected by the closure. Rumors breed anxiety in staff and this can be transmitted to individuals who are undergoing the relocation to community agencies. The newsletters should include time tables, administrative policies including changes in policy, information about employees receiving new positions, job search information, and where to obtain counseling or other services.

10. Use a Participatory Management Approach

Involve top management and employee unions (if applicable) in the initial and ongoing planning for the closure. Make it clear to them that they cannot change the fact that closure is going to happen, but that they can and should influence and help make the decisions about the best way to carry out the closure and implement the relocation process.

6c

Submitted to Senate Approriations Committee by Tim Mathern, 3.9.09

Family HealthCare Center (FHC) is a nonprofit Federally Qualified Health Center. The program reflects a collaborative model to address identified barriers to health care access within Cass County in North Dakota, and Clay County in Minnesota. FHC offers comprehensive primary care services, including medical, dental, lab, radiology, and pharmacy services. Services are provided regardless of ability to pay. Patients can access affordable services through a sliding fee scale (SFS). FHC also operates the Homeless Health Service clinic which provides a medical home to the homeless population in the service area.

In 2008, FHC provided care to over 12,400 unique patients; a 12% increase compared to 2007. 40% of patients were eligible for the SFS, 87.2% had incomes below 200% FPG and 44% were uninsured. 37% of patients received Medicaid. 40% of patients belong to a racial or ethnic minority. Most FHC uninsured patients belong to working families.

FHC is currently in need to increase its medical, dental, pharmacy, and homeless services capacity to be able to better respond to the increase in demand for services. It is estimated that over 22,000 people in our community do not have access to health insurance and do not have a medical home. Increasing physical capacity at FHC will directly benefit the most vulnerable populations in our service area.

FHC is requesting that the State of North Dakota considers supporting our need for a bigger facility. FHC has identified a building that meets our needs for space. It is estimated that the total cost of the construction and renovation project will be $7.7 millon. FHC is requesting the State to support our project in the amount of $3 million. FHC expects to be able to raise $2 million through a capital capaign and grant writing. Research indicates that our project can be financed partially through tax credits in an amount of $2.7 million.

The State's funding will support improving the wellness of vulnerable populations by providing a medical home where patients will have access to a primary care provider who will manage all the health care needs of the patient.

Respectfully,

Patricia Patron
Executive Director
Family Health Care Center

R

Jan 27, 2009 – Testimony in support of the DHS Budget 1012 - provided to the Appropriations Human Resources Division committee of the 61st Legislative Assemble of North Dakota

From: Lynn Fundingsland, Executive Director, Fargo Housing & Redevelopment Authority

Chairman Pollert and members of the committee, thank you for the opportunity to speak today.

My remarks will be confined to that portion of the budget that deals with 24 hour staffing for the Cooper House supportive housing for the homeless project proposed to be built in Fargo this spring. This project is one of the outcomes of both Fargo's and the States' (Governor's) 10 year plans to

end homelessness. Fargo's plan calls for a supportive housing project as a part of the continuum of care for the homeless. The Governor's plan calls for 50 units per year of supportive housing in the state for the next 10 years.

Fargo's homeless population was at something over 600 persons at the last count. From our position at the housing authority we anticipate that this number will be considerable higher at the next census, I say this because in the past 3 years the number of persons on our waiting list for housing assistance has nearly doubled – we now have nearly 2,000 income qualified households on a waiting list for assistance. Most of those households we won't be able to receive housing assistance for at least a year or more. At least some of those households or individuals are at risk of and likely to experience homelessness.

The persons this project is designed to serve are the chronic homeless who are among the hardest to house and, too, are

in that group which uses the bulk of the services which are provided to the homeless population: they are regularly in and out of our social services offices, rehabilitation, detox, police custody and the local hospital emergency rooms. Providing permanent housing to this population and getting them healthy makes great economic sense as well as being the humane thing to do.

