HUMAN SERVICES COMMITTEE

The Human Services Committee was assigned the following responsibilities:

- Section 34 of House Bill No. 1012 (2017) directed a study of public human services.
- Section 12 of Senate Bill No. 2015 (2017) directed a study of the Tompkins Rehabilitation and Corrections Center (TRCC).
- House Bill No. 1427 (2017), as revised by the Legislative Management, directed a study of refugee resettlement.

The Legislative Management delegated to the committee the responsibility to:

- Receive annual reports from the Autism Spectrum Disorder Task Force pursuant to North Dakota Century Code Section 50-06-32.
- Receive a report from the Department of Human Services (DHS) regarding the autism spectrum disorder program pilot project pursuant to Section 50-06-32.1.
- Receive annual reports from DHS describing enrollment statistics and costs associated with the children's health insurance program state plan pursuant to Section 50-29-02.
- Receive a report from DHS before August 1 of each even-numbered year regarding provider reimbursement rates under the medical assistance expansion program pursuant to Section 38 of House Bill No. 1012 (2017).
- Receive a report from DHS pursuant to Section 3 of House Bill No. 1038 (2017) regarding the levels of funding provided for and spent on nursing home services and home- and community-based services by program during the 2015-17 and 2017-19 bienniums. The department also was to provide recommendation on options to include the number and level of services and funding provided for home- and community-based services for the 2019-21 biennium.
- Receive a report from DHS before August 1, 2018, regarding the outcome of the Medicaid fraud control unit feasibility and desirability study pursuant to Section 1 of House Bill No. 1226 (2017).
- Receive a report from DHS before April 1, 2018, on the outcome of the Medicaid waiver study pursuant to Section 2 of Senate Bill No. 2041 (2017).

Committee members were Representatives Kathy Hogan (Chairman), Bert Anderson, Pamela Anderson, Chuck Damschen, Daniel Johnston, Dwight Kiefert, Christopher D. Olson, Mary Schneider, Wayne A. Trottier, and Greg Westlind and Senators Howard C. Anderson, Jr., David A. Clemens, Robert Erbele, David Hogue, Oley Larsen, Judy Lee, and Tim Mathern.

The committee submitted this report to the Legislative Management at the biennial meeting of the Legislative Management in November 2018. The Legislative Management accepted the report for submission to the 66th Legislative Assembly.

STUDY OF PUBLIC HUMAN SERVICES

Section 34 of House Bill No. 1012 (2017) directed a comprehensive study of public human services. The study was to include:

- A review of the continuum of services for each population served, the delivery method for those services, and the efficiency and effectiveness of the services;
- The involvement of federal, state, and local governments and for-profit and nonprofit entities in the provision and funding of services;
- An analysis of the funding levels for the programs and services included in the delivery system;
- Consideration of the appropriate role for each of the entities involved in the delivery system; and
- The development of a comprehensive master structure for the system.

Previous Studies

1985-86 Study of the Delivery of Human Services - Dawes Report

The 1985-86 interim Budget Committee on Human Services contracted with Dr. Kenneth J. Dawes, University of North Dakota, to conduct an in-depth survey of the programs, staff, and structure of DHS. Dr. Dawes identified the

strengths and weaknesses of the human services delivery system and provided recommendations to enhance the delivery of human services in the state.

1990 Study of the Human Services Delivery System

During the 1989-90 interim, the Budget Committees on Long-Term Care and Human Services conducted a joint review of alternatives for restructuring the human service delivery system in North Dakota. The committees were assigned this responsibility after the December 1989 tax referrals and the potential impacts on human service programs of budget reductions resulting from the tax referrals. The committees reviewed social service responsibilities, programs, and funding in North Dakota, Minnesota, Montana, South Dakota, and Iowa.

The committee recommended, and the 1991 Legislative Assembly passed, Senate Bill No. 2033 that created Section 50-01.1-02.1 to provide financial incentives for the creation of multicounty social service districts. The bill included a $200,000 appropriation from the state aid distribution fund for the 1991-93 biennium. The financial incentives were to be based on achieved economies of scale, adherence to caseload standards, reduced administrative costs, specialized staff qualifications, and quality of services provided. The incentives were limited to a 6-year period. The $200,000 appropriation was not spent and financial incentives were not provided to establish any multicounty districts.

