19.0401.08000

FISCAL NOTE

Requested by Legislative Council
04/23/2019

Amendment to: Engrossed HB 1194

1 A. **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.*

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			$2,954,445	$11,817,781	$3,412,930	$13,651,718
Expenditures			$(7,386,113)	$11,817,781	$(8,532,324)	$13,651,718
Appropriations						

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1194 creates a tribal health care coordination fund and 60% of the general fund savings from care coordination would be deposited into the fund.

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.*

HB 1194 section 1 requires the Department to facilitate tribal care coordination agreements. This will generate general fund savings due to federal policy that allows 100% federal financing for services rendered to Medicaid-eligible Indian Health Services/Tribal 638 beneficiaries under a care coordination agreement. These savings are to be tracked by the Department, 60% of the savings is to be deposited in the Tribal Health Care Coordination Fund and are to be used by the tribes for health-related purposes. The remaining 40% shall be returned to the state general fund. For the 2019-2021 biennium, the total savings are projected to be $7,386,113, of which $4,431,668 will go to the Tribal Health Care Coordination Fund and $2,954,445 will go to the general fund.

The projected impact for the 2021 – 2023 biennium is $8,532,324, of which $5,119,394 will go to the Tribal Health Care Coordination Fund and $3,412,930 will go to the general fund.

With the emergency clause the department does not expect a significant impact for the 17 – 19 biennium.

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 services provided under Section 1 of HB 1194 under a care coordination agreement are eligible for 100% federal financing.
The State will recognize revenue from the deposit of the savings amount from Tribal Care Coordination agreements that are to be split 60/40 between the Tribal Health Care Coordination Fund and the General Fund.

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.*

HB 1194 section 1 requires the Department to facilitate tribal care coordination agreements. This will generate general fund savings due to federal policy that allows 100% federal financing for services rendered to Medicaid-eligible Indian Health Services/Tribal 638 beneficiaries under a care coordination agreement. These savings are to be tracked by the Department, 60% of the savings is to be deposited in the Tribal Health Care Coordination Fund and are to be used by the tribes for health-related purposes. The remaining 40% shall be returned to the state general fund. For the 2019-2021 biennium, the total savings are projected to be $7,386,113, of which $4,431,668 will go to the Tribal Health Care Coordination Fund and $2,954,445 will go to the general fund.

The projected impact for the 2021 – 2023 biennium is $8,532,324, of which $5,119,394 will go to the Tribal Health Care Coordination Fund and $3,412,930 will go to the general fund.

With the emergency clause the department does not expect a significant impact for the 17 – 19 biennium.

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 or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

Section 1 contains continuing appropriation authority to disperse funds from the Tribal Health Care Coordination Fund, the Department will need an additional $7,386,113 of federal authority for services rendered under a care coordination agreement that are eligible for 100% federal financing in the 19 – 21 biennium.

For the 21 – 23 biennium the Department will need an additional $8,532,324 of federal authority for services rendered under a care coordination agreement that are eligible for 100% federal financing.

With the emergency clause the department does not expect a significant impact for the 17 – 19 biennium.

Name: Rhonda Obrigewitch

Agency: Human Services

Telephone: 328-4585

Date Prepared: 04/23/2019

19.0401.07000

FISCAL NOTE

Requested by Legislative Council
03/07/2019

Amendment to: HB 1194

1 A. **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.*

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			$2,215,834	$12,556,392	$2,559,697	$14,504,951
Expenditures			$(7,386,113)	$12,556,392	$(8,532,324)	$14,504,951
Appropriations						

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1194 creates a tribal health care coordination fund and 70% of the general fund savings from care coordination would be deposited into the fund.

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.*

HB 1194 section 1 requires the Department to facilitate tribal care coordination agreements. This will generate general fund savings due to federal policy that allows 100% federal financing for services rendered to Medicaid-eligible Indian Health Services/Tribal 638 beneficiaries under a care coordination agreement. These savings are to be tracked by the Department, 70% of the savings is to be deposited in the Tribal Health Care Coordination Fund and are to be used by the tribes for health-related purposes. The remaining 30% shall be returned to the state general fund. For the 2019-2021 biennium, the total savings are projected to be $7,386,113, of which $5,170,279 will go to the Tribal Health Care Coordination Fund and $2,215,834 will go to the general fund.

The projected impact for the 2021 – 2023 biennium is $8,532,324, of which $5,972,627 will go to the Tribal Health Care Coordination Fund and $2,559,697 will go to the general fund.

With the emergency clause the department does not expect a significant impact for the 17 – 19 biennium.

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 services provided under Section 1 of HB 1194 under a care coordination agreement are eligible for 100% federal financing.
The State will recognize revenue from the deposit of the savings amount from Tribal Care Coordination agreements that are to be split 70/30 between the Tribal Health Care Coordination Fund and the General Fund.

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.*

HB 1194 section 1 requires the Department to facilitate tribal care coordination agreements. This will generate general fund savings due to federal policy that allows 100% federal financing for services rendered to Medicaid-eligible Indian Health Services/Tribal 638 beneficiaries under a care coordination agreement. These savings are to be tracked by the Department, 70% of the savings is to be deposited in the Tribal Health Care Coordination Fund and are to be used by the tribes for health-related purposes. The remaining 30% shall be returned to the state general fund. For the 2019-2021 biennium, the total savings are projected to be $7,386,113, of which $5,170,279 will go to the Tribal Health Care Coordination Fund and $2,215,834 will go to the general fund.

The projected impact for the 2021 – 2023 biennium is $8,532,324, of which $5,972,627 will go to the Tribal Health Care Coordination Fund and $2,559,697 will go to the general fund.

With the emergency clause the department does not expect a significant impact for the 17 – 19 biennium.

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 or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

Section 1 contains continuing appropriation authority to disperse funds from the Tribal Health Care Coordination Fund, the Department will need an additional $7,386,113 of federal authority for services rendered under a care coordination agreement that are eligible for 100% federal financing in the 19 – 21 biennium.

For the 21 – 23 biennium the Department will need an additional $8,532,324 of federal authority for services rendered under a care coordination agreement that are eligible for 100% federal financing.

With the emergency clause the department does not expect a significant impact for the 17 – 19 biennium.

Name: Rhonda Obrigewitch

Agency: Human Services

Telephone: 328-4585

Date Prepared: 03/11/2019

19.0401.06000

FISCAL NOTE

Requested by Legislative Council
02/19/2019

Amendment to: HB 1194

1 A. **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.*

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			$3,693,056	$11,079,170	$4,266,162	$12,798,486
Expenditures			$(7,386,113)	$11,079,170	$(8,532,324)	$12,798,486
Appropriations						

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1194 creates a tribal health care coordination fund where general fund savings from care coordination would be deposited. Section 2 proposes to divide the savings between tribal nations and the general fund.

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.*

HB 1194 section 1 reflects the Executive Budget Request (EBR), which includes Medicaid expansion in house at Traditional Medicaid rates, and if the assembly decides to operate Medicaid expansion as managed care and at "commercial" rates, the department projects needing an additional appropriation of $187,277,780, of which $22,345,603 are general fund. The estimated cost assumes an average monthly Medicaid expansion enrollment of 20,739 individuals.

Section 2 requires the Department to facilitate tribal care coordination agreements. This will generate general funds savings due to federal policy that allows 100% federal financing for services rendered to Medicaid-eligible Indian Health Services/Tribal 638 beneficiaries under a care coordination agreement. These savings are to be tracked by the Department, 50% of the savings is to be deposited in the Tribal Health Care Coordination Fund and are to be used by the tribes for health-related purposes. The remaining 50% shall be returned to the state general fund. The total savings are projected to be $7,386,113, of which $3,693,057 will go to the Tribal Health Care Coordination Fund and $3,693,057 will go to the general fund.

The projected impact for the 2021 – 2023 biennium is $8,532,324, of which $4,266,162 will go to the Tribal Health Care Coordination Fund and $4,266,162 will go to the general fund.

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 services provided under Section 2 of HB 1194 under a care coordination agreement are eligible for 100% federal financing.

The State will recognize revenue from the deposit of the savings amount from Tribal Care Coordination agreements that are to be split 50/50 between the Tribal Health Care Coordination Fund and the General Fund.

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.*

HB 1194 section 1 reflects the Executive Budget Request (EBR), which includes Medicaid expansion in house at Traditional Medicaid rates, and if the assembly decides to operate Medicaid expansion as managed care and at "commercial" rates, the department projects needing an additional appropriation of $187,277,780, of which $22,345,603 are general fund. The estimated cost assumes an average monthly Medicaid expansion enrollment of 20,739 individuals.

Section 2 requires the Department to facilitate tribal care coordination agreements. This will generate general funds savings due to federal policy that allows 100% federal financing for services rendered to Medicaid-eligible Indian Health Services/Tribal 638 beneficiaries under a care coordination agreement. These savings are to be tracked by the Department, 50% of the savings is to be deposited in the Tribal Health Care Coordination Fund and are to be used by the tribes for health-related purposes. The remaining 50% shall be returned to the state general fund. The total savings are projected to be $7,386,113, of which $3,693,057 will go to the Tribal Health Care Coordination Fund and $3,693,057 will go to the general fund.

The projected impact for the 2021 – 2023 biennium is $8,532,324, of which $4,266,162 will go to the Tribal Health Care Coordination Fund and $4,266,162 will go to the general fund.

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 or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

Section 1 for the 19-21 biennium agrees with the Executive Budget Request (EBR) and is presented in alignment with the EBR accordingly.

Section 2 contains continuing appropriation authority to disperse funds from the Tribal Health Care Coordination Fund, the Department will need an additional $7,386,113 of federal authority for services rendered under a care coordination agreement that are eligible for 100% federal financing in the 19 – 21 biennium.

For the 21 – 23 biennium the Department will need an additional $8,532,324 of federal authority for services rendered under a care coordination agreement that are eligible for 100% federal financing.

Name: Rhonda Obrigewitch

Agency: Human Services

Telephone: 328-4585

Date Prepared: 02/20/2019

19.0401.05000

FISCAL NOTE

Requested by Legislative Council
02/08/2019

Amendment to: HB 1194

1 A. **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.*

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			$3,693,056	$580,641,381	$4,266,162	$616,844,444
Expenditures			$63,701,054	$580,641,381	$71,214,796	$616,844,444
Appropriations			$63,701,054	$580,641,381	$71,214,796	$616,844,444

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1194 removes the sunset clause for Medicaid Expansion and retains commercial rates, creates a tribal health care coordination fund where general fund savings from care coordination would be deposited. Section 2 also proposes to divide the savings between tribal nations and the general fund.

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.*

HB 1194 Section 1 removes the July 31, 2019 sunset provision for the Medicaid Expansion program. The projected costs of the Medicaid Expansion program to continue as a Managed Care Organization at the commercial fee schedule is $640,649,378, of which $71,087,167 are general fund. The estimated cost assumes an average monthly premium for 20,739 individuals.
The projected impact for the 2021 – 2023 biennium is $683,793,078, of which $79,747,120 are general fund. This estimate includes adjustments for cost and Federal Medical Assistance Percentage (FMAP).

Section 2 requires the Department to facilitate tribal care coordination agreements. This will generate general funds savings due to federal policy that allows 100% federal financing for services rendered to Medicaid-eligible Indian Health Services/Tribal 638 beneficiaries under a care coordination agreement. These savings are to be tracked by the Department, 50% of the balance is to be deposited in the state treasury fund Tribal Health Care Coordination Fund and are to be used by the tribes for health-related purposes. The remaining 50% shall be returned to the state general fund. These total savings are projected to be $7,386,113, of which $3,693,057 will go to the Tribal Health Care Coordination Fund and $3,693,057 will go to the general fund.

The projected impact for the 2021 – 2023 biennium is $8,532,324, of which $4,266,162 will go to the Tribal Health Care Coordination Fund and $4,266,162 will go to the general fund.

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 services provided under Section 1 of HB 1194 are eligible to receive matching federal funds based off the Federal Medical Assistance Percentage (FMAP) for Medicaid Expansion as authorized in the 2010 Affordable Care Act. Services provided under Section 2 and under a care coordination agreement are eligible for 100% federal financing.
   The State will also recognize revenue from the deposit of the savings amount from Tribal Care Coordination agreements that are to be split 50/50 between the Tribal Health Care Coordination Fund and the General Fund.

   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.*

   HB 1194 Section 1 removes the July 31, 2019 sunset provision for the Medicaid Expansion program. The projected costs of the Medicaid Expansion program to continue as a Managed Care Organization at the commercial fee schedule is $640,649,378, of which $71,087,167 are general fund. The estimated cost assumes an average monthly premium for 20,739 individuals.
   The projected impact for the 2021 – 2023 biennium is $683,793,078, of which $79,747,120 are general fund. This estimate includes adjustments for cost and Federal Medical Assistance Percentage (FMAP).

   Section 2 requires the Department to facilitate tribal care coordination agreements. This will generate general funds savings due to federal policy that allows 100% federal financing for services rendered to Medicaid-eligible Indian Health Services/Tribal 638 beneficiaries under a care coordination agreement. These savings are to be tracked by the Department, 50% of the balance is to be deposited in the state treasury fund Tribal Health Care Coordination Fund and are to be used by the tribes for health-related purposes. The remaining 50% shall be returned to the state general fund. These total savings are projected to be $7,389,113, of which $3,693,057 will go to the Tribal Health Care Coordination Fund and $3,693,057 will go to the general fund.

   The projected impact for the 2021 – 2023 biennium is $8,532,324, of which $4,266,162 will go to the Tribal Health Care Coordination Fund and $4,266,162 will go to the general fund.

   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 or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

   Section 1 for the 19-21 biennium the Department of Human Services would need an appropriation increase, of $233,397,000, of which $37,978,000 would be general fund, to the base level budget in SB 2012. The base level budget in SB 2012 already includes appropriation of $407,252,458, of which $33,109,610 are general fund for this program.

   For the 21-23 biennium the Department of Human Services would need appropriation authority of $683,793,078, of which $79,747,120 would be general fund. This is an increase from the 2019 – 2021 budget estimate of $43,143,700, of which $8,659,953 is general fund.

   Section 2 contains continuing appropriation authority to disperse funds from the Tribal Health Care Coordination Fund, the Department will need an additional $7,386,113 of federal authority for services rendered under a care coordination agreement that are eligible for 100% federal financing in the 19 – 21 biennium.

   For the 21 – 23 biennium the Department will need an additional $8,532,324 of federal funds appropriation authority for services rendered under a care coordination agreement that are eligible for 100% federal financing.

Name: Rhonda Obrigewitch

Agency: Human Services

Telephone: 328-4585

Date Prepared: 02/10/2019

19.0401.04000

FISCAL NOTE

Requested by Legislative Council
01/08/2019

Revised
Bill/Resolution No.: HB 1194

1 A. **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.*

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			$2,215,834	$582,118,603	$2,559,697	$618,550,909
Expenditures			$63,701,054	$582,118,603	$71,214,796	$618,550,909
Appropriations			$63,701,054	$582,118,603	$71,214,796	$618,550,909

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1194 removes the sunset clause for Medicaid Expansion and retains commercial rates, creates a tribal health care coordination fund where general fund savings from care coordination would be deposited. Section 2 also proposes to divide the savings between tribal nations and the general fund.

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.*

HB 1194 Section 1 removes the July 31, 2019 sunset provision for the Medicaid Expansion program. The projected costs of the Medicaid Expansion program to continue as a Managed Care Organization at the commercial fee schedule is $640,649,378, of which $71,087,167 are general fund. The estimated cost assumes an average monthly premium for 20,739 individuals.
The projected impact for the 2021 – 2023 biennium is $683,793,078, of which $79,747,120 are general fund. This estimate includes adjustments for cost and Federal Medical Assistance Percentage (FMAP).

Section 2 requires the Department to facilitate tribal care coordination agreements. This will generate general funds savings due to federal policy that allows 100% federal financing for services rendered to Medicaid-eligible Indian Health Services/Tribal 638 beneficiaries under a care coordination agreement. These savings are to be tracked by the Department, 70% of the balance is to be deposited in the state treasury fund Tribal Health Care Coordination Fund and are to be used by the tribes for health-related purposes. The remaining 30% shall be returned to the state general fund. These total savings are projected to be $7,389,113, of which $5,170,279 will go to the Tribal Health Care Coordination Fund and $2,215,834 will go to the general fund.

The projected impact for the 2021 – 2023 biennium is $8,532,324, of which $5,972,627 will go to the Tribal Health Care Coordination Fund and $2,559,697 will go to the general fund.

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 services provided under Section 1 of HB 1194 are eligible to receive matching federal funds based off the Federal Medical Assistance Percentage (FMAP) for Medicaid Expansion as authorized in the 2010 Affordable Care Act. Services provided under Section 2 and under a care coordination agreement are eligible for 100% federal financing.
   The State will also recognize revenue from the deposit of the savings amount from Tribal Care Coordination agreements that are to be split 70/30 between the Tribal Health Care Coordination Fund and the General Fund.

   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.*

   HB 1194 Section 1 removes the July 31, 2019 sunset provision for the Medicaid Expansion program. The projected costs of the Medicaid Expansion program to continue as a Managed Care Organization at the commercial fee schedule is $640,649,378, of which $71,087,167 are general fund. The estimated cost assumes an average monthly premium for 20,739 individuals.
   The projected impact for the 2021 – 2023 biennium is $683,793,078, of which $79,747,120 are general fund. This estimate includes adjustments for cost and Federal Medical Assistance Percentage (FMAP).

   Section 2 requires the Department to facilitate tribal care coordination agreements. This will generate general funds savings due to federal policy that allows 100% federal financing for services rendered to Medicaid-eligible Indian Health Services/Tribal 638 beneficiaries under a care coordination agreement. These savings are to be tracked by the Department, 70% of the balance is to be deposited in the state treasury fund Tribal Health Care Coordination Fund and are to be used by the tribes for health-related purposes. The remaining 30% shall be returned to the state general fund. These total savings are projected to be $7,389,113, of which $5,170,279 will go to the Tribal Health Care Coordination Fund and $2,215,834 will go to the general fund.

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   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 or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

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   For the 21-23 biennium the Department of Human Services would need appropriation authority of $683,793,078, of which $79,747,120 would be general fund. This is an increase from the 2019 – 2021 budget estimate of $43,143,700, of which $8,659,953 is general fund.

   Section 2 contains continuing appropriation authority to disperse funds from the Tribal Health Care Coordination Fund, the Department will need an additional $7,386,113 of federal authority for services rendered under a care coordination agreement that are eligible for 100% federal financing in the 19 – 21 biennium.

   For the 21 – 23 biennium the Department will need an additional $8,532,324 of federal funds appropriation authority for services rendered under a care coordination agreement that are eligible for 100% federal financing.

Name: Rhonda Obrigewitch

Agency: Human Services

Telephone: 328-4585

Date Prepared: 01/14/2019

19.0401.04000

FISCAL NOTE

Requested by Legislative Council
01/08/2019

Bill/Resolution No.: HB 1194

1 A. **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.*

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$582,118,603		$618,550,909
Expenditures			$63,701,054	$582,118,603	$71,214,796	$618,550,909
Appropriations			$63,701,054	$582,118,603	$71,214,796	$618,550,909

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1194 removes the sunset clause for Medicaid Expansion and retains commercial rates, creates a tribal health care coordination fund where general fund savings from care coordination would be deposited. Section 2 also proposes to divide the savings between tribal nations and the general fund.