Fargo is actively responding to the homeless issue. Last year the city sponsored the construction of and is staffing a homeless shelter which will be one of the primary sources of referral for persons who can benefit from the permanent supportive housing environment that Cooper House will offer. Fargo has stepped up for Cooper House too and is acquiring the land to be used for the project, and has paid for the demolition of an existing dilapidated warehouse on the site and is contributing to construction costs. The combined cost of the acquisition, demolition and new construction support is approximately $478,000. The City

has also committed to a construction loan guarantee for a Fannie Mae loan of $2.4 million for the project and, is anticipated to grant a payment in-lieu-of property tax to the project with a value of over $1 million for a 15 year period.

These committed city resources have helped to leverage private investment of over $2.7 million through the Low Income Housing Tax Credit program, a $493,500 grant from the Federal Home Loan Bank, a $50,000 grant from the Otto Bremer Foundation and numerous local contributions from church groups and individuals and – beds for the building being built by a local high-school shop class. The Fargo Housing Authority and its non-profit housing development affiliate "Beyond Shelter Inc." are both making significant cash donations to the project to complete the financing.

As a part of the planning process for Cooper House several local housing and service providers visited existing similar facilities in operation elsewhere. The most important lesson

we came away with from those visits was that 24 hour staffing is essential and critical to the success of this type of project. We learned in our process too, that this is the most difficult piece to get funded as it isn't something that any of our traditional sources of affordable housing capital will, or can, get involved with.

The 24 hour staffing is essential for the support and care of the population to be served, is essential for the security and piece of mind for neighborhood in which the facility is located, and for the larger community. 24 hour staffing allows for a "gatekeeper" who will monitor everyone coming into and going out of the facility and helps enormously to create a calm "home" environment that is needed both for tenant and building security and, to be responsible to the larger community. Many of the homeless in Fargo have arrived from other parts of the state for various reasons; we feel this is not just a Fargo problem but is a state and national issue and trust you see that too and will support

this important piece of the DHS budget. Thank you again for the opportunity to testify.

Lynn Fundingsland

Executive Director, Fargo HRA

701-478-2552

Lynnf@fargohousing.org

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January 30, 2009

Rep. Mary Ekstrom
1450 River Road, S
Fargo ND 58103-4325

Dear Representative Ekstrom;

RE: HB 1012 – DHS Budget

On Monday January 27th the Appropriations – Human Resources Division Committee heard testimony on the DHS Budget. I was one of the individuals invited to testify and addressed that portion of the budget which provided staffing for the Cooper House supportive housing for the homeless project in Fargo. The need for the facility and the importance of having a 24 hour staff presence were addressed. That this type of response to a growing homelessness problem has been shown to be far more economical than the current system of repeated intakes to detox, emergency services etc. was addressed by presenter Michael Carbone of the homeless coalition. It was noted too, that North Dakota's 10 year plan to end homelessness calls for 50 units per year of supportive housing and, that this project is the first of it's kind in the state - which is called for in the Governor's plan. It was noted too, that this is a statewide issue and not just a Fargo issue.

Permanent housing, by definition, ends a person's homelessness. Every study that has been done on successful intervention has stated that housing is a necessary component of a person's ability to maintain stability. Most also note that it must be the first component of any sustainable strategy. Once a person (or family) has obtained decent, safe housing, they are better able to begin addressing some of the factors that ultimately contributed to their homelessness in the first place (mental health, physical health, substance abuse, personal economics).

I am writing today to further address a follow-up question to my testimony on Monday, which asked about the financing of the project.

To begin, we have a design-build contract for the project which gives us a turn-key building as designed so; the potential of a cost overrun is off the table. We have a fixed cost construction contract.

HB 1012 – DHS Budget

Total development costs for the project -		$4,136,607
Sources of Funds committed to the project:		
Low Income Housing Tax Credit Equity (WNC & Associates)	$2,780,849	
Federal Home Loan Bank (Affordable Housing Program grant)	493,500	
Otto Bremer Foundation	50,000	
Fargo Housing Authority	85,000	
City of Fargo (acquisition & demo cost incurred)	278,000	
City of Fargo HOME funds	200,000	
Beyond Shelter Inc.	200,000	
U.S. Bank grant	1,000	
Federal Continuum of Care funds	48,258	
Total Committed Sources		$4,136,607

Enclosed are commitment letters from the major funders listed. Obviously the project couldn't proceed without the private funding commitment from the LIHTC investor - WNC & Associates, Inc. The Fargo HRA and its affiliated non-profit housing developer Beyond Shelter Inc. have a very successful ongoing relationship with WNC – they have invested in three other local affordable housing projects with us in the past 4 years, with a combined capital investment of over $10,000,000 - they are a trusted partner.