1991-92 Update of Dawes Recommendations

The 1991-92 interim Budget Committee on Human Services contracted with Dr. Dawes for a report on the status of the 1987 legislative recommendations regarding DHS. Dr. Dawes provided the committee a historical review of the development of social services in North Dakota and of DHS, conducted a review of the status of recommendations contained in the 1987 report, and conducted interviews of personnel of DHS and county social service agencies. Dr. Dawes provided several recommendations to continue to improve the delivery of human services in the state.

The committee, as a result of Dr. Dawes' study and a State Auditor's office performance review of DHS, recommended 1993 Senate Concurrent Resolution No. 4004 encouraging improvements by DHS.

1995-96 Budget Committee on Human Services Study

The interim Budget Committee on Human Services studied the responsibilities of county social service agencies, regional human service centers, and DHS regarding economic assistance programs. The committee received detailed information regarding central office, human service center, and county social service administrative costs and caseloads for calendar year 1994. The committee recommended, and the 1997 Legislative Assembly passed, House Bill No. 1041 (known as the "SWAP" agreement) requiring counties, effective January 1, 1998, to assume the financial responsibility for the cost of administration of certain economic assistance programs and requiring the state to assume complete financial responsibility for the nonfederal share of the grant costs of medical assistance and basic care and to contribute additional support of administrative costs for counties with Indian land. The state assumed financial responsibility for grant programs, including temporary assistance for needy families, basic care, child care assistance, and Medicaid.

1997-98 Budget Committee on Human Services Study

The 1997-98 interim Budget Committee on Human Services conducted a study of DHS in which Public Administration Services was selected to study the department's organizational structure. The Public Administration Services' study identified opportunities for improvements for the department and provided 18 recommendations relating to DHS' administrative structure and budget presentation methods. The 1997-98 interim committee recommended, and the 1999 Legislative Assembly passed, Senate Concurrent Resolution No. 4003, which urged DHS to implement the recommendations resulting from the Public Administration Services' study.

2003-04 Study of Human Services Administrative Costs

The 2003-04 interim Budget Committee on Human Services studied the administrative costs of human services programs, including costs incurred by the DHS central office, human service centers, and county social services. The committee received and reviewed information regarding the administrative costs of various programs administered by the department. The committee also reviewed costs incurred by counties relating to the delivery of human service programs. The committee did not have any formal recommendations resulting from the study.

History of Human Services

County Authority and State Board of Public Welfare

In the 1860s, the territorial legislature authorized counties as overseers of the poor in their county and were permitted to generate revenue for such purpose. From 1913 to 1933, townships were also authorized to perform the duties of overseeing the poor. Counties continued to perform the overseer duties in unorganized townships and in organized townships that chose not to perform the duties.

In 1933 the Legislative Assembly created the State Board of Public Welfare and authorized the board to accept and disburse federal funds for human services. In 1935 the Legislative Assembly authorized counties to create county welfare

boards to accept funds from the State Board of Public Welfare to administer aid to the poor. From 1933 through 1981, the duties of the State Board of Public Welfare were adjusted to provide for the administration of new programs. In 1971 the name of the State Board of Public Welfare was changed to the Social Services Board of North Dakota.

Counties had a major role in the delivery of human services. In 1963 the Community Mental Health Act resulted in counties establishing community mental health centers. A board of directors was established for each center, which consisted of members appointed by the governing body of the political subdivision in which the center was located.

Statutory provisions also allowed local government entities to enter joint powers agreements to operate human service centers. The human service centers combined the services of social service centers and mental health centers in one location. The centers were under the general supervision of a local board of directors appointed by the local county commission and state social service board.

Creation of the Department of Human Services

The Department of Human Services was created in 1981 through the enactment of House Bill No. 1418. The bill created a new Department of Human Services which, on January 1, 1981, consolidated a number of agencies previously organized under several separate areas of state government. The department assumed the functions, duties, powers, and control of the following agencies:

1. The Social Services Board (including the regional human service centers);
2. The Governor's Council on Human Resources; and
3. Portions of the Department of Health (the Division of Mental Health and Retardation, including the State Hospital; the Division of Alcoholism and Drug Abuse; and the State Council on Developmental Disabilities).

The bill further provided the Executive Director of DHS, who is appointed by and serves at the pleasure of the Governor, is the administrative head of the department and provided for the structure of the new department. The 1981 legislation provided the department was to be divided into three sections--the State Hospital, the Office of Human Services, and the Office of Economic Assistance and County Administration. Contained within the Office of Human Services were the following divisions--developmental disabilities, mental health, social services (including an aging services unit and a children and family services unit), vocational rehabilitation, and alcohol and drug abuse. The Office of Economic Assistance and County Administration included the Public Assistance Division (including a food stamp unit, a housing assistance unit, an assistance payments unit, an energy assistance unit, and a child support unit) and a Medical Assistance Division.