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.*

HB 1194 Section 1 removes the July 31, 2019 sunset provision for the Medicaid Expansion program. The projected costs of the Medicaid Expansion program to continue as a Managed Care Organization at the commercial fee schedule is $640,649,378, of which $71,087,167 are general fund. The estimated cost assumes an average monthly premium for 20,739 individuals.
The projected impact for the 2021 – 2023 biennium is $683,793,078, of which $79,747,120 are general fund. This estimate includes adjustments for cost and Federal Medical Assistance Percentage (FMAP).

Section 2 requires the Department to facilitate tribal care coordination agreements. This will generate general funds savings due to federal policy that allows 100% federal financing for services rendered to Medicaid-eligible Indian Health Services/Tribal 638 beneficiaries under a care coordination agreement. These savings are to be tracked by the Department, 70% of the balance is to be deposited in the state treasury fund Tribal Health Care Coordination Fund and are to be used by the tribes for health-related purposes. The remaining 30% shall be returned to the state general fund. These total savings are projected to be $7,389,113, of which $5,170,279 will go to the Tribal Health Care Coordination Fund and $2,215,834 will go to the general fund.

The projected impact for the 2021 – 2023 biennium is $8,532,324, of which $5,972,627 will go to the Tribal Health Care Coordination Fund and $2,559,697 will go to the general fund.

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 services provided under Section 1 of HB 1194 are eligible to receive matching federal funds based off the Federal Medical Assistance Percentage (FMAP) for Medicaid Expansion as authorized in the 2010 Affordable Care Act. Services provided under Section 2 and under a care coordination agreement are eligible for 100% federal financing.
   The State will also recognize revenue from the deposit of the savings amount from Tribal Care Coordination agreements that are to be split 70/30 between the Tribal Health Care Coordination Fund and the General Fund.

   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.*

   HB 1194 Section 1 removes the July 31, 2019 sunset provision for the Medicaid Expansion program. The projected costs of the Medicaid Expansion program to continue as a Managed Care Organization at the commercial fee schedule is $640,649,378, of which $71,087,167 are general fund. The estimated cost assumes an average monthly premium for 20,739 individuals.
   The projected impact for the 2021 – 2023 biennium is $683,793,078, of which $79,747,120 are general fund. This estimate includes adjustments for cost and Federal Medical Assistance Percentage (FMAP).

   Section 2 requires the Department to facilitate tribal care coordination agreements. This will generate general funds savings due to federal policy that allows 100% federal financing for services rendered to Medicaid-eligible Indian Health Services/Tribal 638 beneficiaries under a care coordination agreement. These savings are to be tracked by the Department, 70% of the balance is to be deposited in the state treasury fund Tribal Health Care Coordination Fund and are to be used by the tribes for health-related purposes. The remaining 30% shall be returned to the state general fund. These total savings are projected to be $7,389,113, of which $5,170,279 will go to the Tribal Health Care Coordination Fund and $2,215,834 will go to the general fund.

   The projected impact for the 2021 – 2023 biennium is $8,532,324, of which $5,972,627 will go to the Tribal Health Care Coordination Fund and $2,559,697 will go to the general fund.

   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 or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

   Section 1 for the 19-21 biennium the Department of Human Services would need an appropriation increase, of $233,397,000, of which $37,978,000 would be general fund, to the base level budget in SB 2012. The base level budget in SB 2012 already includes appropriation of $407,252,458, of which $33,109,610 are general fund for this program.

   For the 21-23 biennium the Department of Human Services would need appropriation authority of $683,793,078, of which $79,747,120 would be general fund. This is an increase from the 2019 – 2021 budget estimate of $43,143,700, of which $8,659,953 is general fund.

   Section 2 contains continuing appropriation authority to disperse funds from the Tribal Health Care Coordination Fund, the Department will need an additional $7,386,113 of federal authority for services rendered under a care coordination agreement that are eligible for 100% federal financing in the 19 – 21 biennium.

   For the 21 – 23 biennium the Department will need an additional $8,532,324 of federal funds appropriation authority for services rendered under a care coordination agreement that are eligible for 100% federal financing.

Name: Rhonda Obrigewitch

Agency: Human Services

Telephone: 328-4585

Date Prepared: 01/14/2019

2019 HOUSE HUMAN SERVICES

HB 1194

2019 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB1194
1/15/2019
30799

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Elaine Stromme by Caitlin Fleck

Explanation or reason for introduction of bill/resolution:

Relating to medical assistance tribal health care coordination agreements and to Medicaid expansion; to provide for a report to the legislative management; to provide a continuing appropriation; to provide a contingent expiration date

Minutes: A,B,C,D

Vice Chairman Rohr Opened the Hearing on HB 1194.

Representative. Keizer: This bill is related to tribal health care coordination's. The interim health care department did quite a bit of research on the tribal health care services. There is an opportunity under Medicaid to pay 50% of every dollar spent to Medicaid. Tribal members frequently are on Medicaid and the state pays 50% of every dollar on their access to it. Tribal Health Care Coordination Agreements represent a program that if tribes enter into a written agreement with Health Care providers, the federal government will pay 100% of the cost of health care. That would be a 50% savings to the state of North Dakota, which would be a huge savings. We have to have a tribal agreement, but what does it mean? The tribal members are most often provided services at Indian Health Services, instead of other health facilities that are funded through the federal government. Whether it is on the reservation or not, under most conditions the health care is frequently adequate, but sometimes the medical problem is large enough to where they should be referred to a larger facility. We do that with all other health care in our system. When we send these people with this agreement from standing rock to CHI and Sanford health, they have been negotiating this agreement. The primary purpose is not the money, but rather the citizens of the state and deserve the best health care provided. This agreement with Coordinated Health Services, outside of Indian Health Services, we can provide an opportunity for referral for these patients to a larger facility. Our goal is to increase that. As we worked on this bill, we discovered that in order to make this work we have to recognize the players in this arrangement. The first player are the tribes. If they don't support this bill, then we can't do it. If we don't provide an incentive for them to participate, then why should they? The second player is the health care facilities that the tribal members will be referred to. The third partner is the state. We can in effect save 50% of that payment that does not have to be made. That will reduce the cost to the state. The issue of incentive for the partnership arises. The tribal members said that if they don't play, then we don't save a cent. The health care facilities said that if they don't play then we

don't save a cent. Yet the state is saying that they should get something because it is their money that is being spent. This bill does many things. It does address policy issues that we need to address. It creates a statute the authority for the partnerships. It continues Medicaid expansion. We are removing the sunset for Medicaid expansion. The Legislature has to deal with this as a policy. There are 22,000 citizens of the state that are receiving health care through Medicaid. If we don't continue this expansion, then a good chunk of the population that is using Medicaid will then fall into the unfunded care group and there will be an increase to providers, and eventually to us. If they have to provide unfunded care, then the rates for the people that do pay will go up. The bill defines a health care coordination agreement and it defines a tribal healthcare organization. We have the department of human services facilitating the coordination agreements. We create a tribal healthcare coordination fund, in which some of these dollars will be directly transferred. 70% of those saved dollars will go into the tribal healthcare coordinating fund, and some of those dollars will be able to be accessed by the tribes for health care related functions. 30% goes back into the general fund of the state of ND. How are the hospitals affected? What do they get out of this? The healthcare providers said that they will participate this as long as you leave the commercial rates in the Medicaid expansion group. The reason we put commercial rates in is because it was a good deal for the healthcare providers. This bill asks you to consider maintaining the commercial rates, recognizing that it will have a significant cost to ND. But we are keeping 30% of the rates in the general fund. It may not be a huge amount, and it will take a while to see a significant amount of increase. What's the difference of the reimbursement rate and the rate that they want to increase it to? I believe that based on the testimony, the providers will take a huge hit if we increase the rate. Why the 70/30? The tribes say they need some kind of an incentive and they need more money because they have poor healthcare services as it is now. That is why we put the 70% in for them. The provider said that they are not getting a good deal if they have to sign an agreement where they take an increased number of patients on Medicaid rates. They will be losing money on those people. Hospitals will not make this agreement, but they need to see some reason as to why they should participate. That is why we put the commercial rates in there. The commercial rates maintain. We had many discussions with the tribal members, and Attorney Danielle Fin is one of the most important factors on this. The statewide tribal organization invited us to talk about this organization. We put into this bill some requirements for the money that is being use. The tribes have to have an audit every 4 years, the money will be distributed based on the % of usage, they have to file a report with the human services department, they have to keep record of who uses it, etc. We have attempted to give oversight and flexibility as much as we can. There was strong dispute throughout the tribes that we were intervening in their sovereignty as a nation. The tribes did not like this agreement, but they did accept it. Given that these are state dollars; we have an obligation to make sure that they are being used appropriately. We also put an emergency clause on this bill.

(19.51) Representative Dobervich: Is there a fiscal note on this?

Representative Keizer: It should be in your file.

Senator Joan Heckaman, District 23: Support this bill. I think this is something that will have a lot of work done on it. This allows the tribes to have continued access to medical care that may not be available. I represent Spirit Lake and they don't have a hospital. We look to our providers to move us onto experts and others that can do care for us, when they cannot.

Brandon Mauai, Councilman and Representative for the Standing Rock Sioux Tribe: (see attachment A)

(30.50) Tim Blasl, President of the ND Hospital Association: (see attachment B)

(35.00) Redfox Sanchez, Tribal Health Director from the Mandan, Hidatsa, Arikara Nation: I am very insulted that it was said that we are losing money off of these people. Are you saying that without our tribal members, you would not receive that 100% rate? You would make it a 30%?

Vice Chairman Rohr: That is correct.

Ms. Sanchez: The Medicaid system is very flawed, because our people are still getting penalized for receiving IM accounts, having royalties, or mineral rights. The wording about being able to ask for our IM account information when apply for Medicaid needs to be taken out because without us being able to get on Medicaid, you can't make money on us. Should the 100% FMap be given to the tribal member when we have the facility?

Vice Chairman Rohr: We can probably address that when Mr. Jones comes up to the podium.

Ms. Sanchez: For the 30% that you do make off of our people, why do we have to give an explanation as to what we are going to use it for? Why do we have to have an independent audit by an independent CPA or by the government and have it every 4 years? When in other states we can have it less than every 4 years. I feel as though there is no trust. Have any of you ever actually gone out to the tribes and seen our hospitals or asked our patients how the Medicaid is working for them?

Vice Chairman Rohr: We would have to differ that to Danielle because she worked closely with Representative Keizer, but we will be taking down your comments here.

Ms. Sanchez: I'm asking if you really want out tribal support then you are going to have to support us in enrolling people into Medicaid.

(39.01) Chris Jones, Director of the Department of Human Services: (see attachment C) We are in support of section 2 of this bill. I am grateful of the discussion about how do we give more coordinated care to our tribal members. There was much discussion about if we should do managed care in ND, but the question of where are we going to get those dollars to support that arose. As this debate has gone on, I think that there has been some confusion of what does 100% FMap mean, where do the savings go? And that has created a lack of transparency on how we do things. If you listen to the discussion, it is clear as to how this program works, but there is still mistrust as to how this program works and where the dollars go. How this bill is written, if we don't continue with the commercial rates of Medicaid expansion we wouldn't work with the tribes at all or go after 100% FMap expansion. Which ultimately, as everyone would tell you, if we do a better job of care coordination we will serve the citizens better, and reduce the cost of care within the state So, while we are in support of section 2, we are in support of removing the sunset clause for Medicaid expansion, we are not in support of combining these two together.

Petra Harman One Hawk, Director for the Title VI Program: In response to Chris Jones, under American Recovery and Reinvestment Act, the term managed care has already been laid out that you cannot subject American Indians covered under Medicaid to managed care. I am in support. These negotiations should have been talked about earlier. We help the elderly with their nutrition, but get almost no funding from the government. I am mandated to accept anyone over the age of 60 that comes in and signs our roster, but how am I supposed to continue to accept people. And there will be and increasing number of people as our population continues to age. We cannot afford to serve the disabled, but we have to. Under the Affordable care act, we should also be addressing the dilemma we are in. Under the Show letter, home and community based services are addressed. I want to know at what rate are we going to be able to bill out because there is a federal employment rate for the tribes. There should be a ND Indian Health Board that works with the Health Equity office to inform the tribes, and perform audits and have connections between the two. This board should also be able to track the number of tribal members that do go to Sanford or St. Alexius, because right now I would have to go to HIS to get those statistics and I don't have to means to do that. Yet we are supposed to be a partner in this.

(50.53) Nathan Davis, Counsel Representative from the Turtle Mountain Band of Chippewa Indians: (see attachment D)

(54.54) Courtney Cowell, ND Medical Association: I would like to say that we support this bill.

Scott Davis, Commissioner for the ND Indian Affairs: This is a process in the making, and is not something new to our office or the tribal leaders. Everyone involved with this bill have been extremely important and have done well for it. We are in support of this bill. If we can do this right, then maybe we can change the medical care on our reservation.

Myra Pearson, Chairman for the Spirit Lake Tribe: We are in support of the bill. My only request is that you keep us at the table so that we can be prepared.

No further questions or testimony. Meeting closed.

2019 HOUSE STANDING COMMITTEE MINUTES

Human Service Committee
Fort Union Room, State Capitol

HB 1194
2/6/2019
32326

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Nicole Klaman

Explanation or reason for introduction of bill/resolution:

Relating to medical assistance tribal health care coordination agreements; Medicaid expansion; and to provide for a report to the legislative management; to provide a continuing appropriation; to provide a contingent expiration date.

Minutes:

Chairman Weisz: opened meeting

Chairman Weisz: I think it's unfortunate that we have 2 issues buried in this bill. Medicaid expansion and tribal health care coordination are unrelated.
The amendments would change what is in the bill not current law. Currently the state receives 100% of any savings that would have come with a tribal care coordination. The bill had it 70/30, the amendment changes it 50/50. It eliminates sunset clause. It doesn't change anything in tribal care coordination agreement. It adds in Medicaid program or private carrier-current law was private carrier or health insurance exchange.

Representative Gretchen Dobervich: I'm concerned moving from 70/30-50/50, wondering if tribal councils have been consulted on that because that is a significant change? This would be impacting tribal communities

Chairman Weisz: I'm not aware of discussions. I would say maybe between the sponsor and tribal council.

Representative Dobervich: Who is bringing forward the amendments?

Chairman Weisz: Me, as a compromise looking to get this moved forward.

Rep Rohr: I motion to add the amendment.

Rep. M. Ruby: Second

Voice Vote: Motion carries to adopt amendment.

Representative Todd Porter: I move a Do Pass as Amended rerefer to Appropriations

Rep. Rohr: Second

Roll Call Vote: Yes 10 No 3 Absent 1
Motion carries, do pass as amended, rerefer to Approps.

Rep. Dobervich: carrier

Chairman Weisz: closes meeting

CM
1 of 1
2/6/19

19.0401.04001
Title.05000

Adopted by the Human Services Committee

February 6, 2019

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1194

Page 1, line 20, remove the overstrike over "~~or~~"

Page 1, line 21, remove the overstrike over "~~utilizing the~~" and insert immediately thereafter "Medicaid program"

Page 3, line 18, replace "seventy" with "fifty"

Page 3, line 18, replace "thirty" with "fifty"

Renumber accordingly

Date: 2-6-19
Roll Call Vote #: 1

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1194

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 19.0401.04001

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Rohr Seconded By Rep. Ruby

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman			Gretchen Dobervich		
Karen M. Rohr – Vice Chairman			Mary Schneider		
Dick Anderson					
Chuck Damschen					
Bill Devlin					
Clayton Fegley					
Dwight Kiefert					
Todd Porter					
Matthew Ruby					
Bill Tveit					
Greg Westlind					
Kathy Skroch					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Voice Vote motion carries to adopt amendment.

Date: 2-6-19
Roll Call Vote #: 2

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1194

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☒ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Porter Seconded By Rep. Rohr

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman		X	Gretchen Dobervich	X	
Karen M. Rohr – Vice Chairman		X	Mary Schneider	X	
Dick Anderson		X			
Chuck Damschen	X				
Bill Devlin	X				
Clayton Fegley	X				
Dwight Kiefert	—	—			
Todd Porter	X				
Matthew Ruby	X				
Bill Tveit	X				
Greg Westlind	X				
Kathy Skroch	X				

Total (Yes) 10 No 3

Absent 1

Floor Assignment Rep. Dobervich

If the vote is on an amendment, briefly indicate intent:

Motion Carries, Do Pass As Amended.

REPORT OF STANDING COMMITTEE

HB 1194: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (10 YEAS, 3 NAYS, 1 ABSENT AND NOT VOTING). HB 1194 was placed on the Sixth order on the calendar.

Page 1, line 20, remove the overstrike over "~~or~~"

Page 1, line 21, remove the overstrike over "~~utilizing the~~" and insert immediately thereafter "Medicaid program"

Page 3, line 18, replace "seventy" with "fifty"

Page 3, line 18, replace "thirty" with "fifty"

Renumber accordingly

2019 HOUSE APPROPRIATIONS

HB 1194

2019 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1194
2/14/2019
32771

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Risa Bergquist and Parker Oswald

Explanation or reason for introduction of bill/resolution:

Relating to medical assistance tribal health care coordination agreements; to amend and reenact relating to Medicaid expansion; to provide for a report to the legislative management

Minutes:

Chairman Delzer: Opens meeting on HB 1194.

Representative Weisz: This bill removes the sunset clause on Medicaid expansion, so it will just keep going. The other thing it does is that when Medicaid expansion was adopted, it was required that it had to be through a private carrier. We took that off, so now it can be open to any type of carrier.

Chairman Delzer: Are you aware whether or not that is in Human Services budget?

Representative Weisz: We struggled to find that out. We were working off of the Governor's recommendation.

Chairman Delzer: It looks to me that this should be discussed when the Human Services budget is before us.

Representative Weisz: I struggled with this bill on how to work this bill. It should be in policy if we are going to continue expansion, but it is hard to work this when you do not have the budget. We wanted to open the discussion on opening in house expansion.

Chairman Delzer: If we wanted to continue this discussion and not make a final decision we could put the sunset back on. Maybe even set a commercial rate.

Representative Weisz: In the bill, the committee decided to leave it at commercial rate. The commercial rate is not uniform for all of the providers. Of the 36 critical care hospitals, 6 of them get $6.6M of the $7M difference in Medicaid expansion.

(4:55) Chairman Delzer: Does that change if it comes in house?

Representative Weisz: It does not necessarily have to change, but if it comes in house it will realistically have to be established across the board using a commercial rate.

Chairman Delzer: I was told that critical care hospitals can only be at 101% of Medicaid.

Representative Weisz: I did not think they had to be because they get a higher reimbursement than one of the big 6. Under current Medicaid expansion you do not have to and a few rural hospitals are huge winners in this.

(7:00) Chairman Delzer: The problem is this is part of the Human Services budget and the only thing that really does not is trying to set up coordination.

Representative Weisz: I do believe the policy of what we want to do with expansion is an overall policy discussion.

Chairman Delzer: It did go through the floor, but there was no discussion. We had language in there that it left if Medicaid expansion dropped below 90%?

Representative Weisz: You can certainly make a case to keep the sunset because this is not mandated. I am not sure where that resides. Those provisions could apply either way and that is correct if the feds pulled out, so would we. I advised the committee to leave the commercial rate open because it is part of the Human Services budget.

(9:50) Chairman Delzer: How much of a floor fight would happen if we remove section 3 and add the sunset?

Representative Weisz: I do not know if there would be a lot of problems. You may have a fight over taking the commercial rate out, but the sunset would not be bad. The committee was very adamant that they wanted to leave the commercial rate.

Chairman Delzer: We will have to establish that rate.

(11:15) Representative J. Nelson: We added the commercial rate in the Human Service budget bill and that did not come out of a policy decision.