In short: we are ready to proceed with this project but cannot do so without a committed revenue source which will ensure that the building will have the 24 hour staffing which is essential to this type of project, and which is a part of HB 1012.

Thank you for the consideration of this most valuable and needed project.

Sincerely,

Lynn Fundingsland
Executive Director, Fargo HRA

Encl: various commitment letters

Cc: Rep. Al Carson, Candace Fuglesten, Southeast Human Service Center

Federal Home Loan Bank of Des Moines
Skywalk Level
801 Walnut Street, Suite 200
Des Moines, IA 50309-3513
515.281.1000
800.544.3452
www.fhlbdm.com

June 27, 2008

Subject: Project Name: Cooper House
AHP Project#: 08A12
Subsidy Awarded: $493,500.00
Member Name: Wells Fargo Bank, National Association
Project Sponsor: Beyond Shelter Inc
Project Owner: Beyond Shelter, Inc.

Dear Peter:

Congratulations! FHLB Des Moines has approved your above referenced application for funding in the 2008A Round of the Affordable Housing Program (AHP) grants. The 2008A Round was very competitive. There were 82 applications for $24.1 million submitted and 25 approved for $7.3 million. For a complete listing of all the 2008A Round awarded projects, please go to our website at www.fhlbdm.com.

You will soon be receiving the appropriate agreements for signature as well as information on funding procedures. The funding for your application is subject to several conditions. As an example, there are various project-related agreements that outline compliance with the Bank's AHP guidelines as well as the rules and regulations of the Federal Housing Finance Board (FHFB). The agreements also cover on going compliance with the AHP guidelines and the projects continued feasibility.

In the next few weeks, FHLB Des Moines will distribute a press release announcing the 2008A Round AHP recipients to state and local media throughout our District. We believe recognition of your and our efforts to help meet critical housing needs is very important. As a part of our recognition efforts, we expect you to acknowledge the Bank's funding in any materials you prepare about your project. We will provide our logo for printed materials or construction signage.

Additionally, the Bank has a cooperative advertising program that can assist you with up to $150 for publicizing your project. We are also interested in attending and assisting in anyway possible with ground breaking or other events you may be planning in conjunction with your AHP project. For more information, please contact Angie Richards at 800-544-3452, ext 1014 or arichards@fhlbdm.com.

We look forward to working with you and your community co-sponsor on your AHP project. As mentioned, you will soon be receiving further documentation regarding your AHP award. In the meantime, if you have any questions, please contact Richard Bloxham at 800-544-3452, ext. 1198 or rbloxham@fhlbdm.com regarding Homeownership Projects and Stacy Snyder at ext. 1042 or ssnyder@fhlbdm.com for Rental Projects.

Sincerely,

Gary Dodge
VP, Director of Community Investment

Enclosure

cc: Project Sponsor
Project Owner

WNC & ASSOCIATES, INC.

October 31, 2008

Ms. Lisa Rotvold
Beyond Shelter, Inc.
325 Broadway
Fargo, ND 58107

Re: Cooper House Apartments
Fargo, North Dakota

Dear Ms. Rotvold:

Thank you for giving us the opportunity to present this offer to provide equity financing for Cooper House Apartments. WNC & Associates, Inc. has been investing in affordable housing for over 37 consecutive years and has capital to invest in quality tax credit properties. We have acquired over 3.3 billion dollars of real estate assets representing more than 1000 properties nationwide.