Since DHS was created, the duties and responsibilities of the department have been adjusted multiple times, including the transfer of the administrative control of the Grafton State School (Life Skills and Transition Center) and San Haven from the Director of Institutions to DHS on July 1, 1989.

Current Structure of the Department of Human Services

Section 50-16-01.3 provides for the Governor to appoint an executive director to oversee the operations of DHS. The department is structured into various divisions with different responsibilities. The following is a summary of divisions within DHS:

Division/Area	Major Programs/Services
Administration/management	• Executive office; • Fiscal administration; • Human resources; • Information technology services; • Legal; and • Public information.
Aging Services	• Adult foster care licensing; • Dementia care; • Family caregiver support program; • Home- and community-based long-term care services paid for by Medicaid, service payments for elderly and disabled (SPED), and expanded SPED; • Long-term care ombudsman program; • Older Americans Act services; and • Vulnerable adult protective services.

Division/Area	Major Programs/Services
Behavioral Health	• Prevention and promotion projects, including Parents Listen, Educate, Ask, Discuss and statewide community prevention; • Gambler's Choice; • Robinson Recovery Center; • Substance use disorder voucher program; and • Brain injury supports.
Child Support	• Establishment of paternity, child support, and medical support; • Enforcement of support orders; • Parent locate services; and • Receipt and distribution of child support payments.
Children and Family Services	• Adoption; • Child protection; • Early childhood services, including child care licensing; • Family preservation services; and • Foster care and placement of children.
Developmental Disabilities	• Development disability home- and community-based Medicaid waivers services; • Early intervention; • Medicaid funding of intermediate care facility services for individuals with intellectual disabilities; • Provider licensing and regulation; and • Training and technical assistance.
Economic assistance	• Alternatives to abortion; • Basic care assistance eligibility; • Child care assistance; • Low-income home energy assistance; • Medicaid and children's health insurance program eligibility; • Supplemental nutrition assistance program; and • Temporary assistance for needy families.
Medical Services	• Assisted living facility licensing; • Basic care assistance funding; • Children with disabilities coverage; • Healthy Steps funding; • Money follows the person program; • Medicaid autism waiver; • Medicaid primary care provider program; • Medicaid coverage, ratesetting, and program integrity; • Medically fragile children coverage and children's hospice waiver coverage; • Program of all-inclusive care for the elderly; • Qualified service provider training; and • Workers with disabilities coverage program.
Vocational rehabilitation	• Centers for Independent Living funding; • Consultation services for businesses;

Division/Area	Major Programs/Services
	• Rehabilitation services to assist disabled people to become employed; • Vision services; and • Federally contracted disability determination services.
Field Services	• Regional human service centers Emergency services, including crisis lines and support, social and medical detoxification, and State Hospital admissions screening; Chronic disease management, including targeted case management, addiction counseling, psychotherapy, psychosocial rehabilitation, medication management, and housing services; and Special services, including intellectual disabilities case management, vocational rehabilitation, adult protective services, regional supervision of child welfare services, and court-ordered psychological assessment. • Life Skills and Transition Center Residential services and supported living arrangements in other communities for people with developmental disabilities; Vocational and outreach services; Independent supported living arrangement program; CARES Medical Clinic; and Intellectual disabilities behavioral health service. • State Hospital Inpatient services for adults with mental illness and substance use disorders whose needs exceed local resources; Psychiatric rehabilitation services for adults with persistent and serious mental illness; Transitional living services for adults with persistent and serious mental illness; Evaluation and treatment services for civilly committed sexually dangerous individuals; and Residential addiction treatment services provided by the TRCC through contract with the Department of Corrections and Rehabilitation (DOCR).