Chairman Delzer: I think that was not talked about when it was originally established and was later added.

Representative J. Nelson: There was an initiative to bring it in house made via executive recommendation and we chose to stay with commercial rates. Section 2 was established in the human service budget last session.

Representative Weisz: When we passed this it was; we required it to be a private carrier and then it was 100% federal. I was surprised to find out how much the commercial rate varies from hospital to hospital. I was trying not to restrict anything.

(13:50) Representative J. Nelson: What was the difference between commercial rate appropriation and the department bringing it in house?

Representative Weisz: We did not get much, but supposedly the difference is $205M and $20M would be the state's share.

Representative J. Nelson: Last session it was $15M I think.

Representative Weisz: I am using the figures that Sanford has and that was part of their testimony. They said if they used the commercial rate it would be about $405M and under Medicaid rate, it would be $205M.

Chairman Delzer: Sanford Health is the current carrier and their fee is considerably higher than what the department claims they can do.

Representative Weisz: There is a lot of administrative cost discussion. I would have been more comfortable with what we did if we had access to the budget.

(15:45) Chairman Delzer: Now on the tribal coordination, we did put that in last time and there was an expectation of a certain amount of money. To my understanding it has not been used yet.

Representative J. Nelson: Indian Health Services (IHS) and Standing Rock have signed with the two major carriers in Bismarck.

Chairman Delzer: When did that start?

Representative Weisz: It was in operation in calendar year of 2018. The issue is that we haven't been paid yet from the feds. That's why it seems like nothing is happening. This came to us at 70-30 where 70% went to the tribes and 30% went to the state. The committee changed that to 50-50.

Chairman Delzer: Did anyone from the tribes or Indian affairs testify at all?

Representative Weisz: The tribes are very supportive in principal. There were issues where they were not happy about how somethings were being portrayed.

(18:35) Chairman Delzer: It does expand their health services as well.

Representative Weisz: We have heard it for years that things are somewhat dismal on the reservations. This is intended to increase collaboration and increase preemptive healthcare and get the providers involved so they do not have to use IHS. They would get a provider that gives full care and we get the benefit of 100% federal match. The number 70-30 was in the bill and there weren't any discussions over that. I think the committee thought it was pretty high, so it was mandated down to 50-50. The tribes more so because if it works, they get great health benefits.

(20:30) Representative Kreidt: Wasn't it the office of Indian affairs that was hired to set up these types of agreements?

Representative J. Nelson: Yes, Brad Hawk is in the IHS office. It's difficult to get a coordinated care agreement signed with the hospitals and then there is an issue that they need a form of identification. It's harder to put in place then it sounds because there is not always that level of understanding. I am curious about that ability to capture that extra 50% because this was an appropriation. The money captured was to pay for commercial rates of Medicaid expansion and it is not doing that.

(23:25) Representative Weisz: You're right and some of the providers are saying they will do it, but we want commercial rates. The original bill took almost all of the money away that could have been used to finance or subsidize the commercial rate.

Chairman Delzer: This was already in place in the budget, so why was this bill put out there?

Representative J. Nelson: To get more tribes to sign the agreement, there's really only one that is doing it.

(26:10) Representative Kreidt: What was the discussion in regards to removing the sunset?

Representative Weisz: We've had this program for a number of years and I think everyone has come to expect that it's part of the continuing health care coverage.

Representative Kreidt: I think we need that option.

Chairman Delzer: Any further questions?

2019 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1194
2/18/2019
32868

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Risa Bergquist

Explanation or reason for introduction of bill/resolution:

Relating to medical assistance tribal health care coordination agreements

Minutes:

1:30 Chairman Delzer: HB 1194 came out of human services, do pass10-3. It does three things; take the effective date off of Medicaid expansion, it sets up tribal health care agreements with the tribes at 50/50, and section 3 says it needs to be commercial rates, this is based on the fact that it is out with a private carrier. I think we should put the sunset back in and I don't think we should pass the bill with the change to commercial rates.

3:45 Representative J. Nelson: I think Medicaid expansion has been good for North Dakota and I think it can stand on its own merits but I agree with you and the need review it every session. **I would move to add the sunset back into section 1 and further amend to remove section 3 from the bill.**

Representative Meier: Second

Chairman Delzer: We have a motion to amend.

Chairman Delzer: Further discussion?

7:05 Representative Bellew: Removing section 3 changes the fiscal note?

Chairman Delzer: I think that is where the fiscal note comes from.

Voice vote, All in favor, motion carries

Chairman Delzer: We have the amended bill before us.

Representative J. Nelson: Motion to pass as amended

Representative Kreidt: Second

Representative Bellew: If we pass this bill it will just go into the human services budget then?

Chairman Delzer: We would be passing section 2 of the bill which is trying to put in line for the tribal health care agreement. This sets it up at 50/50 to try to get more of the tribes to join is.

Representative J. Nelson: This issue was part of the discussion last time.
Unfortunately, the tribal F-MAP program hasn't gained the revenue that we had hoped Standing Rock is the only one that has signed up so far.

Chairman Delzer: Further discussion?

A Roll Call vote was taken. Yea: 18 Nay: 1 Absent: 2

Motion Carries, Representative J. Nelson will carry.

Chairman Delzer: With that we will close this meeting.

19.0401.05001
Title.06000

Prepared by the Legislative Council staff for
the House Appropriations Committee
February 18, 2019

CK
1 of 1
2/18/19

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1194

Page 1, line 4, remove the third "to"

Page 1, line 5, remove "provide a contingent expiration date;"

Page 1, line 9, remove the overstrike over "~~**Effective**~~"

Page 1, line 10, remove the overstrike over "~~**January 1, 2014, through July 31,**~~"

Page 1, line 10, after "~~**2019**~~" and insert "**2021**"

Page 1, line 10, remove the overstrike over the overstruck dash

Page 4, remove lines 27 through 31

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment provides an expiration date of July 31, 2021, and removes the contingent expiration date section relating to Medicaid Expansion program provider reimbursement rates as compared to commercial rates.

Date: 2/18/2019
Roll Call Vote #: 1

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1194

House Appropriations Committee

☐ Subcommittee

Amendment LC# or Description: **Add Sunset and remove section 3 of bill**

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By **Representative J. Nelson** Seconded By **Representative Meier**

Representatives	Yes	No	Representatives	Yes	No
Chairman Delzer					
Representative Kempenich					
Representative Anderson			Representative Schobinger		
Representative Beadle			Representative Vigesaa		
Representative Bellew					
Representative Brandenburg					
Representative Howe			Representative Boe		
Representative Kreidt			Representative Holman		
Representative Martinson			Representative Mock		
Representative Meier					
Representative Monson					
Representative Nathe					
Representative J. Nelson					
Representative Sanford					
Representative Schatz					
Representative Schmidt					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

Voice Vote/Motion Carries

Date: 2/18/2019
Roll Call Vote #: 2

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1194

House Appropriations Committee

☐ Subcommittee

Amendment LC# or Description:

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐

Motion Made By **Representative J. Nelson** Seconded By **Representative Kreidt**

Representatives	Yes	No	Representatives	Yes	No
Chairman Delzer	X				
Representative Kempenich	A				
Representative Anderson	X		Representative Schobinger	X	
Representative Beadle	X		Representative Vigesaa	X	
Representative Bellew		X			
Representative Brandenburg	X				
Representative Howe	X		Representative Boe	X	
Representative Kreidt	X		Representative Holman	X	
Representative Martinson	X		Representative Mock	X	
Representative Meier	X				
Representative Monson	X				
Representative Nathe	X				
Representative J. Nelson	X				
Representative Sanford	A				
Representative Schatz	X				
Representative Schmidt	X				

Total (Yes) 18 No 1

Absent 2

Floor Assignment **Representative J. Nelson**

Motion Carries

REPORT OF STANDING COMMITTEE

HB 1194, as engrossed: Appropriations Committee (Rep. Delzer, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (18 YEAS, 1 NAYS, 2 ABSENT AND NOT VOTING). Engrossed HB 1194 was placed on the Sixth order on the calendar.

Page 1, line 4, remove the third "to"

Page 1, line 5, remove "provide a contingent expiration date;"

Page 1, line 9, remove the overstrike over "~~**Effective**~~"

Page 1, line 10, remove the overstrike over "~~**January 1, 2014, through July 31,**~~"

Page 1, line 10, after "~~**2019**~~" and insert "**2021**"

Page 1, line 10, remove the overstrike over the overstruck dash

Page 4, remove lines 27 through 31

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment provides an expiration date of July 31, 2021, and removes the contingent expiration date section relating to Medicaid Expansion program provider reimbursement rates as compared to commercial rates.

2019 SENATE HUMAN SERVICES

HB 1194

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1194
3/6/2019
Job # 33289

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Justin Velez

Explanation or reason for introduction of bill/resolution:

Relating to medical assistance tribal health care coordination agreements; Medicaid expansion; and to declare an emergency.

Minutes: Attachments #1-4

Vice Chairman O. Larsen opens the hearing on HB 1194

(00:30-16:06) Representative George Keiser, District 47. Introduces HB 1194 and provides testimony. Testimony is as follows: It is a privilege to be before you today. What I would like to do is give you a little background on the original bill, it has been modified slightly but, the reason for doing that is of course occasionally we get appropriations committee delving into policy issues and one of the advantages of having a bill go to both sides is that we can have the discussion and determine the policy that we want. This bill originated simply, there is an issue that we have an opportunity to address. Tribal members in our state are citizens of North Dakota, we are concerned about the quality of health delivery to tribal members just as we are concerned about the delivery of health to all North Dakotans. We would like to improve that and we have what some might say is a golden opportunity to do that here. The point I need to stress upon you is, to be really successful in this endeavor, we have a partnership with three partners involved and if we are going to be successful I would argue to you that we have address all needs of all three partners in this transaction, or it will not ultimately be successful. We have the three partners in order of importance. First, the tribal members need a program that benefits, serves, and meets their needs. The second group are the health care providers in our state. They have to be partners in the proposal that we will make to you today. The third, is the state itself. Can the state benefit? I do recognize that Medicaid expansion is already included in SB 2012 but this bill says that we need to continue Medicaid expansion but more directly to the issue that I addressed was a care coordination agreement. The federal government has provided the opportunity to states to consider and develop care coordination agreements. They involve the tribal membership and health care providers. If we do this, currently Indian Health Services is serving the tribal members specifically on the reservations primarily. I go to the Indian Health Services and they provide health care services to me as a member but, there are times when they don't have the capacity or technology to provide the additional service that I need. What they do in that case is refer them to the larger cities where the specialist primarily resides. In

Bismarck, it would be either St. Aulexis or Sanford and they would be referred up here. Now, with the current FMAP (Federal Medical Assistance Percentage) is about a 50/50 split, of every dollar spent the state is paying 50 cents. What this healthcare coordination agreement does is, if you have an agreement between the tribe and the healthcare provider, the federal government in effect pay 100%. The state is currently paying 50%, so we have an opportunity as a state to save 50% and we also have the opportunity to get and encourage the referral for certain services. The bill designates that the Department of Human Services will facilitate the healthcare coordination agreements, they will be the states representative in coordinating these agreements. Originally, the tribes said that they wanted 100% of those savings and through a lot of discussion and on the final meeting with the tribal leaders, the tribes said that they did not support the 60/40, they support the 70/30, so we put 70/30 in the bill. The bill clarifies very specifically that any money transferred to the tribe through this healthcare coordination agreement, those dollars must be spent directly on healthcare. There are a lot of services and other procedures that aren't available now to them that could be available to them. We did not put a lot of limiters on the definition of health care services, we simply said that the monies they get must be used for health care services and the department will be having oversight on that. In the house they changed that to a 50/50 split on the savings so that the state would keep 50% and the tribes would keep 50%. To make this thing work, it gets back to the partnership. At some point the tribes are saying, for us to participate we need to get a reasonable return for our engagement. They were at 100%, the bill is currently at 50/50, they had signed off on 70/30, personally I support 60/40. That 60% would be going to the tribes for them to determine how to use as long as it is related to health care services. This was a significant element in discussion with the tribes because they are sovereign nations and they have a lot of concerns about the state dictating or having requirements. After long discussion with the leaderships of the tribes understood that because this is an effect state dollar that are going to be given to the tribes, the state not only has some right to oversee it, they have an obligation to monitor these dollars. The bill requires an annual report to human services detailing on how the dollars would be spent.

(9:40) Senator O. Larsen: When we had a discussion about the oil funding going to the affiliated tribes, I heard that exact same language that they will submit an annual report and just in the beginning of the session I asked for the report and, I was told that they are a sovereign nation and they don't have to give us a report. Are they going to give us a report or is this a suggestion that they will give a report and it will be showing where the money went because I was told that a couple of years ago?

Representative Keiser: It's in the bill that it is a requirement, also in the bill it says that every four years, there does need to be an audit done and the audit can be funded out of the dollars that are returned to the tribe but an official formal audit must be done. We also have placed into the legislation that the dollars will be distributed by the Department of Human Services upon completion of the report, so that is the one piece of leverage that we have as these dollars are earned, they will be distributed only after the completion and submission of the report. Human services will withhold the money until receiving the required reports. The other question that you should have is; what if the tribes use these dollars for a non-qualified health related purpose? The human services department will withhold those dollars that were misapplied from future distribution in an equal amount until those dollars that were misapplied are placed back into the fund. We have tried to put some reasonable guard rails without being unreasonable in monitoring the transfer of these dollars. The other important point is the

distribution of funds to the tribe will be done proportionally. If one tribe can account for 70% of the utilization in the care coordination agreements, they would receive 70% of the funds that will be transferred. There is an emergency clause on the bill and we had in the original bill that commercial rate would be maintained. That brings in the second leg of the partnership. The hospital said to us, why would we sign a care coordination agreement when you are going to send us more patients at the Medicaid rate and we lose money. In business McDonalds doesn't want to correct for loss of margin by more volume, that is not a principle of business. The hospitals and health care providers are saying, we think this health care coordination agreement is a great concept and we are willing to participate in a partner in it but we would like to have the commercial rates maintained for Medicaid expansion to help us support the Medicaid rate for these referrals. That really is the bill as it was introduced, the house did make a change with the 50/50 split and I think they took the commercial rates out as well. In doing that, the chair of appropriations said that they are going to deal with the commercial rates in I believe is SB 2012. So commercial rates aren't out, they are just out of the bill. These are state savings dollars but there are no savings without these contracts and that is imperative for you to understand. 100% of zero is still zero. It is imperative if we want to participate at any level, we are going to have to have the contracts established and do it in a manner in which the tribes support, participate, and utilize it. I have had a lot of discussion about how many dollars are we talking about. I don't have an answer for you but, it's not going to be a lot in the first biennium, that I can assure you. South Dakota is kind of ahead of us on it, they have done it a little differently, I don't think they have done it as well as this bill is trying to do it. The savings are not that great. It will take time to build up the program and the utilization of the program. I would happy to try to answer any questions.

Senator Anderson: It was my impression that if a patient was a member of a federally recognized tribe and also eligible for Medicaid, that those were 100% reimbursable by the fed. Then we have a group of people who are tribal members but are not Medicaid eligible and I would like to hear how those people would be treated differently as far as the reimbursement in health care is concerned.

Representative Keiser: You people on this committee understand this issue much better than I do. What we do know is that there is a potential to serve some people and save 50% and again whether it is a million dollars in the biennium or five million dollars, we are not talking about 50 million or 100 million. The key isn't the money, if that is the focus that the legislature has from a policy stand point then I have failed. The key focus is to provide improved health care delivery to tribal members and increase utilization of specialists that when appropriate, which will lead to savings to the state.

Senator Anderson: An IHS facility on any reservation in ND serves people from any tribe in the country. Was there discussion about how those people will be affected?

Representative Keiser: Absolutely not. My guess is, if they are going through a tribe here and that qualifies them, if they are Medicaid eligible, the state of North Dakota gets to participate but that is a guess on my part in don't know that.

Senator Hogan: Do you know how many states are currently doing that and is there any data on how this has worked in other places?

Representative Keiser: I don't know the complete answer to that. We have been talking about it and I think the chair person has been actively engaged in this basically, standing rock and the facilities in Bismarck have done everything besides sign an agreement as far as I understand it. We are ready to launch but we don't have the formal agreement.

Senator Hogan: Do we need this enabling legislation to implement that agreement?

Representative Keiser: I'm not sure, but if you want to talk about how the monies are going to be used and those types of things, then you do.

Senator Hogan: I knew that there was major work being done.

Representative Keiser: I can't speak to this but, certainly in terms of the other programs where the federal governments involved they very often if not always require state enabling legislation to implement it but I am not sure in this case.

Madam Chair Lee: Better safe than sorry I think.

(22:06) Kenneth Baker Jr, Health Board Chairman for Spirit Lake Health Center. Testifying in support of HB 1194. Testimony is as follows:

To answer your question about somebody coming up from a different tribe, so what typically happens in IHS, if a patient comes from a different tribe they are eligible to receive services at any IHS and tribal facility as long as the tribe has not given some money back where you could limit to serving only your enrolled members. For example, if someone came up from Louisiana and came to the health system they are eligible for the services they offer at the health center. If they were to need specialty care they would have to travel back home to get those referrals to a facility because what happens is IHS, where they have your home clinic and that is where the funding for PRC (purchase referred care) dollars is given to that clinic and that is to help people to go to the referrals and that is very limited and I'll explain some of that in my testimony today.

Senator Anderson: If the tribe has assumed their own healthcare responsibilities, 638 is what we call that and I think spirit lake has done that now.

Kenneth Baker: Yes, we are title 5.

Senator Anderson: Can you make an election about whether you are going to take care of those people from other tribes or does IHS say that since you took the 638 money you have to take care of them?

Kenneth Baker: With 638, you design your program how you would like, the government doesn't have too much of a say anymore. If we want to, we can refer those folks out if they come to our health center.

Madam Chair Lee: So if someone comes up from Louisiana and needed primary care, I know the IHS facility can provide it but if they needed specialty care they would have to go back to their home area?

Kenneth Baker: Yes, IHS has a regulation so it surrounds your counties around your reservations. Those are the folks that you can offer services to and anything for referrals would have to go back to their home clinic.

Madam Chair Lee: Ok, you can continue.

Kenneth Baker (continues testimony): Thank you for allowing me to be here to testify on the FMAP bill 1194. I would like to thank Rep. Keiser for working with us a number of times we have met and hammering this bill out and we believe that it is very important as tribes to be at the table so we want to thank everyone on the committee here for allowing us to be here. I would like to make a case on why the tribes should get the 70/30 split. First, I would like to share some background on IHS. We are currently funded at approximately 0.49 cents to the dollar per patient. Our grade is about three times the need. Congress in the last couple of years has slightly given us increases in IHS but we still have a lot of short comings. This is very challenging for us as tribes to provide basic care for our people. Things that we might take for granted, our people don't have that luxury. IHS has a priority system, it is 1-4 and this tells you if you are going to get treatment for the year or not and a lot of times many of our tribes only do 1 and 2 priorities which are life threatening and cancer. A lot of our folks walk around needing joint hip replacements but they have to wait. Sometimes care is delayed because funds run out and they have to wait until October 1st before they can get a referral for treatment. These are some of the disparities that we face on Spirit Lake and other tribes here. That is why we support 70/30, we know it's not going to be a lot of money like what Rep. Keiser said but anything would help us. We always have programs that we start with grants. Suicide in tribes leads the nation. What happens is we are not able to sustain these programs so, we get a grant for five years and it gets up and running and everything is going good but once those five years are over the funding is gone and everyone stops doing anything, then we have someone who commits suicide and we are scrambling to be proactive after that. We believe with some of this funding we would be able to create programs for prevention. Prevention is a big deal and if you see the special diabetes and the projections on how it has enhanced and decrease diabetes in Indian country. This program too, is also under attack. It is funded until the 19th of this year and after that we will have to go back and fight for funding again. These programs have made strides in diabetic management and we believe with cooperation with these agreements that with between us as the facility referring a patient out to the hospitals we believe that will be a better care of delivery. We need to have the commercial rate back in there because what hospital wants to lose money and take our patients. Our patients do not get treated very well at this time, we have issues with hospitals so with these agreements we can strengthen those partnerships and our folks can get treated better. I believe with the partnership between the three of us that the healthcare delivery would be better and also save not only the tribe but the Medicaid program with savings because if we are preventing disease that is going to cut back on our medical needs, so we believe that this could be an all-around savings for us. Lastly, I believe that section 1 with the expansion Medicaid should be removed from this bill and be put on a bill by its self, it doesn't pertain to the expansion of Medicaid, it really pertains to traditional Medicaid.