This Letter of Understanding is designed to address the basic business terms under which WNC, on behalf of an affiliate (the "Investment Partnership") and WNC Housing, L.P., as the special limited partner (the "SLP"), will acquire limited partnership interests in Cooper House Limited Partnership (the "Project Partnership") which owns Cooper House Apartments. Based on the terms specified below, the Investment Partnership and the SLP agree to make a capital contribution payment to the Project Partnership in the amount of $2,780,849 ("Capital Contribution") (includes the SLP's Capital Contribution) based on a price of $0.74 for each dollar of Tax Credits allocated to the Investment Partnership over the Tax Credit Period. The Capital Contribution will be payable in installments based upon the schedule and conditions set forth below:

1. $139,137 will be payable upon the Investment Partnership's admittance into the Partnership.

2. $2,363,637 will be payable upon the Investment Partnership's receipt and approval of the following: (a) documents substantiating lien free construction completion; (b) the issuance of a permanent certificate of occupancy; (c) payoff letter from the contractor; and (d) insurance required during operations.

3. $253,075 will be payable upon the later of the Investment Partnership's receipt and approval of the following: (a) verification that all the conditions referenced above have been met; (b) fully signed permanent mortgage documents; (c) verification the Project Partnership has maintained a debt service coverage of 1.15 for 90 consecutive days; (d) an updated title insurance policy; (e) 90% tax credit qualified occupancy and 90% actual occupancy for 90 consecutive days; (f) construction cost certification; (g) an as-built survey; (h) tenant files to determine that 100% of the tax credit apartment units in the Apartment Complex qualify under Section 42 of the Internal Revenue Code; (i) a fully executed IRS Form 8609; (j) the first year tax return in which Tax Credits are taken; and (k) a copy of the Project Partnership's property audited financial statement, or October 10, 2010.

4. $25,000 will be payable upon the SLP receipt and approval of initial tenant files.

would be of benefit to the Project Partnership or the Apartment Complex. If such Voluntary Funding is provided in the form of a loan, the terms of such loan shall be mutually satisfactory to the General Partner and the Investment Partnership and shall be evidenced by a written agreement.

G. DUE DILIGENCE REVIEW

1. Commencing upon the receipt in our offices of this executed Letter of Understanding and terminating 45 days after the date WNC has received the Project Documents listed in The Due Diligence and Document Checklist of Exhibit A ("Document Review Term"), WNC shall have the exclusive right to acquire the interests in the Project Partnership. Accordingly, by executing this Letter of Understanding, you agree on your own behalf and on behalf of any persons associated with or employed by you or the Project Partnership, not to disclose any of the terms or provisions in this letter to any other person or entity other than to those with the state tax credit agency.

2. The acquisition of the limited partnership interests in the Project Partnership is subject to the satisfactory review and approval of the Project Documents and is based on the Investment Partnership's admittance into the Partnership in a 90 day period from the execution date of this letter. If such admittance does not occur within this time frame, the Capital Contributions set forth in this Letter of Understanding may be recalculated based on the market conditions at the time of admittance.

Again, thank you for considering WNC as your equity partner for Cooper House Apartments. If this Letter of Understanding meets with your approval, please execute and return via fax or e-mail.

Very truly yours,

Darrick Metz
Managing Director - Central States
Senior Vice President - Originations

DDM

ACCEPTED BY:
Beyond Shelter, Inc.

By: _____

Date: 11.3.08

Enclosures: Exhibit A - Documentation Required/TBD

Phone: (701) 478 2560
Fax: (701) 478 2626
E-Mail: lroivold@beyondshelterinc.com
originalsword\
DDM0109.3558

CITY OF Fargo

PLANNING AND DEVELOPMENT
200 Third Street North
Fargo, North Dakota 58102
Phone: (701) 241-1474
Fax: (701) 241-1526
E-Mail: planning@cityoffargo.com
www.cityoffargo.com

May 28, 2008

Lisa Rotvold
Housing Development Coordinator
Beyond Shelter, Inc
325 Broadway
Fargo, ND 58102

Dear Lisa,

I am writing to let you know that the City of Fargo can assist with $200,000 construction financing for property located at 414 11th Street North, Fargo, to be used for the Cooper House apartments.

This amount includes $100,000 that has already been allocated to the Fargo Housing and Redevelopment Authority for the project. The remaining balance of $100,000 will be allocated from the City's 2009 HOME allocation, contingent on approval from the Fargo City Commission.