Department Funding and Full-Time Equivalent Positions

The 2017-19 biennium appropriations for DHS total $3,913,112,132, of which $1,339,231,350 is from the general fund. The schedule below provides information regarding funding for DHS since the 2009-11 biennium:

	2009-11 Biennium	2011-13 Biennium	2013-15 Biennium	2015-17 Biennium	2017-19 Biennium
General fund	$650,645,814	$932,025,219	$1,171,116,129	$1,281,017,188	$1,339,231,350
Other funds	1,637,100,137	1,673,400,832	1,778,336,465	2,246,039,963	2,573,880,782
Total	$2,287,745,951	$2,605,426,051	$2,949,452,594	$3,527,057,151	$3,913,112,132

The schedule below details the full-time equivalent (FTE) positions authorized for DHS since the 2009-11 biennium:

	2009-11 Biennium	2011-13 Biennium	2013-15 Biennium	2015-17 Biennium	2017-19 Biennium
FTE positions	2,216.88	2,189.35	2,201.08	2,211.08	2,162.23

Delivery of Services

Human service programs are delivered by a variety of methods. Counties are the first point of contact for individuals seeking economic assistance and family services programs. Services are provided directly by DHS, by the county, or by contracted private providers.

State Takeover of Human Services Costs

The Legislative Assembly has authorized several changes which resulted in the state paying certain social services costs rather than counties. In 1997 the counties assumed the cost of administering selected economic assistance programs in exchange for the state to pay for the direct programs costs. In 2007 the state assumed the costs of administering child support enforcement. In 2015 the state assumed costs of foster care and subsidized adoption assistance payments, medical assistance payments for therapeutic foster care services, SPED, county administrative costs for providing family preservation services, computer processing costs for the technical eligibility system, and the costs of electronic benefit transfers for the supplemental nutrition assistance program.

In 2017 the Legislative Assembly approved Senate Bill No. 2206 which created a 2-year pilot program for the state payment of county-funded economic assistance and social services costs (social services redesign pilot project). The bill also removed the authority of counties to levy a property tax for social services programs. The bill appropriated $160.7 million to DHS to pay county social services during calendar years 2018 and 2019 based on a formula using 2015 costs. As of August 2018, the estimate is that $156.4 million of the appropriation will be distributed to counties.

Social Services Redesign Project

The committee received information regarding the social services redesign project. The committee learned the project is the result of Senate Bill No. 2206, which requires DHS to develop a plan to implement a state-paid economic assistance and social service program. The project is using four teams to review service needs and provide recommendations--children and family services, economic assistance eligibility, adults (aging and developmental disabilities), and administrative. The teams include representation from various stakeholder groups, including counties.

The committee was informed several issues have been identified during project meetings. There are a number of services being provided which are based on structures that existed before the creation of DHS. Representatives of DHS also expressed concern that laws relating to a program may not align with best practices for serving individuals with needs.

The project committees will continue to meet and DHS will develop recommendations for the redesign of the social services system. The recommendations will be provided to the Legislative Assembly for its consideration. If approved, any changes to the design of the social services system will take several bienniums to implement.

Information presented to the committee indicated the project committees are reviewing options to reorganize the structure of human services delivery. One option is to use multicounty zones for the delivery of services. The zones would have advisory boards consisting of representatives of the areas being served. Transitioning to a zone delivery model for social services would adjust certain job responsibilities and reduce some administrative positions. Vacant positions could be reclassified to service delivery positions. Statutory changes may not be needed to establish social service delivery zones as DHS currently has the authority to establish multicounty social service districts.

Behavioral Health

The committee received information regarding DHS actions relating to behavioral health. The Department of Human Services contracted with the Human Services Research Institute for $160,000 to conduct a review of the state's behavioral health system. The goals of the study were to conduct an in-depth review of the state's behavioral health system; to analyze current utilization and expenditure patterns by payer source; to provide recommendations for enhancing the integration, cost-effectiveness and recovery orientation of the system to effectively meet community needs; and to establish strategies for implementing the recommendations. The study gathered data by reviewing existing reports and documents, by conducting stakeholder interviews, and by reviewing Medicaid claims and state service utilization data for behavioral health services.

The committee received the following study report recommendations and strategies:

Recommendation	Strategy
1. Develop a comprehensive implementation plan	1.1 Reconvene system stakeholders, including service users and their families 1.2 Form an oversight steering committee to coordinate with key stakeholder groups 1.3 Establish workgroups to address common themes identified in this report
2. Invest in prevention and early intervention	2.1 Prioritize and implement evidence-based social and emotional wellness initiatives 2.2 Expand existing substance use prevention efforts, restore funding for the Parents Listen, Educate, Ask, Discuss program 2.3 Build upon and expand current suicide prevention activities 2.4 Continue to address the needs of substance exposed newborns and their parents 2.5 Expand evidence-based services for first-episode psychosis
3. Ensure all North Dakotans have timely access to behavioral health services	3.1 Coordinate and streamline information on resources 3.2 Expand screening in social service systems and primary care 3.3 Ensure a continuum of timely and accessible crisis response services