Senator Anderson: Isn't it true that the feds provide half of the money because they expect the tribes to bill third party payers and Medicaid for those other 50% of the money that has not been provided by the federal government directly?

Kenneth Baker: Yes, part of it was not until a few years ago federal agencies couldn't bill each other so congress came to the conclusion that we can't hold our trust responsibilities to you guys so we are going to allow you guys to be able bill Medicaid and Medicare and that finally came into place, even with the ability to do that, not all of our folks do qualify for Medicaid so that leaves some of our folks of 7,500, 30% won't get qualify for coverage.

Senator Anderson: Some of those people would have jobs with companies that provide insurance or may have insurance through blue cross and blue shield like the rest us and you can also bill those third party payers when someone is getting care that is eligible for those.

Kenneth Baker: Yes, we do have employees come to the health center. We see about 7,000 visits per month now. This creates a problem for us because we aren't used to that patient load and the funding is becoming an issue now. We believe that with these savings that we can get would help us tremendously.

Senator Anderson: If a tribal member is Medicaid eligible and gets services through the tribe or outside of a different facility, it is 100% reimbursement for the feds. Is that not true? For example, Medicaid pays the bill and they send the bill to the feds to get that money back 100%?

Kenneth Baker: Yes.

Senator Anderson: So the FMAP doesn't apply for those people because it is 100% reimbursable to the feds so if you can explain to me where these people are that the FMAP is going to apply to.

Kenneth Baker: I'm not too sure on that. I'm not sure how that would work.

Madam Chair Lee: Do you work with any of the prevention programs with the department of health?

Kenneth Baker: Our behavioral health program and our Medicaid assistance program. We are the only tribe in the state that offers a Ceboxin clinic. Currently right now we have two suicide prevention grants that will expire in two years.

Senator O. Larsen: With Medicaid expansion and the negotiation with the tribes to secure a 300% of poverty guideline to qualify for that and being able to enroll whenever they want. How many enrolled members are around spirit lake and how many are enrolled at the 300% of poverty?

Kenneth Baker: I'm not sure about that but it has helped tremendously with the Medicaid expansion. We do still have some short comings and it has helped tremendously and that's why it has helped us get our uninsured down to about 30% of our membership.

Senator Hogan: The Columbia public health program, spirit lake has taken a very big role in healthcare and expanding your services, your board has done amazing work. Is the Columbia public health initiative that was going on in the last four or five years still existing?

Kenneth Baker: Not that I know of.

Senator Hogan: At least five years' public health brought in the Columbia public health master's program brought in physicians and trained leaders in your community and it was innovative and their idea was to train leaders so that you could run your own healthcare delivery with a primary emphasis on primary prevention. It's exciting because I spoke at that program 4-5 years ago and their vision was that we need strong local leadership and you are a great example of it.

Kenneth Baker: We have always invited people out to our health center to see the improvements and the comparison of IHS and the title 5 and what you can do. We have made tremendous strides and we would invite any of you guys out to come and see that.

Madam Chair Lee: You have for many years had a tobacco cessation person who was very good at clarifying with us the difference spiritual tobacco uses versus recreational tobacco use. I think Spirit Lake was the one who did it.

Kenneth Baker: I believe so, we still have prevention. We have two programs, on through our health system and the other through the state grant that we receive.

Madam Chair Lee: Perfect.

(40:20) Maggie Anderson, Director of Medical Services Division for the Department of Human Services. Testifying support of HB 1194. Please see **Attachment #1** for testimony and **Attachment #2** for a copy of Unduplicated Count of Medicaid Recipients by Race.

(48:17) Senator O. Larsen: If we go back to Burleigh county and there were 2,779 folks in the native population that receives services, of that number how many are just the Medicaid expansion the 300% of poverty? Do we have that data?

Maggie Anderson: I just want to be clear, so Medicaid expansion is 138% not 300%.

Senator O. Larsen: For native population it is 300% isn't it?

Maggie Anderson: No, its 138% across the board. What I think you are referring to, within the affordable care act it's up to 300% that Native Americans do not have cost sharing even within the products that are purchased on the healthcare marketplace but with Medicaid expansion our eligibility only goes up to 138%, that does not change by race.

Senator O. Larsen: Correct, but can't our tribal members go on to the marketplace at 300% of poverty and select and get a policy and we could be holding a policy?

Maggie Anderson: Certainly, but they wouldn't be Medicaid expansion so, then your question would need to go to the insurance department. We don't process those claims.

Senator O. Larsen: Right, but that would pay the bills to the hospitals when I have that 300% of poverty and I enroll, correct?

Maggie Anderson: That is correct, they would a third party biller.

Senator O. Larsen: So we have no idea of how many people are enrolled in the 300% of poverty above 138% to 300% of poverty.

Maggie Anderson: That would be a question for the insurance department we don't maintain that.

(50:10) Maggie Anderson continues her testimony.

(54:49) Senator Anderson: If they were Medicaid eligible, they would have to bill Louisiana Medicaid if they wanted to get payed for that.

Maggie Anderson: They would and then the provider would have to be an enrolled Louisiana Medicaid provider which is probably not going to happen.

Senator K. Roers: Without the signed agreement the person who normally gets their care through one of the tribal things then comes to my employer and they are Medicaid eligible, right now it is a 50/50 federal state correct?

Maggie Anderson: Yes.

Senator K. Roers: With this it just makes it 100% federal so at the end of the day the healthcare organization is still getting the same amount of money theoretically.

Maggie Anderson: Exactly, we cannot change the reimbursement rates.

Senator K. Roers: It's just on the back end of who is paying the bill whether the state is splitting that or not and so if someone is Medicaid eligible but they have never actually done this how would that scenario play out today if they get their care on the reservation then it is covered by IHS?

Maggie Anderson: If they are eligible to receive services at IHS and they go there and they don't have another party payer whether its Medicaid, Medicare, or something else then that would be funded by the funding that IHS receives.

Senator K. Roers: But then they come to now a non-tribal healthcare, the federal government will still cover a portion of it?

Maggie Anderson: There is contract health services and if you want any details about that I'm going to have to ask someone else to come back up here but there are options within their use of the funding that they receive to do contract health but there is a whole process. I will tell you that we have tried to utilize that process because it already exists as much as possible to facilitate what needs to happen under these care coordination agreements because the mechanics are already in place and the places where we can use it we have tried to use it, recognizing that those contract health staff are already maxed out based on the work that they need to do for contract health which again, leaves us to the shared savings

and where the tribes or Indian health services may need to increase their staffing attention to this in order to facilitate the coordination.

Senator Hogan: Today without this care coordination agreement the tribe would receive no more money, if we kept going the way we are they would get whatever the get and that's what it is so essentially what we are saying is if the state is going to save money, the tribes should benefit from that because they are taking on the work of the care coordination. That is essentially the theory behind this?

Maggie Anderson: That is correct.

Senator Hogan: In terms of the cost sharing, the first issue is how much additional burden does this put on the department? In terms of processing cases on a day to day basis what additional costs with the state have?

Maggie Anderson: During the last session the legislator authorized an additional FTE to DHS to the medical services division to focus on some of this work as well as just helping tribes and Indian health services identify and access those points where they can bill us as a third party payer. We have that position filled and that individual works on this area but also probably one of the most important pieces of that is the relationships and helping establish provider enrollment contacts and understanding services in those and that is a huge benefit of this involvement overall. Let's just say that individual, that is their full time job. There are five or six others of us who have been engaged in this on a regular basis, those are people who understand the claims payment system, and enrollment sides of the system. In addition to that, we anticipated as part of this that we would do routine audits on the actual care coordination. Again, we are capturing 100% federal funding, we want to make sure that all the ducks are in a row and if we are asking for 100% federal funding that everything that happened under that care coordination agreement. Some of our staff members have created an audit process and we have actually tested that with some of the claims and some of the things that have come through. We would see that become a routine part that our program integrity group would do just as part as their routine program integrity. Once this initial work is done and we work to engage the remainder of the tribes and the 638, and the IHS programs, that just becomes part of our regular job. In terms of distributing the funding and reviewing the report and what proportion of that needs to go to each of the tribes, we didn't include an FTE or anything like that within the fiscal note but we recognize that there will be increases and some of those increases will happen in our fiscal administration area and some of those will happen within medical services and we will need to figure that out and absorb that as we move forward. As that becomes a rather large issue we will need to address that in the interim and bring that to the next legislative assembly.

Senator Anderson: The scenario, let's say this bill is 100 dollars and under the 50/50 deal the state would keep 25 dollars and the 25 would go to the tribes where the patient came from theoretically?

Maggie Anderson: Correct.

Senator Anderson: Under to 70/30 scenario, 35 dollars would go to the tribe and the state would keep 15. Is that 15 enough to cover our costs and so forth? Do we have any idea of how much that would be over a period of a year?

Maggie Anderson: We did not anticipate in the fiscal estimate that the states savings would come to the department to offset our administrative cost increases. The bill calls for that to be deposited into the general fund and of course that is where the conversation comes back with the commercial rates and some of the things with expansion, that is ultimately the legislatures decision what happens with those general funds savings. The department would deposit the 50% into the general fund, because we can anticipate the dollar for dollar true savings are going to be, the legislature will need to fund the department whole and our general funds for Medicaid grants and so we are saying whatever savings is left we will put back into the general fund we aren't even offsetting our expenditures in that biennium. I'd be happy to walk through the fiscal note if there are questions on that because it is essentially about the shared savings. The original bill said with Medicaid expansion at commercial rates, the fiscal note because that has now been removed by the house, now it is truly just the shared savings that is in the fiscal note. The original fiscal note had to include the cost of Medicaid expansion at the commercial rates because that was not a part of the executive budget request. If you look at the current fiscal note, I think the most important thing is to read the narrative under item B where it says, "HB 1194 section 1 reflects the executive budget request which includes Medicaid expansion operated in house and at traditional Medicaid rates, if the assembly decides to operate Medicaid expansion as manage care and at the commercial rate the department projects needing an additional appropriation of about 187 million dollars of which 22.3 million would be general funds.". Then the second paragraph is where we talk about the shared savings, "Section 2 requires that we facilitate the care coordination agreements. This will generate general funds savings due to the federal policy that allows 100%, the savings would be tracked by the department, 50% of those savings would be deposited into the tribal healthcare coordination fund and those would go to the tribes proportionately based on the referrals that were made that generated those savings, the remaining 50% shall be returned to the state general fund. We are projecting the total savings for the biennium to be about 7.4 million dollars and the 50/50 split about 3.7 million of that would go to the tribal healthcare coordination fund and 3.7 would go to the go to the general fund.". Then for the 2023 biennium our projections are a little higher than that and what we did with medical services, fiscal staff ran estimates. We looked at the American Indian population who is also Medicaid eligible, we looked at where they have received services over the past years, did some estimates on whether they have that established arrangement with a local Indian health services. Again, individuals who are living in Cass county and may have lived there for 5,10,15 years probably don't have that established relationship. We assume that there probably wouldn't be care coordination for some of those costs and then we also looked at the big costs (hospital, physician, etc.). We feel it is very reasonable based on the expenditures from our past experience.

Senator Hogan: The sharing is a big issue; do you have any sense on how this is being done in other states?

Maggie Anderson: It is different in every state and there are different drivers in every state. If you think of south Dakota, what was on the table was Medicaid expansion and that was part of the reason why the federal government revisited this policy and so everybody was in

because the tribes and the providers wanted Medicaid expansion and the state would realize the savings so what brought them to table was a different conversation. We already had expansion. There are some shared savings agreements in Wyoming and Arizona is working on some things, Alaska is claiming this but I don't believe they are doing shared savings again because their landscape and what brings people to the table is different but we have every three weeks a call between us, South Dakota, Wyoming, Montana, Arizona, and Oklahoma. We think it is important to continue that dialogue of how are they doing this, how are they working through this, etc. Whatever we can learn from each other and use that to advance this and recognizing that each one of us will also have to take it forward in our state based on the circumstances that are presenting to us.

Senator Hogan: Are all the tribes looking at this issue and have they been engaged in some of your discussions?

Maggie Anderson: Our staff has meet with all the tribal nations, we also have a quarterly Medicaid tribal consultation meeting and we talk about this in every one of the meetings to see what issues there are or concerns. Pending the outcome of this bill we would expect to look forward from standing rock to the other tribes.

Senator O. Larsen: Do you think that this will start pulling enrolled members off the marketplace?

Maggie Anderson: I don't think so because if you go to the marketplace and apply for coverage and the marketplace assess you are eligible for Medicaid based on income they are going to send that file to our office because they are doing an assessment so, if I am income eligible for Medicaid whether I'm Native American or not, I can't choose to stay on the market place if I am eligible for Medicaid. I have to be sent to the Medicaid agency for processing. Now, of course if there is an error in that assessment and our eligibility staff determine that they are not eligible for Medicaid they could be sent back to the marketplace but I don't think people can self-select and say I'm going to leave the marketplace and come to this because they would have already been Medicaid eligible so I don't think that would happen.

(1:12:44-1:16:21) Nathan Davis, Council Representative of the Turtle Mountain Band of Chippewa Indians. Testifying in support of HB 1194. Please see **Attachment #3** for testimony.

(1:16:48-1:19:25) Brad Hawk, Indian Health Systems Administrator on behalf of the Standing Rock Sioux Tribe. Testifying in support of HB 1194. Please see **Attachment #4** for testimony.

Senator O. Larsen: Do you know how many enrolled members there are in North Dakota?

Brad Hawk: We are at 5%, so I don't know the exact number. Even that percentage is understated because that is a U.S. Census number which we are coming up with the 2020 census again but we feel from our office it is probably anywhere from 7-9 percent so that kind of doesn't give you the accurate picture but kind of gives you an idea.

Senator O. Larsen: Of those 9% do you know how many are enrolled in the Medicaid expansion at the 300% of poverty.
Brad Hawk: We do not have the exact numbers and I think this is something that we have been talking with Maggie Anderson and her staff about the expansion numbers because what has happened is when a person applies for the expansion, they have the option to click on whether they are a tribal member or not and so that is part of the issue. We cannot say exactly how many tribal members are in the expansion but we have a good idea of what that number is but I don't remember exactly what that is.

(1:21:25) Petra Harmon One Hawk, I'm in support of the bill, my concern is the shared savings because often time when you work off the reservation which I do, I commute to standing rock, I am the director for title 6 services which is the equivalent to aging services for the state. There's no housing down there so when we are often off the reservation we take for granted all the infrastructure that we enjoy and there is just no infrastructure in Indian country in every sense of the word. In my program we deliver 430 meals a day and 80% are home delivers meals to low income who are home bound with disabilities that keep them at home so we really depend on donations and it is difficult because there are days when we can't deliver the meals because of transportation issues. We are the only tribe also that works with the state title 3 program that provides meals for the elderly and the disabled and together we are able to try to figure out how to provide services not just for Indian people but for non-Indian people who live on Standing Rock. That is something I am really proud of being able to provide those services. That 70%, my question in regards to that is if the state is to provide oversight for the tribes in regards to, we have to submit a report and we have to in my eyes I'm hearing, I have to ask for permission. What part of that money that is set aside for the tribe is going to be taken for administrative costs for that to be done. We are not going to get the full 70% because there is going to be a percentage that is going to administer those funds.

Madam Chair Lee: That would be true no matter what the percentage is.

Petra One Hawk: Right, and so that means less for our infrastructure. Yesterday as im driving home from work, I'm looking and they have all of the snow plows out which is very limited and so they are using a front loader to dig out one of our elderly and they had to go into special appropriations, and of course everyone has issues with money, but more so when there's nothing coming into Indian country. It was stated that IHS historically has only been funded at 40% never anything more. One of the tid-bits I wanted to share with you also is that when IHS is providing services not only to its tribal members on the reservation, it can also provide services that are adjacent to that reservation but then comes the issue of transportation. I work with health foods and addressing that diabetes rate. North Dakota in its self is a rural location except for the major cities, the rest of North Dakota is a food desert. It's no mistake that we would have that high diabetes rates but what you see when people don't have food security and they are living within a food desert is that they don't have access to transportation. That aspect of transportation becomes a component of how are they going to access those health services through IHS and so that is something that would definitely help out of that savings is to help support our transportation services. We do have a sitting bull college transit that tries to help as much as possible. Thank you.

Senator Anderson: You live off the reservation so in order for this to be effective for the state and the tribe you would have to establish the relationship with the facility on the reservation, do you see this as an incentive for other people who live off the reservation who live off the reservation to establish that relationship so that they could participate in this as a referral service.

Petra One Hawk: Yes, I do. My husband is a federal employee we have Blue Cross and Blue Shield, we buy the family rate and then I am a tribal employee so the cost of communing for us is very high and plus I work down there so it is easier for me to access my Indian health service benefits that are treaty benefits. That way I am saving on that 25-dollar fee that I have to fee and of course I get my medications there because I'm not paying that co-pay and between my husband and I, those co-pays start to accumulate especially with our children. My husband doesn't utilize IHS but I do.

Madam Chair Lee closes the hearing on HB 1194.

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1194
3/6/2019
Job # 33329

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Justin Velez

Explanation or reason for introduction of bill/resolution:

Relating to medical assistance tribal health care coordination agreements; Medicaid expansion; and to declare an emergency.

Minutes: No Attachments

Madam Chair Lee opens the discussion on HB 1194.

Senator K. Roers: So, today the state is paying 50%. We aren't really making more money; we are just spending less.

Senator Hogan: That's it.

Senator K. Roers: So what we are really doing is taking what would have been an appropriation to the department of human services and sending that money to the tribe instead and I think that the whole time here it sounded like we were making income which we technically aren't.

Senator Anderson: That's almost the same thing.

Senator Clemens: We are the ones who are spending the money, it's our 50% from the state so why do they feel that they should have any part of that?

Madam Chair Lee: With the federal reimbursement with that program that they would be in with the care coordination they would getting 100% reimbursement by the feds.

Senator Hogan: From their view because it is intended to improve the quality of health for the tribes. That is the intent, they have to do extra work and the motivation to be able to do the extra work is to be able to address the health disparities. That is why the feds did it, targeted at improving this. If we got the money and just put it in the general fund, we are not doing the intent of improving healthcare so all the work on cooperative agreements won't happen.

Senator K. Roers: I think the struggle for me was if they didn't sign this cooperative agreement the money wasn't coming to the tribe either.
Senator Hogan: That is why they are working to get that money.

Senator Clemens: If we go 70/30, essentially we are giving them a gift to help out.

Madam Chair Lee: It's not a gift.

Senator Hogan: Its targeted health improvement because they have to have outcomes to get the health care. Its healthcare expenses.