Thanks again for your good work on this project. If you have questions or would like more information, please contact me at 476-4144 or dmahli@cityoffargo.com.

Sincerely,

Dan Mahli
Senior Planner, Community Development

Fargo-Moorhead All-America City 2008

Update on Central Office Addition Project
The roof is installed but still needs to be sealed around the edges. The building has experienced more leaks due to the heavy rains. The offices upstairs are sheet rocked and taped. Construction is on schedule and the front lobby renovation will begin next month.

Progress Report on Cooper House
Demolition of the house located at 1111 4th Avenue North is to be completed by June 11th. The grant application for the cultural market will be submitted next week by the consultants. Due to an error of the legal description for the property located at 414 11th Street North; Mr. Fundingsland asks that the Board amend the option to purchase agreement to reduce the dimension by five (5) feet on the north/south axis.

M/S/P	Leier/Jefferson	To amend the option to purchase agreement to reduce the dimension by five (5) feet on the north/south axis of the property located at 414 11th Street North.

A Sources and Uses form on Cooper House was included in the Board packet by Ms. Rotvold. Mr. Fundingsland informed the Board that on June 19th Beyond Shelter, Inc. will be notified if they are awarded the $493,500 AHP grant. Otto Bremer has scheduled a visit within the next week to review the project and discuss the projects' request for a $200,000 grant. There is currently a $262,368 gap in funding which may be partially obtained in donations from the City of Fargo, a fundraising drive for the furnishings, and by possibly reducing the building cost. A McKinney grant has been submitted which would cover $150,000 a year in operations.

Beyond Shelter, Inc. is seeking a letter of commitment from the FHRA for a soft loan in the amount of $85,000 for construction of Cooper House. BSI needs to have a letter of commitment for all funding sources by October in order to secure the tax credits.

M/S/P	Jefferson/Hanson	To authorize a letter of commitment to Beyond Shelter, Inc. for a soft loan in the amount of $85,000 for construction of Cooper House.

NEW BUSINESS
Report on PHADA Conference
Mr. Fundingsland gave a brief report of his attendance at the conference where he visited with the Chicago Special Applications Center (SAC). The SAC reviews, processes, and approves non-funded, non-competitive applications related to demolition/disposition of public housing. He also attended a workshop held on voluntary conversion from public housing to vouchers. Mr. Fundingsland stated that the FHRA will need to hire a consultant to assist in evaluating which route would be better financially for the public housing properties.

Term Life Insurance Offer
The FHRA's property insurance group is offering a $5,000 no-cost life insurance benefit to all full-time staff members and Board Commissioners.

OTTO BREMER FOUNDATION
Suite 2250, 445 Minnesota Street, St. Paul, MN 55101-2107 (651) 227-8036 (888) 291-1123 Fax (651) 312-3665 email: obf@ottobremer.org

July 28, 2008

Lynn Fundingsland
Beyond Shelter, Inc.
325 Broadway
Fargo, ND 58102

Dear Ms. ~~Fundingsland~~ Lynn:

At the most recent meeting of the Trustees of the Otto Bremer Foundation, consideration was given to the request from Beyond Shelter, Inc. for funding for Cooper House, a supportive housing project for homeless individuals. This is to advise that the Trustees have approved a grant in the amount of $50,000 to be used toward this project.

The Trustees request that the accompanying Donee Agreement be signed by the appropriate administrative officer indicating acceptance of the grant and the conditions stipulated therein. Please retain one copy for your file and return one to our office. Upon timely receipt of signed donee agreement, grant payment will be scheduled within several weeks.

Regarding publicity, the Foundation will issue a press release to several media contacts announcing all authorized grants, shortly after the completion of a grants round. To leverage local coverage, you may want to issue a press release yourself or host a press event. If you need assistance with this, please feel free to contact me.

Both Trustees and staff of the Foundation are pleased that the Foundation can participate in the support of this program.

Sincerely,

OTTO BREMER FOUNDATION

Lue Her
Program Officer

LH/dc

Ekstrom, Mary O.

From: Weisz, Brenda M.
Sent: Wednesday, February 04, 2009 1:12 PM
To: Woeste, Roxanne K.
Subject: if interested the amount for Staffing of 24/7 contracted position at cooperhouse

	Total	General	Federal / Other	FTE
Contracted Program Assistant 24/7 at Cooperhouse	315,360	236,520	78,840	

Brenda M. Weisz, CFO
Fiscal Administration
ND Department of Human Services
701.328.2397

Please Note: Change in email address: bweisz@nd.gov

Appropriations Committee HB 1012

Chairman Pollert, committee members, thank you for the opportunity to testify in support of HB 1012.

My name is Michael Carbone and I am the Executive Director of the North Dakota Coalition for Homeless People. We are a state-wide group of service providers who work to mitigate the devastating effects of homelessness on individuals and families in North Dakota. Our members include local homeless coalitions, homeless shelters, housing providers, supportive service providers, and entities of government including law enforcement and planning departments.

I would like to discuss the cost of benign neglect—the cost of the status quo when it comes to supportive services for the homeless. Currently we are combating a chronic problem, homelessness, primarily through emergency services. This is both expensive and ineffective.

There is a story of a man nicknamed "Million Dollar Murray" who was a subject of a Reno Nevada study that was reported in the *New Yorker* magazine. After tracking the cost of emergency services used by "Murray" over a year's time, it was determined that Murray used a million dollars in services and was still homeless.

While Murray is an outlier, studies in Portland Oregon and in New York City have shown that people who are long-term homeless use an average of over $42,000 and $40,000 in emergency services per year respectively. These services include emergency shelter, emergency rooms, detox, incarceration and outpatient care. In contrast, long-term homeless people who were placed into housing with supportive services used less than $26,000 per year including the cost of housing. This represents a savings of $16,000 per unit of supportive housing.

A similar study is being conducted in the Fargo-Moorhead area by the FM Coalition for Homeless Persons, Centre, Inc. and Dr. Mark Hansel of MSUM. While the study is not ready for publication, preliminary results indicate similar findings.

A HUD study published in 2006 shows that chronically homeless people placed in housing first programs with supportive services have an 86% tenure rate after one year. Some of these people had been homeless for a decade or more.

It is clear that placing long-term homeless people into housing with supportive services is less expensive than providing them with an endless stream of emergency services. This option also frees up emergency services for those who are experiencing episodic homelessness—people who are most often able to recover through the use of emergency services alone.

While providing housing with supportive services represents significant cost savings, it also provides the long-term homeless with greater opportunities for recovery. They no longer receive mental health and chemical dependency services intermittently as they do when on the street. Instead, their treatment has continuity and is more effective. Housing with supportive services enables them to develop a sense of security, stability and community. Many eventually become employed, contributing to society.

North Dakota's 10-Year Plan to End Long-Term Homelessness developed by the North Dakota Interagency Council on Homelessness recognizes this type of supportive housing as an effective means of solving this finite problem. The 10-Year Plans developed by many of the state's major communities also call for such supportive housing opportunities.

Clearly, providing housing together with supportive services for the hardest to house is both the smart thing to do, and the right thing to do. The North Dakota Coalition for Homeless Persons strongly urges passage of HB 1012.

March 4, 2009 – Testimony in support of the DHA Budget HB 1012 – provided to the Senate Appropriations committee of the 61st Legislative Assembly of North Dakota

From: Lynn Fundingsland, Executive Director, Fargo Housing and Redevelopment Authority

Chairman Holmberg and members of the committee, thank you for the opportunity to speak today.

My remarks will be confined to that portion of the budget that deals with 24-hour staffing for the Cooper House supportive housing for the homeless project proposed to be built in Fargo this spring. This project is one of the outcomes of both Fargo's and the States' (Governor's) 10-year plans to end homelessness. Fargo's plan calls for a supportive housing project as a part of the continuum of care for the homeless. The Governor's plan concurs with that need.

Fargo's homeless population was a something over 600 persons at the last count. From our position at the Housing Authority we anticipate that this number will be considerably higher at the next census, I say this because in the past 3 years the number of persons on our waiting list for housing assistance has nearly doubled – we now have nearly 2,000 income qualified households on a waiting list for

assistance. Most of those households won't be able to receive housing assistance for at least a year or more. At least some of those households or individuals are at risk of and likely to experience homelessness.