Senator Clemens: There's formula that says 70/30 should go there so it's to help improve their healthcare.

Senator Hogan: That is why the federal government did it was for that purpose. That is why they gave us the 100%.

Senator Clemens: I guess; I just question that higher number.

Senator O. Larsen: My take on this bill is that one person said that there was about 9% of the population could be enrolled native population or have the means to do that so that is about 80,000 people and then they said that 30% couldn't get coverage so now you have 50,000. If they enroll on the marketplace at 300% of poverty, they can get the coverage. They don't have to pay co-pays; they don't have to do any of that. When I go up to the Turtle Mountains which is one of my clients to enroll people in benefits like cancer and all that other stuff and I ask them, are you also enrolled in the marketplace and it takes some individual initiative to jump on board and get the paper work done and get your documents faxed. There could be a huge pool of people that aren't doing it. I think I enrolled five people one time and it took all day to get that done. They aren't enrolling and going out to get the benefit that is due them already so if we are just going to roll them in and say we take what we have and split it with the tribes. If we send them any money, we are not going to see it. We aren't going to get paper work saying where the money went. It's the same exact thing, when we were in the harvest room and they said they were going to open, bottom line is they are a sovereign nation and they can do their own rules and I'm dealing with two pieces of property that my constituent ended up getting out on Mandaree and he cannot get it back and so with the FBI we were asking what we can do and it's impossible to get it back. They can sit there and say that we aren't giving them any money until they, it's not going to happen. I think that they need to utilize the marketplace that they are doing now or put in an amendment saying that they all have to have gone through the application process. They aren't going and getting the benefits that are due them now.

Senator K. Roers: What I heard from Maggie Anderson was that the marketplace doesn't apply if they qualify for Medicaid at the 138%. That what this particular program is about. This is not the 300% it is the 138%.

Senator Anderson: Between 138%-300% that is a different group of people, those are not the ones that we are talking about here.

Senator O. Larsen: But Medicaid expansion.

Senator Hogan: This is pure Medicaid.

Senator O. Larsen: All of the native population can get coverage and have coverage and the thing is, is that they don't have coverage. They aren't going out to secure that coverage so that they have a policy, even if it is above 300% of poverty. These people aren't giving the 300% of poverty coverage to get this for free. If they would do that, then we wouldn't be in this position.

Madam Chair Lee: I don't know how we are going to overlap that other population though because this is just as Maggie said up to the 138%. If there were some way to incentivize enrolling as you just described.

Senator O. Larsen: I can't wrap my head around this. When I go to enroll a native member and they are making 51,000 dollars which is 300% of poverty, the slide under that. They get a policy and then that policy is the second policy when they go to IHS or Trinity or wherever, they have their card and they say this is covering it and what this doesn't cover IHS will cover. That is the primary insurance. They don't pay co-pays they don't pay anything.

Senator Anderson: However, if when they go to enroll what I heard from Maggie Anderson was, if they meet the 138% or less it goes Medicaid eligible, and they are not eligible then for the expanded affordable care act stuff. Now that goes up to 138% as long as we have Medicaid expansion, if we don't have that it goes to 100% but right now we have it so this would be for those people then who get referred out from IHS and it's only those who get referred out because if they don't first seek IHS care or if the tribes are doing their own healthcare, if they don't seek that first then we don't get the other 50% and that won't be shared because they won't get it. It is only if they get referred out to some specialist and then the FMAP would go up to 100% and we are talking about that 50%.

(10:13-12:28) Senator K. Roers draws a diagram on the white board showing how the reimbursement from the federal government and the savings would go to the tribal nations and the state.

(12:30) Senator Hogan: I thought Maggie Anderson was saying that we should take all the references to expanded Medicaid out of this.

Senator Anderson: That is only because it is already in SB 2012.

Senator Hogan: I think we should take it out so that whatever they decide in SB 2012, is what applies and we don't have it in two places. I think that makes sense.

Madam Chair Lee: I don't think Rep. Keiser would have overlooked making sure that he was trying to be fair all the way around, and I understand what Senator O. Larsen is saying and I wish there was a way to make some of those things happen with a lot of the people in the population to get them to sign up.

Senator Clemens: On these numbers, the 100-dollar example that Senator Anderson used, currently we are paying 50% so we could give them all of the savings and we would be back to where we are right now.
Senator Hogan: Exactly.

Senator Anderson: Except we are going to do some work to get that 50%.

Senator Hogan: She (Maggie Anderson) didn't think it was much. There are some costs but she did not think that it was significant.

Senator Anderson: Our Medicaid people are probably only running three percent administrative costs over the whole program.

Senator Clemens: So if we give them 70% instead of spending 50 dollars, we are spending 35 dollars plus our expense which is hopefully less than 15 dollars.

Madam Chair Lee: Right.

Senator Anderson: I don't think there are any provisions for expenses in here. Forget about it.

Madam Chair Lee: Expenses come out of what you get so to speak.

Senator O. Larsen: Why doesn't the money follow the person?

Senator Anderson: Which money are you talking about?

Senator O. Larsen: The money that we are talking about that the tribes want.

Senator Anderson: It does follow the person indirectly because we give it based on whichever tribe they came from so it does follow them indirectly. If those people come from Spirit Lake, then we give Spirit Lake the 50 dollars or whatever it is.

Senator K. Roers: My other confusion is, if we got 200 dollars isn't that 200 dollars to actually going to pay the medical bill? Where is this money actually coming from?

Senator Anderson: We already paid the bill.

Senator K. Roers: So this is to pay it back? Okay, that is where I was confused.

Madam Chair Lee: Trying to move on and focus a bit on what our solution might be on this, we would be looking at an amendment probably deleting section 1 because Maggie Anderson said it was in SB 2012 and that removes all of that language. I believe the other change would just be in the percentage, which is going to be on page 3 line 18.

Senator Hogan: The other thing that Maggie Anderson referenced was liking section 3 of the first bill.

Senator K. Roers: That because it was already gone.

Senator Hogan: But did she talk about wanting to reinstate that?
Madam Chair Lee: She supported the re-engrossed version because she didn't think it would be contingent upon the existence of Medicaid expansion. So what we are down to if we all agree that section 1 can go away is what are we going to do with the percentages?

Senator Anderson: I move we change the percentages to 70% to the tribal healthcare fund and 30% kept in the state and delete section 1.
Seconded by Senator Hogan

ROLL CALL VOTE TAKEN
5 YEA, 1 NAY, 0 ABSENT
MOTION CARRIES TO ADOPT AMENDMENTS

Senator K. Roers: I move a **DO PASS AS AMENDED AND REREFFER TO APPROPRIATIONS.**
Seconded by Senator Hogan

Senator O. Larsen: I just think that there is more people that are enrolled members that need to sign up and even though it seems that they are the folks that are not being affected, the more people you sign up into this program would help alleviate the tribal issue and I have real heartburn about giving money to the tribes and saying that they are going to be all open and showing us where it is going because that is not going to happen.

Senator Anderson: There are provisions that you will withhold the next payment if they don't provide that and I agree with Senator O. Larsen here, we are unlikely to get it then you are going to be in the position of saying why you don't get your money and they will complain about that but, at least there is an incentive here. This is money they wouldn't get otherwise so if they want it they got to provide the report. The audit is in there and they will agree to that, at least it's in there.

Madam Chair Lee: I'm also experienced enough here to recall when we were having the renewal of compacts when Governor Schafer was here and we had a Mexican standoff in the senate, the head of Senate Judiciary at the time felt strongly that in the same sense as on the federal level, treaties are advice and consent from the U.S. senate and should be the same for compacts on the state level, I agree and most of the senate did but we lost that ultimately and it's because of sovereignty. I also understand that sometimes they say things are going to happen and they don't happen, that risk is there.

Senator Anderson: I think this is an opportunity that we can get an agreement with the tribes and should they sign the agreement they are also agreeing to the report and get the money so I think it's an opportunity to show that they can work with the state and this as well. I can think it can only be positive in the long term.

Madam Chair Lee: I also think that we have better relationships with the tribes then we did at that time and there is some good faith involved all the way around. It's a trust and verify

thing for me but I'm anxious to go forward and see if we can make this work because I think it's a good proposal. Is there any further discussion on the motion? If not, please call the roll.

ROLL CALL VOTE TAKEN
5 YEA, 1 NAY, 0 ABSENT
MOTION CARRIES DO PASS, AS AMENDED, REREFFER TO APPROPRIATIONS.
Senator K. Roers will carry HB 1194.

Madam Chair Lee closes the discussion on HB 1194 and moves on to HB 1033.

SR 3/6 1051

19.0401.06001
Title.07000

Adopted by the Senate Human Services Committee

March 6, 2019

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1194

Page 1, line 2, remove "to amend and reenact"

Page 1, line 3, remove "section 50-24.1-37 of the North Dakota Century Code, relating to Medicaid expansion;"

Page 1, remove lines 7 through 22

Page 2, remove lines 1 through 30

Page 3, remove lines 1 and 2

Page 3, line 18, replace "fifty" with "seventy"

Page 3, line 18, replace "fifty" with "thirty"

Renumber accordingly

Date: 3/6/19
Roll Call Vote #: 1

2019 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1194

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: Tribal fund for 70% to tribes and 30% to the state

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen. Anderson Seconded By Sen. Hogan

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee	X		Sen. Kathy Hogan	X	
Sen. Oley Larsen	X				
Sen. Howard C. Anderson	X				
Sen. David Clemens	X				
Sen. Kristin Roers	X				

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Delete section 1.

Date: 3/6/19
Roll Call Vote #: 2

2019 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1194

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☒ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen. K. Roers Seconded By Sen. Hogan

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee	X		Sen. Kathy Hogan	X	
Sen. Oley Larsen		X			
Sen. Howard C. Anderson	X				
Sen. David Clemens	X				
Sen. Kristin Roers	X				

Total (Yes) 5 No 1

Absent 0

Floor Assignment Sen K. Roers

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1194, as reengrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (5 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). Reengrossed HB 1194 was placed on the Sixth order on the calendar.

Page 1, line 2, remove "to amend and reenact"

Page 1, line 3, remove "section 50-24.1-37 of the North Dakota Century Code, relating to Medicaid expansion;"

Page 1, remove lines 7 through 22

Page 2, remove lines 1 through 30

Page 3, remove lines 1 and 2

Page 3, line 18, replace "fifty" with "seventy"

Page 3, line 18, replace "fifty" with "thirty"

Renumber accordingly

2019 SENATE APPROPRIATIONS

HB 1194

2019 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

HB 1194
3/21/2019
Job # 34137

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Rose Laning and Alicia Larsgaard

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to create and enact section 50-24.1-40 of the North Dakota Century Code, relating to medical assistance tribal health care coordination agreements.

Minutes: Testimony # 1.

Legislative Council: Levi Kinnischtzke
OMB: Stephanie Gullickson

Chairman Holmberg: Called the committee to order on HB 1194.
Do we have anyone that is going to be telling us why this is good and we should focus on the dollars? Give us the concept and let us talk about the money because that is our job. The other committee talked about the policy.

Nathan Davis, Council Representative Turtle Mountain Band of Chippewa Indians
Testimony in support of HB 1194 - Attached # 1. The extra funding, as you can see in the fiscal note, is not going to be great. It is not going to grow very much in the first biennium. Moving forward, as we teach our people about how to use Medicare and Medicaid, and we advocate for that 70/30 today. Over time that would really help address a lot of the health care disparities we face on tribal communities.

The American Indian population in Rolette County is 77.8%. According to ND's 2019 county health ranking report, Rolette County ranks 48 out of 53 counties in health care outcomes. That measures how long people live and how healthy they are. Rolette County also ranks 49 out of 53 counties in health factors. These factors focus on how long we live including to health behaviors, clinical access, social and economic factor, and the physical environment.

77.8% of the population in the county is American Indian and experiences the fullest health care amongst counties in the state. Benson county is home to the Spirit Lake nation which is 47th. Sioux County, which is home to the Standing Rock nation is 49th in the state. This is North Dakota data from 2018 reports of the public health department.

We in the Turtle Mountains believe that if we are able to use these funds and reallocate them to preventative measure to battle chronic disease such as diabetes, alcoholism,

cancer, heart disease, etc., we can attack these disparities at the source before they outgrow out capabilities at the local level. Once they outgrow liabilities, they are truly a financial burden on the state of ND. In proving that government to government relationship and moving forward together as members of this great state, I think this piece of legislation will speak volumes for the health care state of ND as a whole.

Kenny Baker, Jr., Spirit Lake Tribe
No written testimony.
Speaking in support of HB 1194
Currently, IHS is funded at about 49 cents to 51 cents to the dollar. That is what we get for our budget to administer health care for our folks. We get a grant for 5 years and we have suicide prevention. After 5 years is done, the people that are in place to help with the issue go away. And our folks are falling into a trap again and committing suicide. Anything we can get extra over that 49 cents to $1 would be tremendous. Tribes are really resilient. We have made that 49 cents to a dollar stretch. Yet people who are in federal system are about $1+ a patient. We are wondering why we are lagging so far behind. I know you don't control the federal government on what they do for appropriations. But 1194 will really help us. In turn, we believe it will strengthen our partnership with our hospitals we are going to make these agreements with for better health care for our people. We believe that it will save not only the tribes money, but also save Medicaid and state money as well. I will stand for questions.

Danielle Finn, Standing Rock Indian Reservation
No written testimony, but speaking in favor of HB 1194.
The Standing Rock Sioux Tribe has a government to government relationship with the United States of America and including their subdivisions which are the states. This relationship is reflected in our treaties which were signed in 1851 and 1868. The treaties underscore the ongoing promises and obligations of the United States to the tribe. Our testimony is submitted with those promises and obligations in mind. Standing Rock reservation encompasses 2.3 M acres in North and South Dakota in which over 700,000 are in ND. The Standing Rock Tribe has approximately 14,000 tribal citizens. Many of which reside in 8 districts and communities spread across our rural reservation. The tribe struggles to provide central government services as well as adequate health services to our citizens. Despite the tribe's best efforts, our unemployment rate is over 50%. Over 40% of Indian families on our reservation live in poverty. That is more than triple the average U.S. poverty rate. The disparity is worse for children as 52% under 18 live in poverty compared to just 16% to the rest of ND. The Standing Rock Sioux Tribe had many public health concerns.

The following is a list to give this committee an idea of what the citizens of the Standing Rock Sioux Tribe face on a regular basis:
Diabetes, heart disease, substance abuse, mental health, suicide, cancer, infant fatality rate, infant morbidity rate, high risk pregnancy, increased autism, inadequate clean water supply, aging plumbing systems, lead in pipes in all water systems, inadequate sewer, mold in homes, lead paint in homes, and STDs.

This is not a complete list of health concerns but all these concerns need funding to be adequately addressed by the Standing Rock Tribes. We have many health related needs.

We need a new Indian house service building, nursing home with at least 10 beds, an in-patient treatment center along with in and out-patient services. We also need more health care professionals. health beds and more health care professionals. Currently, there is a lack of professionals due to poor salaries and poor benefits. The reservation is facing the crisis with opioid and meth abuse. This problem is a lifelong condition that has been treated as a rural behavior health illness. The tribe needs additional mental health specialists and special abuse counselors to be able to combat this issue. There are several other programs that could use this funding. Those could be the Community Health Representative programs, special diabetes programs, master contract for the emergency department, radiology, emergency medical services, cancer funds, the wellness program, the alcohol tobacco drugs program, and elderly nutrition.

Again, this is not a complete list, but a quick run through of some of the major needs and the programs that could benefit from the 70% that you could give us. Agreements were signed in 2018. In June of 2018, Standing Rock gave testimony to the health care reform and review committee stating that we wanted 100% of the tribal health care coordination fund due to the health concerns, disparities, and needs of the tribe.

Standing Rock tribe began to negotiate on a percentage rate for the tribe and the state. The tribe wanted the bill to be introduced at 95% to 5% or 90% to 10% or even 80% 20%. The tribe came to the point where the lowest we could go was 70% to 30% while keeping the Active Care Coordination agreement. We are the only tribe that has an active care coordination agreement. Representative Kaiser introduced bill that would allow the tribes 70% of the tribal health care coordination fund where the other 30% would return to the state's General Fund. We agreed to submit annual reports in an audit every 4 years to the state upon receiving the 70%. That is outlined in the bill. In conclusion, the tribe has not halted the process of the agreement in the hopes that the state and tribe can work together to move forward for a better outcome for the people of our tribe. We need the 70% from the tribal care coordination fund and nothing less due to our health disparities, concerns, and needs that I just outlined for you all. This funding may mean the life and death of our people.

We would like to state out opposition to section 1 of HB 1194 as it has nothing to do with the tribal care coordination agreements and the Standing Rock Sioux Tribe. Thank you for your time.

(13:14) Chairman Holmberg: You said you were against section 1 which is the whole bill.

Danielle Finn: Oh, it's been amended. Nevermind, we are good.

(13:40) Senator Mathern: As you know, we authorized this last session and it takes a while to get up to speed so the amount of dollars was considerably less that the reality of this biennium. I am wondering if that might be the case with the other tribes as well. Are you advising them on getting a coordination agreement in place so this could be going?

Danielle Finn: They are in place but need to be signed. The tribal councils have to adopt. We are the only ones where we are collecting at this point. If they're going to get a good percentage rate and we can all agree on the 70-30, they would join in.

Nathan Davis: Turtle Mountain does have an agreement with CHI/Sanford. It is just not active right now pending the outcome of this piece of legislation.

Senator Mathern: I think you could have started. Or did we limit this biennium to one tribe.

Nathan Davis: It could start but it was a consensus at our tribe that we were going to wait to see what happened with the percentage before we participated.

Senator Mathern: What is the percentage right now?

Nathan Davis: There is none. It has not been set. Anything below 70, we will not participate in.

Senator Mathern: So this biennium, there is an agreement with Standing Rock but there is no set percent? So what does the agreement say, what do you get?

Chairman Holmberg: I am in a fog as to why we should be against this.

Maggie Anderson, Department of Human Services: We are in support of the bill. We do believe there should be some shared savings with the tribes. The % needs to be decided by the committee.

In February of 2016, the Medicare and Medicaid services clarified their long standing policy which was that a service received through Indian health service or a tribal 6-38 entity was not eligible for 100% federal Medicaid match. Services for Medicaid individuals that are received at a tribal 638 or IHS facilities have long had 100% Medicaid FFP or FMAP.

In February of 2016, the administration clarified that as long as there was a care coordination agreement in place and there was an appropriate request for services and sharing of information back and forth between the non-IHS provider and the Indian health services of tribal 638 providers, those services could get 100% FMAP for services.

SB 1012 of last session had a section added that there should be a coordination agreement with tribes. We decided to start in the Bismarck region with the two health care systems that are here in this region and with Standing Rock. It was mostly about logistics. We did not want to do this state wide because we wanted to make sure we had all the system pieces worked out, as well as the language of what that care coordination agreement would entail. We started working with CHI, Sanford, Standing Rock Indian health services, and we have held a number of meetings.

There are signed active care coordination agreements between Aberdeen IHS, Standing Rock IHS, and Turtle Mountain IHS. Turtle Mountain is signed but not active. That is the background. We continued to work on the system pieces and making sure as the claims come in from the non-IHS providers. If someone from Standing Rock was referred to CHI, that service is always a $1,000 service we pay. We would receive 50-50 FMAP on that under an approved care coordination agreement and we would receive 100% of that from the federal government.

We cannot stand here today and tell you how much we have incurred or saved from those agreements. It is being worked out. We are able to go back to the effective date of when those agreements were signed and claim that enhanced federal match. I know there were hopes that that would be more than what our fiscal note shows for the next biennium. We believe our fiscal not is practical looking the number of Indians who are Medicaid eligible and have received services outside of Indian health services and depending on where their residence is.