The persons this project is designed to serve are the chronic homeless who are among the hardest to house and, too, are in that group which uses the bulk of the services which are provided to the homeless population: they are regularly in and out of our social services offices, rehabilitation, detox, police custody and the local hospital emergency rooms. It is a very expensive proposition to provide service to this population as we do now. Providing permanent housing to this population and getting them healthy makes great economic sense as well as being the humane thing to do.

Fargo is actively responding to the homeless issue. Last year the City sponsored the construction of and is staffing a homeless shelter which will be one of the primary sources of referral for persons who can benefit from the permanent supportive housing environment that Cooper House will offer. Fargo has stepped up for Cooper House too and is acquiring the land to be used for the project, and has paid for the demolition of an existing dilapidated warehouse on the site and is contributing to construction costs. The combined cost of the acquisition, demolition and new construction support is approximately $478,000. The City has also committed to a construction loan guarantee for a Fannie Mae loan of $2.4

million for the project and, is anticipated to grant a payment in-lieu-of property tax to the project with a value of over $1 million for a 15 year period.

These committed City resources have helped to leverage private investment of over $2.7 million through the Low Income Housing Tax Credit program, a $493,500 grant from the Federal Home Loan Bank, a $50,000 grant from the Otto Bremer Foundation and numerous local contributions from church groups and individuals and beds for the building being built by a local high school shop class. The Fargo Housing Authority and its non-profit housing development affiliate "Beyond Shelter, Inc." are both making significant cash donations to the project to complete the financing.

As a part of the planning process for Cooper House several local housing and service providers visited existing similar facilities in operation elsewhere. The most important lesson we came away with from those visits was the 24-hour staffing is essential and critical to the success of this type of project. We learned in our process too, that this is the most difficult piece to get funded as it isn't something that any of our traditional sources of affordable housing capital will, or can, get involved with.

The 24-hour staffing is essential for the support and care of the population to be served, is essential for the security and peace of mind for the neighborhood in

which the facility is located, and for the larger community. 24-hour staffing allows for a "gatekeeper" who will monitor everyone coming into and going out of the facility and helps enormously to create a calm "home" environment that is needed both for tenant and building security and, again, to be responsible to the larger community. Many of the homeless in Fargo have arrived from other parts of the state for various reasons; often we hear they come because they heard there was work. We feel this is not just a Fargo problem but is a state and national issue and trust you see that too and will support this important piece of the DHS budget. Thank you again for the opportunity to testify.

Lynn Fundingsland

Executive Director, Fargo HRA

701-478-2552

lynnf@fargohousing.org

Testimony on HB 1012
Senate Appropriations Committee
Chairman Ray Holmberg
March 9, 2009

Submitted by: Cass County's Jail Intervention Coordinating Committee

Chairman Holmberg and members of the Committee, thank you for the opportunity to speak on behalf of Cass County's Jail Intervention Coordinating Committee (JICC). My name is Sheree Spear, grant manager for the Program developed by this committee: the Cass County Justice & Mental Health Collaboration Project which was awarded a Department of Justice grant, and is managed by the Cass County Sheriff's Office. (A list of members and advisors is attached for you.) First, we want to thank you and the other legislators who made 8 additional crisis beds in our region possible last session. That was a great investment; those beds are never empty. They provide a safe place for people to stabilize when they don't need the full range of care provided by an in-patient hospital stay.

Our Committee is respectfully asking today that you re-instate funding for the Cooper Apartments project which was cut on the House side. This project rolls up into state objectives including: finding alternatives to incarceration, and the State's 10 year plan to end homelessness. Often, finding the most effective solutions to those issues occurs when people from a variety of disciplines come together at a community level to identify gaps and extensively research options. That happened with the Cooper Project, which, with your support, will provide stable supportive housing to 42 individuals. The target population are individuals who will continue to frequent the emergency room – at a high cost to the state, and will continue to frequent the County Jail without the Cooper Apartment Project.

Lynn Fundingsland, Director of the Fargo Housing Authority, is a master at building funding packages utilizing federal funds and private investors. When he retires in a few years he will leave a legacy of finding innovate ways to not only address the needs of under-served persons, but also of re-vitalizing the downtown and other areas in the community. Not only has he applied his skills to bring together the funding for the Cooper facility to address the concerns of the police department, human services, the local hospitals and others who regularly interact with the target population. He has also researched and visited models that are working in other states. This project is as solid as it gets, and we believe that the Senate can feel very confident endorsing it. The piece that we need your help with is the staffing, which I believe Lynn and the Department of Human Services has outlined.

Second, we ask for your support in addressing the shortage of psychiatric beds in the state, and the need for access to medical care by indigent persons. Two items in DHS's original budget spoke to those: re-basing and increasing funds for local hospitals when they provide care, and the FTE's that would allow the State Hospital to operate at full capacity. We see people who need hospitalization and cannot access it. Too often beds are full or, hospitals are not willing to admit people or keep them for an appropriate amount of time.

The National Association of State Mental Health Program Directors (NASMHPD) published a report in 2006 entitled "The Crisis in Acute Psychiatric Care." It notes the collateral effects that the dramatic decrease in hospital level psychiatric beds is having on hospital emergency departments and on the increased number of mentally ill individuals in the nation's jails and prisons. The report summarizes steps taken by

some states to increase in-patient capacity, including modestly increasing state hospital bed capacity, expanding contracts with private and community hospitals, and developing residential and non-hospital crisis services for pre- and post-hospital services. While some of us believe the original budget put forward by the N.D. Dept. of Human Services may not have gone far enough, we ask that you support funding those items the Department did included that move us toward closing this gap.

Finally, we would like you to be aware that there is a waiting list of very ill individuals who are in need of case management services. Our case managers are carrying case loads that are nearly double what best practices recommends, leaving them often only time to "put out fires" as they are spread so thin. Intensive Case Management, where there is a ratio of 10 clients per 1 case manager, is an Evidence-Based Practice – shown to play a role in recovery and reduced recidivism. But Intensive Case Management services are not available in our state.

Thank you very much Chairman Holmberg and members of the Committee, we appreciate your time today and your willingness to take time out of your lives to come here each session and serve the people of North Dakota.

Cass County

Development & Oversight

Jail Intervention Coordinating Committee

Cass County Commission	Commissioner Scott Wagner; *former members:* Commissioners Vern Bennett and Darryl Vanyo
Cass County Sheriff's Office	Lt. Colonel Glenn Ellingsberg, Capt. Carlos Perez, Mary Geller, Lynette Tastad
Centre, Inc.	Keith Gilleshammer
Dacotah Foundation	Patty McKenzie
Dept. of Corrections, Adult Services Div.	Richard Hoekstra
DOCR, Parole & Probation	Dan Seymour
Dept. Human Services, SE Human Service Center	Jeff Stenseth, Beth Gravalin, Candace Fuglesten
Fargo Cass Public Health	Heidi McLean
Fargo City Planning	Dan Mahli
Fargo Housing Authority	Lynn Fundingsland, Jill Elliott
Fargo Police Department	Officer Scott Stenerson
Mental Health America, N.D.	Susan Helgeland
Nat'l Alliance on Mental Illness, N.D.	Sheree Spear
N.D. State University	Dr. Thomas McDonald
The Prairie St. John's	State Senator Tim Mathern, Dawn Hoffner
West Fargo Police Department	Asst. Chief Michael Reitan

Advisory Board

The Honorable Steven McCullough. *East Central Judicial District Court*

States Attorney Birch Burdick. *Cass County*

Dr. Andrew McLean. *Medical Director, Southeast Human Service Ctr. & N.D. State Hospital, N. D. Dept. of Human Services*

Attorney Douglas Nesheim. *Public Defender*

Capt. Carlos Perez. *Administrator, Cass County Jail*

Richard Hoekstra. *Deputy Director of Programs, Adult Services Div., N. D. Dept. of Corrections*

Keith Gilleshammer. *Executive Director, Centre, Inc.*