The services have to be received thru IHS or triabl 638 and it has to be done within the expects of the care coordination agreements. If someone is living in Fargo and does not have a connection back to Standing Rock IHS, they cannot just ask to be referred to Sanford in Bismarck and we receive 100% FMAP on that claim. There has to be a relationship, a request from services, and the records from that visit need to go back to the IHS provider and they need to coordinate that care.

I would like to explain the fiscal note to you since you are the appropriations committee. We looked at the data. The number of Native Americans who are Medicaid eligible and receiving services at these non-IHS providers and systems were prioritized and we looked at the services that were realistic to potentially be claimed at the 100%. That is where we come up with section 2B of the fiscal note. We are projected to save $7.4 M dollars in the next biennium. That is where the General Fund expenditure savings of the $7.4 M is at the top. As the 70-30, $5.2M would be deposited in the Tribal Health Care Coordination Fund. When you add those two together, that is where you get the $12.5 M of other funds for both the revenues and the expenditures. $2.2M would go to the General Fund which is why you are seeing a positive $2.2 M in the General Fund.

In SB 2012, you are appropriating the dollars we need to pay the health care providers as is and that is assuming 50-50 FMAP. If we are able to capture the 100% FMAP for any of those services, that is where those savings come in. These are offset. You are appropriating the General Fund for these services at 50-50 in 2012. In this bill, we are saying we would save these dollars and that is why the $2.2 M would go back to the General Fund.

(22:49) Senator Robinson: Is your fiscal note based on all coverage for all of the reservations in ND?

Maggie Anderson: It's based on all of them being online. As you look at the coming biennium, the expenditures go up a bit. We continue to believe we will be able to add more communities and more services. We started with the hospital providers. Those are where your large dollars are. That is how we would prioritize our work.

(23:44) Senator Dever: Does it apply to traditional Medicaid and expansion?

Maggie Anderson: The estimated apply to traditional Medicaid. If we did have expansion in House, we would expect to receive additional revenues. There is a possibility within the expansion where we could try to go into that premium and figure out if some of these services would qualify. That is not a priority on our work plan because there are a lot of cost allocations. We have note explored that at this time. I do not want to say it is not possible

because it is. You would have to figure out the proportion of those services that were related to this while keeping in mind that Medicaid expansion is 90-10. Your incremental savings are much smaller.

Senator Dever: The money flows in from various tribes. Does it flow out to the tribes based on the usage?

Maggie Anderson: That is exactly how the bill is written. We would know from the way we are capturing the data in MMIS. When we get a bill from CHI, there is going to be intelligence in a code that is used within that claim that tells us that the referral comes from Standing Rock. We know that that $500 savings on that claim was attributable to a referral from Standing Rock. When we split the money between the Tribal Health Care Coordination Fund and the General Fund, we issue those payments on a quarterly or semi-annual basis. We would know that 70% of that $500 savings should go specifically to Standing Rock. It will be shared based on the volume of referrals from the tribes.

Senator Dever: There is an emergency clause. Is this going to apply retroactively?

Maggie Anderson: We understood it would be based on days of service. If the emergency carries and the bill is enacted, it would be based on claims that were submitted to us with that date of service or beyond.

Chairman Holmberg: Closed the hearing on HB 1194.

Senator Mathern: Moved Do Pass on HB 1194.

Senator Robinson: Seconded the Motion.

A Roll Call Vote Was Taken: 14 yeas, 0 nays, 0 absent.

Motion carried.

The bill will go back to the Human Services committee.

Date: 3-21-2019
Roll Call Vote #: 1

2019 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1194

Senate Appropriations Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Mathern Seconded By Robinson

Senators	Yes	No	Senators	Yes	No
Senator Holmberg	✓		Senator Mathern	✓	
Senator Krebsbach	✓		Senator Grabinger	✓	
Senator Wanzek	✓		Senator Robinson	✓	
Senator Erbele	✓				
Senator Poolman	✓				
Senator Bekkedahl	✓				
Senator G. Lee	✓				
Senator Dever	✓				
Senator Sorvaag	✓				
Senator Oehlke	✓				
Senator Hogue	✓				

Total (Yes) 14 No 0

Absent 0

Floor Assignment HS

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1194, as reengrossed and amended: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Reengrossed HB 1194, as amended, was placed on the Fourteenth order on the calendar.

2019 CONFERENCE COMMITTEE

HB 1194

2019 HOUSE STANDING COMMITTEE MINUTES

Human Service Committee
Fort Union Room, State Capitol

HB 1194
4/8/2019
34591

☐ Subcommittee
☒ Conference Committee

Committee Clerk Signature Nicole Klaman

Explanation or reason for introduction of bill/resolution:

Relating to Medicaid Expansion; to provide for a report to the legislative management; to provide a continuing appropriation; and to declare an emergency.

Minutes:

Chair Karen Rohr: Opened conference.

Chair Rohr: We have everybody present. Senator Anderson, would you please explain the amendment? You changed the position from 50/50 that the house upheld to 70/30. Please explain position changing

Senator Anderson: We got the perception from the people working on the bill from the department and from the commissioner of Indian Affairs, that the tribes were less likely to sign the agreements if we dropped it to 50/50. This is why we went to 70/30. I think our people generally felt that without their participation we weren't going to get anything so we might as well try out best to get them involved. We know the department was already working on some agreements and whether they were 5050 or 70/30, I'm unsure. The tribes want it all, which isn't practical as it doesn't pay for the state to do the work if we don't get anything.

Rep. Anderson: I spoke to people in Appropriations and they wanted less, 70/30. This may be why we went to 50/50.

Chair Rohr: I heard the same.

Senator Larsen: Whatever will kill the bill, I will support.

Chair Rohr: Okay, alright.

Rep. Dobervich: In conversation I've had with Indian Affairs and with council members of different tribes, the 70/30 is where the tribes are in agreement right now. That leaves 30% for the state to cover administrative costs, offset providers, providers cost and reinvest 70% into tribal health. We know that our tribal communities have the worst health outcome. Without agreement by the tribes, we get nothing. I think if the tribes are in agreement I

believe 70/30 is a good spot to be. There is a state where 100% goes back into tribal communities. Initially this was discussed at 90/10.

Senator Roers: Help me understand the process. The house came out at 50%/50%, Senate came out at 70%/30%. Were we to amend it to 60/40 and split the difference then what is the next step? Please help me understand the process.

Chair Rohr: I would close the hearing and we would go back and speak with the committee chair.

Senator Roers: Ok. Is this a policy decision, or will it go back to Appropriations?

Senator Anderson: If we would agree, it would be your job to sell it to the House and ours to the Senate. It would be your committee chair that would decide to concur or not concur, whether they consult with the rest of the committee or not is up to them.

Chair Rohr: Ok, thank you.

Rep. Anderson: I think if we take it to the floor with 70/30 it would be defeated. I think we should speak with Chairman Weisz about 60/40 and see how he feels about that.

Rep. Rohr: Is that a motion?

Senator Anderson: I'm not sure it was Senator Roers was trying to reach a compromise, at this point. I believe she was trying to understand the process.

Senator Roers: No, not yet.

Chair Rohr: Understood.

Rep. Anderson: I don't think I would make that a motion just yet, as we would have to keep Chairman Weisz included.

Rep. Dobervich: I still hold at 70/30, this is where the tribes are in agreement. Without their signature the state gets nothing. If we keep lowering it please keep in mind we could end up with nothing.

Senator Roers: This is no additional state dollars, instead it's putting money back into the fund. This is one of the challenges in selling this bill is discussing this cost split. Any percent that the state gets is a gain, not a loss.

(0:06:50)
Senator Anderson: The history of tribes coming forth with their information, that these agreements are supposed to require, has not been that exploratory. However I think this is an opportunity to get them onboard. Obviously, if they do not come forth with the reports or references showing where they spent the money, we have the option or the state has the option not to fund in the future. I think it's in their interest to provide the information we've asked for here and in signing they make that commitment. Now, they all have to go back to

the next tribal council man and make sure they are willing to follow through. I see an opportunity to work together with them and try and get additional funds for them and the state for things we would like to see done. It's in our interest if they are in agreement 70/30 we should get on board with that.

(0:08:06)
Senator Larsen: Regarding Senator Anderson's discussion, I was here when the split went with the oil money. We were in the room and everybody said they were going to be open we are going to have audits, we are going to have all of this. We have no idea what is going on with those funds, not that I care. Except that I do care! This is the same. I'm hearing the same thing I heard with the oil bill. The tribes are sovereign nations, they can do what they want when they want. They don't have to give us that information. I know they say we aren't going to get funding if we don't get the audit and all of that. There's 9% of enrolled members in ND that could be enrolled. There are twenty thousand or less that are enrolled. I think if we push the enrollment part for tribes to get on the marketplace to get in the system, funds will become available then.

Rep. Dobervich: I respectfully counter that. Unlike the oil, this is federal dollars and there are requirements per both state and tribes will have that come with these dollars, unlike the oil dollars which are not federal dollars. Also this is "a deal" that the federal government has put out. If we don't do this now and we work on getting more and more folks enrolled, this deal can go away just as fast as it came. When I look at efforts on the part of Turtle Mountain Band, their enrollment rates for Medicaid are exemplary. They are the model for how other tribes can get higher enrollment rates in Medicaid. There are not navigators anymore. These dollars could be used for hiring navigators to get more people enrolled in Medicaid. These dollars can be used for purchasing a mammogram machine, for upgrading pharmacies and different things like that. Whereas a lot of other federal dollars have strings attached to where the money can or cannot be spent, this offers leeway for what the needs actually are. Unlike oil, this is a different deal.

Rep. Anderson: I still think we need to sell it to the House, and at 70/30 I don't think that will happen. That is my opinion.

Senator Anderson: Senator Larsen understands the insurance business related to the Affordable Care Act better than most of us. I'd ask him to explain how a Native American can get on the Affordable Care Act and what the costs are.

Senator Larsen: Madam Chair, that is a great question. As a matter of fact, in Turtle Mountains, I am one of the insurance agents that deals with all the political subdivisions including the casino.
My experience with the enrollment process is everybody is eligible to be enrolled. They do not want to be enrolled because they do not want to take the time. The time is extensive. And the paperwork is extensive to have to feed that program. I do agree they have the most robust enrollment in the state. But that still goes back to there being fifty thousand people that are enrolled members. If you look at Medicaid expansion, there is not even twenty thousand people signed up. Of those twenty thousand, how many are Native American population? They can enroll up to 300% of poverty. Every child, every person in that household brings that cost up, so everybody qualifies. but everybody is not signing up. If

we can get people to sign up with Indian Health Services and Sanford Insurance, it's a dual insurance. Indian Health Services being secondary to Medicaid expansion.

Rep. Dobervich: So ideally, if we can come to some agreement along with the tribes, the more people that are enrolled, the more money the state will make?

Senator Larsen: They will not sign up. Obama Care has been going on forever.

Rep. Dobervich: Excuse me, it's the Affordable Care Act.

Senator Larsen: Madam Chair, The President of the United States, when in power, loved Obama Care. So if the past president of the United States agreed and embraced the word Obama Care, I'm using it. So that's what it is, Obama Care, as from the past president.

Chair Rohr: Any further discussion?

Senator Larsen: We had navigators throughout the state and I think there was a $600,000 grant that I think went to Minot State University. That individual, Neil Shark, was the one that was spear heading that. We also had navigators for the tribes and their main office was down in Omaha, I believe. There was no movement on it. What little they tried to do to enroll people was ineffective. So I go back, since the inception of Obama Care, everybody could have jumped on board to sign up and nobody is signing up.

Chair Rohr: Thank you. Further discussion? You are holding your position of 70/30?

Senator Anderson: You indicated you need to get back to the committee chair and we are comfortable with that. We could always throw out a compromise but whether that would accomplish our long term goal of getting the tribes to sign these agreements, which is completely voluntary on their part. I think that's the important message. If we have an agreement at 70/30, I think we should try and stick with that.

Rep. Anderson: But we don't have agreement with all of them, just 3 affiliated tribes?

Audience: Just Standing Rock

Chair Rohr: Just Standing Rock.

Rep. Dobervich: Last week there was a meeting of the tribal chairs and councils at United Tribes. This issue was discussed, while there is no signed agreements but there was verbal at the 70/30 on part of all the tribes.

Chair Rohr: Further discussion? Seeing none.
Adjourned the conference.

2019 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1194
4/11/2019
34692

☐ Subcommittee
☒ Conference Committee

Committee Clerk: Nicole Klaman by Donna Whetham

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to create and enact section 50-24.1-40 of the North Dakota Century Code, relating to medical assistance tribal health care coordination agreements; to provide for a report to the legislative management; to provide a continuing appropriation; and to declare an emergency

Minutes:

Chair Rohr: Opened the Conference Committee meeting HB 1194. Senator Anderson would you like to explain your point?

Senator Anderson: The Senate would like to stay at the 70/30 split the tribes have agreed to that and we need an incentive for them to work with the providers. We don't have any money now in this. I also think a little background would be beneficial, if we could talk with some of the providers in the room. This is an agreement between the tribe and the provider. The state and the tribe benefits from that. Let's talk with the providers in the room and see where they stand because this is an agreement between the tribe and the provider.

Chair Rohr: For a point of position for the House, we are going to stay at 50/50 as well. Who could come up and give us some background.

Marnie Walth, Sanford Health: When the department decided to pilot the project in Bismarck it made a lot of sense for a lot of reasons geography wise we partner with Standing Rock. Sanford brought this forward and we are fully committed. Both Sanford and CHI signed care coordination agreements with the Great Plains Area Indian Health Services, and there needs to be a referral process on the front and back end. Working with Standing rock they have the front end referral process hardwired because of the contract dollars there is an elaborate system which is now in place to make referrals to the hospitals. Where there is a lot of room for improvement on our part, sending information back to the IHS facility. electronic health record. One thing we were able to do is put in an epic electronic connection to the IHS, no more faxing no more lost health records. We've been working on the MMIS system, and how they can recognize these claims which requires the provider to use a special element on the claim. Last month, the first claim was recognized by MMIS. But we still aren't there because MMIS can't yet send it to CMS, but it's a work in progress

I would tell you that I can pull a report from my facility to show which charges we have for patients that are dually enrolled in Indian Health Services and Medicaid and from the date that the care coordination was signed it's more than a million dollars in payments not charges. In theory that is a $800,000 check going into the trust care fund that we are talking about we just need to figure out how to process those claims.

Senator Anderson: We have also heard that there are some that think the state is doing all the work and we should be getting more of the money. Please ask the department how much work is involved.

Marnie Walth: We are fully committed to make this work. We have staff that works with patients to help enroll.

Senator Hogan: Are you doing both Medicaid expansion and traditional Medicaid cases? The real issue is improved healthcare and also improved relationships between local providers and bigger health systems. Do you have any feedback about how that is going?

Marnie Walth: Right now we are focusing on traditional Medicaid and the relationships are going fantastic. The group of people we were working with at Standing Rock are collectively realizing that there is lots of room for improvement.

Senator Hogan: Are able to identify unmet health needs in the tribal communities that you could see some good use for those funds?

Marnie Walth: Well certainly, one example would be in working together in Standing Rock and as we are trying to hardwire these processes I was asking them to send me a sheet of referrals to compare and see if we are really catching them. As I went through the list there were quite a few individuals that weren't enrolled in traditional Medicaid. It looks like there are a lot of eligible patients who aren't enrolled in Medicaid yet.

Senator Hogan: Do you think if the tribes got a higher share of the savings there would be higher enrollment?

Marnie Walth: I can't speak to the share but just fully supportive of supporting tribal care.

Senator Anderson: I want to ask the Department how much work is this?

Maggie Anderson, North Dakota Department of Human Services: During last session you authorized one FTE to the Department to work on the tribal relations piece and the care coordination. Once the changes are made to MMIS and we have all the Federal recording pieces in place that is just routine pieces that happen behind the scenes and we capture the extra match and it goes on the Federal report. That individual FTE provided will continue to work with the tribes on this and do the auditing of the claims. So the department of human services so to speak does not have significant ongoing administrative expenses.

Senator Anderson: To follow up, we have been working on this during the biennium so we have been spending some money on that. Do you see that we are getting some additional?

That 50 % that comes to the state now and are we going to lose that if we give half or 70% away. What do we look at going forward here?

Maggie Anderson: Technically we started working on it when the state officer letter came out in February of 2016. Then you provided the FTE last session. A bulk of that persons' time has been gaining relationships and sustaining relationships and working on third party billing for the tribes as well as this project. Anything we realize before June 30, 2019 will be deposited into the health care trust fund. The emphasis was to help offset the state share of keeping Medicaid expansion at commercial rates. Whatever savings deposited before June 30 that will be the legislative decision of how you want to use those funds. Whether you want to offset Medicaid grant expenditures into a future biennium. The department does not have the ability to pull from the Healthcare trust fund. Whatever is deposited will sit there until the next session.

Senator Anderson: What if we go to 70-30% what happens to the 30%?

Maggie Anderson: It is deposited to the general fund is the way the bill reads. Then as lawmakers you would determine how to appropriate that the next time.

Senator Anderson: Right now 100% of the 50% that we might get from the Feds is going to the healthcare trust fund. Correct?

Maggie Anderson: Whatever savings we have before June 30,2019 healthcare trust fund. 100% of the savings is going to the state it just happens to be deposited into the healthcare trust fund. That savings is all to the state right now and into the health care trust fund and depending how lawmakers want to spend that in an upcoming session. The healthcare trust fund was an existing fund last session.

Senator Hogan: If we are at 60-40% or 70-30% that money goes directly to the general fund not the healthcare trust fund according to this bill. I don't think we talked about that in our committee the difference between the healthcare trust fund and the general fund. So it is no direct benefit immediately to the Department of Human Services.

Maggie Anderson: Speaking to the Medicaid expansion piece, the reason for not prioritizing that is the majority of the Medicaid expansion population is a 90-10 Federal Medical Assistance Percentage (FMAP) the marginal increase is very low. The other piece of that is those of us that work in the department know that in order to do that we are going to have to do an incredible amount of work within the cost allocation. Within the managed care program rather than fee for service we would have to decide which proportion of the expenditures might be related to someone who is in a care coordination agreement. With the way the amendments are in HB 1374 and SB 2012 bringing pharmacy in house. We want to prioritize that work and get that done and that will impact our premiums that are made for Medicaid Expansion. Having the Children's Health Insurance program as a fee for service will impact our expenditures on what will now be Traditional Medicaid. It would widen the number of services and the number of individuals that we could potentially get that match for so the managed care premiums will probably continue to be a lower priority because of the 90-10 match and the complications with allocating those premiums.

Senator Hogan: If the goal of these agreements and advanced funding is better health care for our tribal partners there is nothing that you really need in the Department at this time?

Maggie Anderson: No.

Chair Rohr: Any other providers you want to hear from? Any other questions? Seeing none. Meeting is adjourned.

2019 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1194
4/22/2019
34916

☐ Subcommittee
☒ Conference Committee

Committee Clerk: Carmen Hart

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to create and enact section 50-24.1-40 of the North Dakota Century Code, relating to medical assistance tribal health care coordination agreements; to provide for a report to the legislative management; to provide a continuing appropriation; and to declare an emergency

Minutes: Attachment 1

Chair Rohr: Opened the conference committee meeting on HB 1194. Other members present were Rep. D. Anderson, Dobervich, Senator H. Anderson, K. Roers, and Hogan.

Senator H. Anderson: The Senate is pretty firm on we are not going to 100% just the tribes.

Chair Rohr: I think we left it last time you were holding at 70% in tribal coordination fund and 30% in the general fund and we were holding at 50-50%. Is there any discussion or desire to decrease that 70 to 30%.

Senator H. Anderson: My discussions with this business is we need to come to some compromise that would be good. We have pretty much decided we would not have any trouble in the Senate because we already passed 70-30%. There are options, we can leave it at 70-30% and you can accede and see what happens on the floor or we could try to compromise at 60-40%. If you think you can't sell that we can recede and then at least and then it would be 50-50%. I don't think we would have trouble with any of those three options. We would not like to see the House kill the bill. It is still up to the tribes whether they want to sign or not on whatever we come up with. We would like to make it a little friendlier toward them.

Rep. Dobervich: I would like us to consider the Oregon model of 100%. While the House is at 50-50% I still hold at 70-30%. With my last conversation with the tribal government they are holding at 70-30% is what they are willing to sign. Without their agreement the state will not be receiving any funds either. While we need to make it palatable to pass the on the floor and if the tribes are not in agreement with it is for naught.

Senator H. Anderson: I think 60-40 might have a chance to pass. 70-30 wouldn't pass and 50-50 may pass us. Still it's up to the tribes.

Senator Roers: The selling point is the same whether you are talking to the tribes or you are trying to sell your colleagues on the plan. If we were to go to 60-40 from the tribal perspective 60% of something is still better than 70% of nothing. On the flip side of that on the floor 40% of something is still better than 50% of nothing. I feel that the 60-40 might be that balance point where it would make it enough to make it worth the effort for the tribe and yet it be palatable to sell it to colleagues.

Chair Rohr: So I hear that 60-40 is palatable. Any other comments?

Senator K. Roers: I move the Senate recede and we amend HB 1194 to 60-40% for cost split.

Senator H. Anderson: Seconded the motion.

Chair Rohr: We will have to retract this motion because there is another consideration since we are looking at 60-40 being palatable on the Senate side. On page 2 on the amendment there is a desire to be more specific on language Line 5, where it reads the use of the money distributed. After visiting with the chair he would like us to be more specific on the language on how the money is actually used. There was conversation that he had with Maggie from the department of Human Services and she was going to work on some language.

Senator K. Roers: I rescind my motion.

Senator H. Anderson: I rescind my second.

Maggie Anderson, Department of Human Services: Appeared and presented a proposed amendment. On page 2 as the Chair indicated there was request to be more specific about the funding and Rep. Weisz said they did not want it to be used for capital construction. On page 2 line 8 it is replacing the words capital construction with developing or enhancing representative programs or services and on line 6 it would insert the word "population". He wanted included things it may not be used for so you see it 'may not include capital construction, stipends to individual for services, or services that are covered by Indian health services, Medicaid or other third-party payers or state–funded programs. The intent there was if there was a funding stream such as Medicaid or Indian Health Services or something like the substance use disorder voucher that those funding streams should be looked at first prior to using this funding. We looked at this as the Departments role, this is in subsection 1 on page 2. In subsection 2 it says the tribal governments will submit to the department annual reports detailing the use of the money. Certainly those reports would need to be more detailed. We wouldn't want the department in the position of auditing this and knowing everyone eligible for these funding. So let's assume all of you would have may have benefited from this and you could have received services through the voucher but how would we have known that. So if it's okay to rely on the audit that is done every 4 years which is in subsection 3 on page 2. That is fine. If there is some expectation of the department that changes a lot of things in terms of our oversight of this because we did not look at that when we did the original fiscal note. **See Attachment 1.**

Chair Rohr: Another thing we were going to suggest is on Line 11 changing that to audited biennually every two years instead of every 4 years.

Senator Hogan: In terms of the stipend for individuals for services, so a tribal government couldn't set up a voucher program at all similar to the what we have done on substance use disorder? We don't want to supplant existing resources. Would this prohibit them from doing it?

Maggie Anderson: My take on this language is the substance abuse disorder voucher is not a stipend for me as an individual, it is a stipend to the program where I am receiving services. I think that would still be allowable. Let's say someone needed services at Heartview and it is something that the voucher doesn't cover then that should be perfectly fine because the amount would be going to Heartview and not to me as an individual.

Senator Hogan: So we are clear that they could have a voucher program but the actual payment would go to provider not an individual. At least we have that on the record.

Rep. Dobervich: In page 2 line 8 says community health representative programs and services can't be funded through these dollars?

Maggie Anderson: No, those are allowable.

Rep. Dobervich: If you read further it may not include services that are covered by Indian Health Services. So that is funded at less than 60% usually they are out of money by August. So hypothetically if a person gets sick in November and IHS has no money are they able to use these funds to make up that difference.

Maggie Anderson: If IHS no longer has the funding to cover it then it wouldn't be a service covered by them because they have run out of funding.

Rep. D. Anderson: In Paragraph 3 on page 2 it says submit to the Department every 4 years and that would have to be changed to 2 and on changed on line 16 also. Or to biannually.

Chair Rohr: Any further discussion?

Senator K. Roers: I move that the Senate recede from their amendment and amend HB 1194 with the proposed amendment and the change from 4 years to biannual and the 60-40.

Senator Hogan: Seconded.

Chair Rohr: Any further discussion? Seeing none.

Roll Call Vote: Yes 5 No 1 Absent 0. Motion carries.

Senate Carrier: Senator K. Roers. **House Carrier:** Rep. Rohr.

Meeting closed.

DO 4/22/1

19.0401.06002
Title.08000

Adopted by the Conference Committee

April 22, 2019

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1194

That the Senate recede from its amendments as printed on pages 1326-1327 of the House Journal and pages 868 of the Senate Journal and that Reengrossed House Bill No. 1194 be amended as follows:

Page 1, line 2, remove "to amend and reenact"

Page 1, line 3, remove "section 50-24.1-37 of the North Dakota Century Code, relating to Medicaid expansion;"

Page 1, remove lines 7 through 22

Page 2, remove lines 1 through 30

Page 3, remove lines 1 and 2

Page 3, line 18, replace "fifty" with "sixty"

Page 3, line 18, replace "fifty" with "forty"

Page 3, line 26, after "include" insert "population"

Page 3, line 27, remove "and"

Page 3, line 28, replace "capital construction directly related to health-related programs or services" with "or developing or enhancing community health representative programs or services. Health-related purposes may not include capital construction, stipends to individuals for services, or services that are covered by Indian health services, Medicaid, or other third-party payers, or state-funded programs"

Page 4, line 1, replace "four" with "two"

Page 4, line 6, replace "four" with "two"

Renumber accordingly

Date: _____
Roll Call Vote #: ____

2019 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

HB 1194 as (re) engrossed

House Human Services Committee

Action Taken
☐ **HOUSE accede to Senate Amendments**
☐ **HOUSE accede to Senate Amendments and further amend**
☐ **SENATE recede from Senate amendments**
☐ **SENATE recede from Senate amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: _____ Seconded by: _____

Representatives	4/8	4/11		**Yes**	**No**		**Senators**	4/8	4/11		**Yes**	**No**
Rep. Rohr, Chairman	x	x					Senator H.Anderson, Jr.,Chair	x	x			
Rep. D. Anderson	x	x					Senator K. Roers	x	x			
Rep. Dobervich	x	x					Senator Hogan (in place of Larsen 4-11)		x			
							Senator Larsen-replaced 4/11	x	--	--		
Total Rep. Vote							Total Senate Vote					

Vote Count Yes: _____ No: _____ Absent: _____

House Carrier _____ Senate Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

Date: 4-22-19
Roll Call Vote #: 1

2019 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1194 as (re) engrossed

House Human Services Committee

Action Taken

- ☐ **HOUSE accede to Senate Amendments**
- ☐ **HOUSE accede to Senate Amendments and further amend**
- ☐ **SENATE recede from Senate amendments**
- ☒ **SENATE recede from Senate amendments and amend as follows**
- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Senator K. Roers Seconded by: Senator H. Anderson

Representatives	4-22			Yes	No	Senators	4-22			Yes	No
Rep. Rohr, Chairman	X					Sen. H. Anderson, Jr., Chair	X				
Rep. D. Anderson	X					Sen. K. Roers	X				
Rep. Dobervich	X					Sen. Hogan	X				
Total Rep. Vote						Total Senate Vote					

Rescinded their motions

Vote Count Yes: _____ No: _____ Absent: _____

House Carrier _____ Senate Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

Date: 4-22-19
Roll Call Vote #: 2

2019 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1194 as (re) engrossed

House Human Services Committee

Action Taken

- ☐ **HOUSE accede to Senate Amendments**
- ☐ **HOUSE accede to Senate Amendments and further amend**
- ☐ **SENATE recede from Senate amendments**
- ☒ **SENATE recede from Senate amendments and amend as follows**
- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Senator K. Roers Seconded by: Senator Hogan

Representatives	Yes	No	Senators	Yes	No
Rep. Rohr, Chairman	X		Sen. H. Anderson, Jr., Chair	X	
Rep. D. Anderson	X		Sen. K. Roers	X	
Rep. Dobervich		X	Sen. Hogan	X	
Total Rep. Vote			Total Senate Vote		

Vote Count Yes: 5 No: 1 Absent: 0

House Carrier Rep. Rohr Senate Carrier Senator K. Roers

LC Number 19.0401 . 06002 of amendment

LC Number 19.0401 . 08000 of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

Insert LC: 19.0401.06002
House Carrier: Rohr
Senate Carrier: K. Roers

REPORT OF CONFERENCE COMMITTEE

HB 1194, as reengrossed: Your conference committee (Sens. Anderson, K. Roers, Hogan and Reps. Rohr, D. Anderson, Dobervich) recommends that the **SENATE RECEDE** from the Senate amendments as printed on HJ pages 1326-1327, adopt amendments as follows, and place HB 1194 on the Seventh order:

That the Senate recede from its amendments as printed on pages 1326-1327 of the House Journal and pages 868 of the Senate Journal and that Reengrossed House Bill No. 1194 be amended as follows:

Page 1, line 2, remove "to amend and reenact"

Page 1, line 3, remove "section 50-24.1-37 of the North Dakota Century Code, relating to Medicaid expansion;"

Page 1, remove lines 7 through 22

Page 2, remove lines 1 through 30

Page 3, remove lines 1 and 2

Page 3, line 18, replace "fifty" with "sixty"

Page 3, line 18, replace "fifty" with "forty"

Page 3, line 26, after "include" insert "population"

Page 3, line 27, remove "and"

Page 3, line 28, replace "capital construction directly related to health-related programs or services" with "or developing or enhancing community health representative programs or services. Health-related purposes may not include capital construction, stipends to individuals for services, or services that are covered by Indian health services, Medicaid, or other third-party payers, or state-funded programs"

Page 4, line 1, replace "four" with "two"

Page 4, line 6, replace "four" with "two"

Renumber accordingly

Reengrossed HB 1194 was placed on the Seventh order of business on the calendar.

2019 TESTIMONY

HB 1194

HB1194
1/15/2019
A

TESTIMONY OF BRANDON MAUAI FOR THE STANDING ROCK SIOUX TRIBE BEFORE THE HOUSE COMMITTEE ON HUMAN SERVICES CONCERNING HB: 1194; THE TRIBAL HEALTH CARE COORDINATION AGREEMENTS JANAURY 15, 2019

Chairman & Distinguished Members of the Committee:
Good morning, allow me to introduce myself, my name is Councilman Brandon Mauai, I am the representative from the Standing Rock Sioux Tribe and serve as the Secretary of the Health, Education, and Welfare Committee. Our testimony today will outline the Standing Rock Sioux Tribe's thoughts on HB: 1194 and the number of health disparities the Standing Rock Sioux Tribe faces

The Standing Rock Sioux Tribe has a government-to-government relationship with the United States of America and including their subdivisions, which are the States. This relationship is reflected in our Treaties, which were signed in 1851 and 1868. These Treaties underscore the ongoing promises and obligations of the United States to the Tribe, and our testimony today is submitted with those promises and obligations in mind.

The Standing Rock Sioux Reservation encompasses 2.3 million acres in North and South Dakota of which 721,920 acres are in North Dakota. The Standing Rock Sioux Tribe has approximately 14,000 Tribal Citizens; Many of which reside in the eight districts and communities spread across our rural reservation. The Tribe struggles to provide essential governmental services as well as adequate health services to our citizens.

Despite the Tribe's best efforts, our unemployment rate remains above 50%. In fact, over 40% of Indian families on our Reservation live in poverty – more than triple the average U.S. poverty rate. The disparity is worse for children, as 52% of the Reservation population under the age of 18 lives below poverty, compared to 16% in North Dakota.

The Standing Rock Sioux Tribe has many public health concerns. The following is not an exhaustive list, rather a list to give this Committee an idea of what the citizens of the Standing Rock Sioux Tribe face on a regular basis.

- Diabetes
- Heart Disease
- Substance Abuse (specifically with methamphetamine and opioids)
- Mental Health Issues
- Suicide
- Cancer
- Infant Mortality
- Infant Morbidity
- High Risk Pregnancies
- Increased Autism Rates
- Inadequate Clean Water Supply
- Aging Plumbing System's (currently, we still have lead and mercury pipes)
- Inadequate sewer infrastructures
- Mold (in both new and old homes)
- Lead paint in homes
- Sexually Transmitted Infections/Diseases

Again, this is not a complete list of the public health concerns, but all of these concerns need

HB1194
1/15/2019
A

funding to be adequately addressed by the Standing Rock Sioux Tribe.

The Standing Rock Sioux Tribe has many health-related needs. The Standing Rock Sioux Tribe needs a new Indian Health Service Building, a Nursing Home with at least ten beds, an in-patient treatment facility along with in-patient services, an out-patient facility along with out-patient services, and more health care professionals. Currently, we there is a lack of health care professionals due to poor salaries and poor benefits.

The Standing Rock Sioux Reservation is facing the same crisis with opioid and methamphetamine abuse that all of Indian Country is facing. This problem is a life long condition that has to be treated as a real behavioural health illness. The Tribe needs additional mental health specialists and substance abuse councillors to be able to combat this issue in a holistic and productive way.

There are several other Tribal Health Programs that could use funding and help, such as: the Community Health Representatives Program (CHRs), Special Diabetes Program for Indians, Master Contract for Emergency Department, Radiology, and Emergency Medical Services, the Kay Murphy Cancer Fund, the Wellness Program, the Alcohol, Tobacco and the Other Drugs Program, and Elderly Nutrition.

Once more, this is not a complete list but rather a quick run through of some of the major needs the Standing Rock Sioux Tribe needs funding for.

Currently, the IHS Great Plains Area Office signed two Care Coordination Agreements with Sanford Health and St. Alexius Medical Center that affect the Standing Rock Sioux Tribe. The Care Coordination Agreement between the IHS Great Plains Area and Sanford was signed by James Driving Hawk, the Director of the HIS Great Plains Area Office, on February 2, 2018 and the Chief Administrative Officer, Randy Bury, of Sanford on December 1, 2017. The Care Coordination Agreement between the IHS Great Plains Area and St. Alexius Medical Center was signed by James Driving Hawk, the Director of the IHS Great Plains Area Office, on February 14, 2018 and the President of the St. Alexius Medical Center, Kurt Schley, on February 15, 2018.

On June 28, 2018, I provided testimony to the Healthcare Reform and Review Committee, stating the Standing Rock Sioux Tribe wants 100% of the Tribal Health Care Coordination Fund due to the health concerns, disparities, and needs of the Standing Rock Sioux Tribe. Upon meeting with Representative Keiser, the Standing Rock Sioux Tribe began negotiations on a percentage rate for the Tribe and the State. No doubt, the Standing Rock Sioux Tribe wanted the bill to be introduced at 95% to %5 or 90% to 10% or even 80% to 20%; nonetheless the Standing Rock Sioux Tribe came to a point where the lowest, we would go was 70% to 30% while keeping the active Care Coordination Agreements.

Representative Keiser agreed to introduce a bill that would allow the Tribe 70% of the Tribal Health Care Coordination Fund, whereas the other 30% would return to the State's General Fund.

The Standing Rock Sioux Tribe agrees to submit annual reports and an audit every four years to the State upon receiving 70% of the Tribal Health Care Coordination Fund as outlined in the bill. The Standing Rock Sioux Tribe has in good faith not halted the process of the Care Coordination Agreements, in hopes that the State and Tribe can work together to move forward to a better outcome for the people of Standing Rock Sioux Tribe. In conclusion, we need the 70% from the Tribal Care Coordination Fund and nothing less due to our health disparities, concerns, and needs.

HB 1194
1/15/2019
B

North Dakota Hospital Association Est. 1934

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony: 2019 HB 1194

House Human Services Committee

Representative Robin Weisz, Chairman

January 15, 2019

Good morning Vice Chairman Rohr and Members of the House Human Services Committee. I am Tim Blasl, President of the North Dakota Hospital Association. I am here to testify regarding House Bill 1194 and ask that you give this bill a **Do Pass** recommendation.

We support this bill and the collaboration it envisions between hospitals and North Dakota tribes to improve access to health care, strengthen continuity of care, and address disparities in health outcomes for American Indians. This joint effort not only provides improved access to health care for American Indians, but it also provides the state with the opportunity to benefit from a new Centers for Medicare & Medicaid Services (CMS) policy which provides 100 percent federal payments when an American Indian Medicaid beneficiary who is also eligible to receive care through Indian Health Services (IHS) receives care from a non-IHS/Tribal facility, so long as the referring and receiving facilities have in place a care coordination agreement.

Care coordination agreements under this new policy were signed in February 2018 between the two large hospitals in Bismarck and the Great Plains Area Indian Health Services (IHS) office. A great deal of work has been done since then by the two hospitals and the Standing Rock Sioux Tribe to coordinate the care of American Indians in the region who need to be referred outside the IHS facility for specialized health care. Both hospitals are now tracking referrals and reporting them to the North Dakota department of human services via the Medicaid billing process.

The "savings" returned to North Dakota from being able to claim the enhanced 100 percent FMAP will be deposited in the North Dakota Health Care Trust Fund. While such claims have

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1

not yet been filed by the department of human services with the federal government due to the need for reprogramming of the Medicaid management information system (MMIS), it is estimated it could provide millions in state general fund savings annually.

We hope that other hospitals and Tribes will agree to join in this project in order to better coordinate health care and take advantage of this enhanced FMAP payment. With everyone working together, we hope to be able to realize those additional federal funds. We support sharing the additional federal funding with participating Tribes in order to incentivize participation in the project and to recognize the additional work Tribes will need to do if they join the project.

In addition to improving coordination efforts and increasing access to care, this initiative is an important step towards finding solutions to ensure sustainability of our state's Medicaid Expansion program. Medicaid Expansion reimbursement rates are the reason many of our critical access hospitals are able to keep their doors open. Working together with state and tribal leaders to support this critical program is a top priority for North Dakota hospitals.

We support removal of the sunset clause on Medicaid Expansion (section one). Medicaid Expansion was first authorized by the legislature in 2013 and has been continuously reauthorized. The contingent effective date (section three) provides that the Medicaid Expansion program continues until the federal government ends it or until program provider reimbursement rates are less than current rates. We support keeping Medicaid Expansion at current rates. If the rates are reduced to traditional Medicaid rates, it represents a $220 million cut to health care providers. All North Dakotans, including tribal members, benefit from reimbursement rates that cover the cost of care and allow hospitals and other health care providers to keep their doors open. It is simply unsustainable to take that much out of our state's health care infrastructure and expect health care won't suffer as a result.

We support the bill and ask that you give it a **Do Pass** recommendation. I would be happy to try to answer any questions you may have. Thank you.

Respectfully Submitted,
Tim Blasl, President
North Dakota Hospital Association

HB1194
1/15/2019
C

Testimony
House Bill 1194 – Department of Human Services
House Human Services Committee
Representative Robin Weisz, Chairman
January 15, 2019

Chairman Weisz, members of the House Human Services Committee, I am Chris Jones, Director for the Department of Human Services. I am here today in support of section 2 of House Bill 1194.

In February 2016, the Centers for Medicare and Medicaid Services (CMS) announced a re-interpretation of statute related to federal match available for services provided to Medicaid-eligible individuals receiving services "through" Indian Health Services (IHS)/Tribal 638. The re-interpretation was intended to help states increase access to care, strengthen continuity of care and improve population health, and made 100% federal financing available for services "received through" IHS/Tribal 638 facilities. Previous federal interpretation did not generally extend to services provided outside of IHS/Tribal 638 facilities.

In order to qualify for 100% federal financing, a request for services must be in accordance with a written care coordination agreement and there must be an established relationship between the American Indian Medicaid beneficiary and the IHS/Tribal 638 facility practitioner. There must be a written care coordination agreement between the IHS/Tribal 638 facility and the non-IHS/Tribal 638 provider. The IHS/Tribal 638 facility practitioner provides a request for specific services and provides relevant information about the beneficiary to the non-IHS/Tribal 638 provider. The non-IHS/Tribal provider sends information about the care provided back to the IHS/Tribal 638 facility practitioner. The IHS/Tribal 638 facility practitioner continues to assume responsibility for the beneficiary's care by assessing the

HB1194
1/15/2019
C

information received from the non-IHS/Tribal 638 provider and taking appropriate action.

During the current biennium, the Medical Services Division has convened a work group to implement the care coordination agreements with Standing Rock Indian Health Services and the Bismarck Health Systems. The work group has identified many important pieces for care coordination and better patient outcomes and has continued to work on the electronic exchange of information rather than the historical, paper processes. The agreements have been signed and eligible services are being rendered.

Additional discussion regarding care coordination have occurred with the other North Dakota Tribal Nations and at the quarterly Tribal Consultation meetings hosted by Medical Services. It is clear the Tribal Nations are committed to the process; however, full implementation of care coordination is tied to assurance of "shared savings" with the Tribes.

The Department recognizes the extra effort that must be invested by Tribal Nations and cognizant of the health care disparities that Tribes could target, and we support the idea of shared savings. The percentage of savings will need to be negotiated between the Legislature and the Tribal Nations.

Section 1 of House Bill 1194 removes the sunset clause from Medicaid Expansion, which is consistent with the Executive Budget Request.

However, as introduced, Section 1 retains the operation of Medicaid Expansion as managed care and maintains Medicaid Expansion at commercial rates; both of which are inconsistent with the Executive Budget Request. During the current biennium, the Department identified Medicaid Administrative Simplification as a priority, not only to reduce overall administrative costs, but also to attempt to simplify programs to benefit those we serve. Transferring Medicaid Expansion to fee-for-

HB1194
1/15/2019
C

service operations is one of the essential components to simplifying Medicaid administration and the savings from the transitioning to the Medicaid traditional fee schedule are proposed to be invested in various behavioral health initiatives.

In addition, the Department does not believe the care coordination efforts should be contingent upon the existence of Medicaid Expansion and payment of providers at commercial rates. The ultimate goal of the care coordination agreements is to improve health outcomes for Native Americans and the work on this effort should continue even if Medicaid Expansion ended or if the rates are not equal to commercial rates.

This concludes my testimony. I would be happy to address any questions that you may have.

HB1194
1/15/2019
D

House Human Services Committee

State Capitol

600 East Boulevard

Bismarck, ND 58505-0360

RE: House Bill 1194

66th Assembly (2019)

Dear Chairman and Committee members,

The Turtle Mountain Band of Chippewa Indians supports House Bill 1194, and have drafted this letter for future reference of our support. We firmly believe that the extra funding that will be made available from the enactment of this bill will greatly impact our community. As you all know the Turtle Mountain Band of Chippewa Indians is a Direct Service Tribe from the Indian Health Service. Our community members have been actively involved in administration, the Director and Assistant Director of Quentin N. Burdick Memorial Healthcare Facility (QNBMHCF) are both tribal members. The service population in and around the TMBCI reservation served by the QNBMHCF is approximately 33,000 plus members. With approximately 15,000 members actively receiving treatment.

With such a high service volume and our local IHS clinic being so underfunded it is impossible to provide proper care to our members in need. QNBMHCF is unable to focus on educational and preventative programs that our people so desperately need. If appropriated, the funds made available by HB 1194, would enable Tribal Health Programs to provide education for our members. Primarily the funds would be used to focus on preventing chronic diseases (diabetes, cancer, heart disease) and addiction (opioids, meth, alcoholism). Another avenue would be to reach out to our high-risk members (youth and our elders) so that they can have access to services that they don't have access to right now. Many of our members don't possess means of transportation and additional funding will help us provide access to healthcare for our impoverished members.

Being able to provide educational and preventative programs to members of our community would benefit not only our tribe, but the state as well. We are all members of the great state of North Dakota no matter what walk of life we come from. As chosen leaders by the people of our respective communities, it's our duty to make sure they are provided for. Not only would these funds provide a brighter, healthier, and prosperous future for our community. It would enable us to take a preventative stand against the chronic diseases and addictions that currently plague our

HB1194
1/15/2019
D

people. If we can attack these health disparities at the source before they outgrow our capabilities, it would be a huge burden taken off the state.

In closing I would just like to reiterate that the funding made available by HB 1194 would be a huge step forward for not only TMBCI but the state of North Dakota as well. As aforementioned that as leaders it's our duty to improve the welfare of our people. HB 1194 will give tribes the ability to vastly improve the healthcare of their people, and in turn that would drastically improve the overall health of the state of North Dakota.

Sincerely,

Nathan A. Davis

Council Representative

Turtle Mountain Band of Chippewa Indians

HB 1194
3/6/19
#1 pg. 1

Testimony
Reengrossed House Bill 1194 – Department of Human Services
Senate Human Services Committee
Senator Judy Lee, Chairman
March 6, 2019

Chairman Lee, members of the Senate Human Services Committee, I am Maggie Anderson, Director of the Medical Services Division for the Department of Human Services. I am here today in support of section 2 of Reengrossed House Bill 1194.

In February 2016, the Centers for Medicare and Medicaid Services (CMS) announced a re-interpretation of statute related to federal match available for services provided to Medicaid-eligible individuals receiving services "through" Indian Health Services (IHS)/Tribal 638. The re-interpretation was intended to help states increase access to care, strengthen continuity of care and improve population health, and made 100% federal financing available for services "received through" IHS/Tribal 638 facilities. Previous federal interpretation did not generally extend to services provided outside of IHS/Tribal 638 facilities.

In order to qualify for 100% federal financing, a request for services must be in accordance with a written care coordination agreement and there must be an established relationship between the American Indian Medicaid beneficiary and the IHS/Tribal 638 facility practitioner. There must be a written care coordination agreement between the IHS/Tribal 638 facility and the non-IHS/Tribal 638 provider. The IHS/Tribal 638 facility practitioner provides a request for specific services and provides relevant information about the beneficiary to the non-IHS/Tribal 638 provider. The non-IHS/Tribal provider sends information about the care provided back to the IHS/Tribal 638 facility practitioner. The IHS/Tribal 638 facility practitioner continues to assume responsibility for the beneficiary's care by assessing the information received from the non-IHS/Tribal 638 provider and taking appropriate action.

During the current biennium, the Medical Services Division has convened a work group to implement the care coordination agreements with Standing Rock Indian Health Services and the Bismarck Health Systems. The work group has identified many important pieces for care coordination and better patient outcomes and has continued to work on the electronic exchange of information rather than the historical, paper processes. The agreements have been signed and eligible services are being rendered.

Additional discussion regarding care coordination have occurred with the other North Dakota Tribal Nations and at the quarterly Tribal Consultation meetings hosted by Medical Services. It is clear the Tribal Nations are committed to the process; however, full implementation of care coordination is tied to assurance of "shared savings" with the Tribes.

The Department recognizes the extra effort that must be invested by Tribal Nations and cognizant of the health care disparities that Tribes could target, and we support the idea of shared savings. The percentage of savings will need to be negotiated between the Legislature and the Tribal Nations.

Section 3 of the original bill was removed by the House. The Department supports the Reengrossed version of the bill as the Department does not believe the care coordination efforts should be contingent upon the existence of Medicaid Expansion and payment of providers at commercial rates. The ultimate goal of the care coordination agreements is to improve health outcomes for Native Americans and the work on this effort should continue even if Medicaid Expansion ended or if the rates are not equal to commercial rates.

This concludes my testimony. I would be happy to address any questions that you may have.

HB 1194
3/6/19
#2 pg. 1

UNDUPLICATED COUNT OF MEDICAID RECIPIENTS BY RACE

FOR STATE FISCAL YEAR 2018 (July 2017- June 2018)

COUNTY	TOTAL RECIPIENTS	RACE					
		AMERICAN INDIAN	ASIAN/ PACIFIC ISLANDER	BLACK	CAUCASIAN	OTHER	NOT IDENTIFIED
1 Adams	326	4	1	3	315	3	0
2 Barnes	1,901	92	4	111	1,678	15	1
3 Benson	3,684	3,186	8	11	465	12	2
4 Billings	70	0	0	0	68	0	2
5 Bottineau	1,047	118	12	9	896	11	1
6 Bowman	384	25	0	0	358	0	1
7 Burke	250	0	0	0	247	3	0
8 Burleigh	12,172	2,779	103	747	8,330	201	12
9 Cass	26,210	1,523	2,027	6,629	15,699	280	52
10 Cavalier	489	29	3	7	448	0	2
11 Dickey	756	20	9	13	703	10	1
12 Divide	307	6	1	2	295	3	0
13 Dunn	617	129	2	7	471	8	0
14 Eddy	468	76	2	1	383	6	0
15 Emmons	514	15	0	1	485	13	0
16 Foster	421	20	0	7	385	8	1
17 Golden Valley	246	3	0	0	241	0	2
18 Grand Forks	11,028	1,177	590	1,626	7,507	104	24
19 Grant	468	7	0	8	448	3	2
20 Griggs	365	13	1	1	349	1	0
21 Hettinger	393	48	1	4	336	4	0
22 Kidder	413	2	1	3	403	3	1
23 LaMoure	499	13	1	10	465	9	1
24 Logan	318	6	0	2	303	7	0
25 McHenry	946	23	9	8	901	4	1
26 McIntosh	452	6	0	3	442	1	0
27 McKenzie	1,776	478	10	53	1,217	15	3
28 McLean	1,270	249	9	15	988	8	1
29 Mercer	941	71	5	19	832	14	0
30 Morton	4,892	718	39	228	3,863	40	4
31 Mountrail	1,634	981	19	15	617	2	0
32 Nelson	447	13	0	2	429	2	1
33 Oliver	212	9	3	0	191	7	2
34 Pembina	1,034	70	0	4	952	8	0
35 Pierce	780	75	1	10	688	6	0
36 Ramsey	2,588	1,034	11	37	1,488	16	2
37 Ransom	742	19	6	13	701	2	1
38 Renville	283	0	0	1	278	4	0
39 Richland	2,602	287	15	71	2,202	23	4
40 Rolette	6,869	6,218	2	24	602	17	6
41 Sargent	442	22	7	9	399	4	1
42 Sheridan	288	14	0	6	268	0	0
43 Sioux	2,675	2,584	9	7	73	2	0
44 Slope	69	4	0	0	65	0	0
45 Stark	4,628	187	45	360	3,993	35	8
46 Steele	227	15	1	6	203	2	0
47 Stutsman	3,192	117	25	208	2,819	18	5
48 Towner	377	62	0	4	309	2	0
49 Traill	1,065	44	10	22	980	5	4
50 Walsh	2,202	88	7	15	2,086	5	1
51 Ward	10,260	1,012	116	1,000	7,966	133	33
52 Wells	628	18	0	8	596	6	0
53 Williams	4,634	377	59	476	3,645	58	19
Total	121,501	24,086	3,174	11,826	81,071	1,143	201
Percent of Total	100.00%	19.82%	2.61%	9.73%	66.72%	0.94%	0.17%

HB 1194
3/6/19
#3 pg. 1

Senate Human Services Committee

State Capitol

600 East Boulevard

Bismarck, ND 58505-0360

RE: House Bill 1194

66th Assembly (2019)

Dear Chairman and Committee members,

The Turtle Mountain Band of Chippewa Indians supports House Bill 1194, with the redaction of the amendment of a 50/50 percentage split. We would like to see the original percentage that was agreed upon by the United Tribes and Representative Keiser, that was 70/30. We firmly believe that the extra funding that will be made available from the enactment of this bill with the original percentage will greatly impact our community. As you all know the Turtle Mountain Band of Chippewa Indians is a Direct Service Tribe from the Indian Health Service. Our community members have been actively involved in administration, the Director and Assistant Director of Quentin N. Burdick Memorial Healthcare Facility (QNBMHCF) are both tribal members. The service population in and around the TMBCI reservation served by the QNBMHCF is approximately 33,000 plus members. With approximately 15,000 members actively receiving treatment.

With such a high service volume and our local IHS clinic being so underfunded it is impossible to provide proper care to our members in need. QNBMHCF is unable to focus on educational and preventative programs that our people so desperately need. If appropriated, the funds made available by HB 1194, would enable Tribal Health Programs to provide education for our members. Primarily the funds would be used to focus on preventing chronic diseases (diabetes, cancer, heart disease) and addiction (opioids, meth, alcoholism). Another avenue would be to reach out to our high-risk members (youth and our elders) so that they can have access to services that they don't have access to right now. Many of our members don't possess means of transportation and additional funding would potentially help us provide access to healthcare for our impoverished members.

Being able to provide educational and preventative programs to members of our community would benefit not only our tribe, but the state as well. We are all members of the great state of North Dakota no matter what walk of life we come from. As chosen leaders by the people of our respective communities, it's our duty to make sure they are provided for. Not only would these funds provide a brighter, healthier, and prosperous future for our community. It would enable us

to take a preventative stand against the chronic diseases and addictions that currently plague our people. If we can attack these health disparities at the source before they outgrow our capabilities, it would be a huge burden taken off the state.

In closing I would just like to reiterate that the funding made available by HB 1194 would be a huge step forward for not only TMBCI but the state of North Dakota as well. As aforementioned that as leaders it's our duty to improve the welfare of our people. HB 1194 will give tribes the ability to vastly improve the healthcare of their people, and in turn that would drastically improve the overall health of the state of North Dakota.

Sincerely,

Nathan A. Davis

Council Representative

Turtle Mountain Band of Chippewa Indians

HB 1194
3/6/19
#4 pg. 1

TESTIMONY FOR THE STANDING ROCK SIOUX TRIBE
BEFORE THE SENATE COMMITTEE ON HUMAN SERVICES
CONCERNING HB: 1194; THE TRIBAL HEALTH CARE COORDINATION AGREEMENTS
MARCH 6, 2019

Chairman & Distinguished Members of the Committee:

On June 28, 2018, the Standing Rock Sioux Tribe provided testimony to the Healthcare Reform and Review Committee, stating the Standing Rock Sioux Tribe wants 100% of the Tribal Health Care Coordination Fund due to the health concerns, disparities, and needs of the Standing Rock Sioux Tribe. Upon meeting with Representative Keiser, the Standing Rock Sioux Tribe began negotiations on a percentage rate for the Tribe and the State. No doubt, the Standing Rock Sioux Tribe wanted the bill to be introduced at 95% to 5% or 90% to 10% or even 80% to 20%; nonetheless the Standing Rock Sioux Tribe came to a point where the lowest we would go was 70% to 30% while keeping the active Care Coordination Agreements.

Representative Keiser agreed to introduce a bill that would allow the Tribe 70% of the Tribal Health Care Coordination Fund, whereas the other 30% would return to the State's General Fund. On January 15, 2019, the Standing Rock Sioux Tribe testified to the House Committee on Human Services and agreed to submit annual reports and an audit every four years to the State upon receiving 70% of the Tribal Health Care Coordination Fund as outlined in HB 1194.

The Standing Rock Sioux Tribe has in goodfaith not halted the process of the Care Coordination Agreements, in hopes that the State and Tribe can work together to move forward to a better outcome for the people of Standing Rock Sioux Tribe. The Tribe needs the 70% from the Tribal Care Coordination Fund and nothing less due to our health disparities, concerns, and needs.

In conclusion, as the bill stands, due to the amendments in the House with the percentages of the FMAP being changed to 50% and 50%, the Standing Rock Sioux Tribe will not support HB 1194. We ask today for the Senate to amend HB 1194 back to the original, supported percentage of 70% and 30%. The Standing Rock Sioux Tribe would also like to state their opposition to Section 1 of HB 1194 as it has nothing to do with the Tribal Care Coordination Agreements and the Standing Rock Sioux Tribe.

Thank you for your time and consideration in this very important matter.

The Standing Rock Sioux Tribe

#1 HB 1194
3-21-2019
Pg 1

Senate Appropriations Committee

State Capitol

600 East Boulevard

Bismarck, ND 58505-0360

RE: House Bill 1194

66th Assembly (2019)

Dear Chairman and Committee members,

The Turtle Mountain Band of Chippewa Indians supports House Bill 1194, and have drafted this letter for future reference of our support. We firmly believe that the extra funding that will be made available from the enactment of this bill will greatly impact our community. As you all know the Turtle Mountain Band of Chippewa Indians is a Direct Service Tribe from the Indian Health Service. Our community members have been actively involved in administration, the Director and Assistant Director of Quentin N. Burdick Memorial Healthcare Facility (QNBMHCF) are both tribal members. The service population in and around the TMBCI reservation served by the QNBMHCF is approximately 33,000 plus members. With approximately 15,000 members actively receiving treatment.

With such a high service volume and our local IHS clinic being so underfunded it is impossible to provide proper care to our members in need. QNBMHCF is unable to focus on educational and preventative programs that our people so desperately need. If appropriated, the funds made available by HB 1194, would enable Tribal Health Programs to provide education for our members. Primarily the funds would be used to focus on preventing chronic diseases (diabetes, cancer, heart disease) and addiction (opioids, meth, alcoholism). Another avenue would be to reach out to our high-risk members (youth and our elders) so that they can have access to services that they don't have access to right now. Many of our members don't possess means of transportation and additional funding will help us provide access to healthcare for our impoverished members.

Being able to provide educational and preventative programs to members of our community would benefit not only our tribe, but the state as well. We are all members of the great state of North Dakota no matter what walk of life we come from. As chosen leaders by the people of our respective communities, it's our duty to make sure they are provided for. Not only would these funds provide a brighter, healthier, and prosperous future for our community. It would enable us to take a preventative stand against the chronic diseases and addictions that currently plague our

people. If we can attack these health disparities at the source before they outgrow our capabilities, it would be a huge burden taken off the state.

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Sincerely,

Nathan A. Davis

Council Representative

Turtle Mountain Band of Chippewa Indians

Working off the 19.0401.07000 version

#1
HB 1194
4-22-19

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1194

Page 2, line 6, after "include" insert "population"

Page 2, line 7, remove "and"

Page 2, line 8, replace "capital construction directly related to health-related programs or services" with "or developing or enhancing community health representative programs or services. Health-related purposes may not include capital construction, stipends to individuals for services, or services that are covered by Indian health services, Medicaid or other third-party payers, or state-funded programs"

Renumber accordingly