Recommendation	Strategy
	3.4 Develop a strategy to remove barriers to services for persons with brain injury 3.5 Continue to invest in evidence-based harm-reduction approaches
4. Expand outpatient and community-based service array	4.1 Ensure access to needed coordination services 4.2 Continue to shift funding toward evidence-based and promising practices 4.3 Expand the continuum of substance use disorder treatment services for youth and adults 4.4 Support and coordinate efforts to enhance the availability of outpatient services in primary care 4.5 Address housing needs associated with behavioral health needs 4.6 Promote education and employment among behavioral health service users 4.7 Restore/enhance funding for recovery centers 4.8 Promote timely linkage to community-based services following a crisis 4.9 Examine community-based alternatives to behavioral health services currently provided in long-term care facilities
5. Enhance and streamline system of care for children and youth	5.1 Improve coordination between education, early childhood, and service systems 5.2 Expand targeted, proactive in-home supports for at-risk families 5.3 Develop a coordinated system to enhance treatment-related foster care capacity and cultural responsiveness 5.4 Prioritize residential treatment for those with significant/complex needs
6. Continue to implement and refine criminal justice strategy	6.1 Ensure collaboration and communication between systems 6.2 Promote behavioral health training among first responders and others 6.3 Review behavioral health treatment capacity in jails 6.4 Ensure Medicaid enrollment for individuals returning to the community
7. Engage in targeted efforts to recruit and retain competent behavioral health workforce	7.1 Establish a single entity for supporting workforce implementation 7.2 Develop a single database of statewide vacancies for behavioral health positions 7.3 Provide assistance for behavioral health students working in areas of need in the state 7.4 Raise awareness of student internships and rotations 7.5 Conduct comprehensive review of licensure requirements and reciprocity 7.6 Continue establishing training and credentialing program for peer services 7.7 Expand credentialing programs to prevention and rehabilitation practices 7.8 Support a robust peer workforce through training, professional development, and competitive wages
8. Expand the use of telebehavioral health	8.1 Support providers to secure necessary equipment/staff 8.2 Expand the availability of services for substance use disorders, children and youth, and American Indian populations 8.3 Increase types of services available 8.4 Develop clear, standardized regulatory guidelines
9. Ensure the system reflects values of person centeredness, cultural competence, and trauma-informed approaches	9.1 Promote shared decisionmaking 9.2 Promote mental health advance directives 9.3 Develop a statewide plan to enhance commitment to cultural competence 9.4 Identify cultural/language/service needs 9.5 Ensure effective communication with individuals with limited English proficiency 9.6 Implement additional training 9.7 Develop/promote safe spaces for LGBTQ individuals within the behavioral health system 9.8 Ensure a trauma-informed system 9.9 Promote organizational self-assessments

Recommendation	Strategy
10. Encourage and support the efforts of communities to promote high-quality services	10.1 Establish a state-level leadership position representing persons with lived experience 10.2 Strengthen advocacy 10.3 Support the development of and partnerships with peer-run organizations 10.4 Support community efforts to reduce stigma, discrimination, and marginalization 10.5 Provide and require coordinated behavioral health training among related service systems
11. Partner with tribal nations to increase health equity	Collaboration within and among tribal nations, and with state and local human service agencies
12. Diversify and enhance funding for behavioral health	12.1 Develop an organized system for identifying/responding to funding opportunities 12.2 Pursue 1915(i) Medicaid state plan amendments 12.3 Pursue options for financing peer support and community health workers 12.4 Sustain/expand voucher funding and other flexible funds for recovery supports 12.5 Enroll eligible service users in Medicaid 12.6 Join in federal efforts to ensure behavioral and physical health parity
13. Conduct ongoing, system-side data-driven monitoring of needs and access	13.1 Enhance and integrate provider data systems 13.2 Develop system metrics to monitor progress on key goals 13.3 Identify and target services to those with highest service costs

The committee was informed DHS is contracting with the Human Services Research Institute for $178,000 to begin implementing the recommendations. The Department of Human Services is in the drafting and planning stages and the implementation process is anticipated to be completed in June 2019.

The committee received updates on the free through recovery program which will provide behavioral health services to individuals in the criminal justice system. The mission of the program is to reduce recidivism by delivering high-quality community behavioral health services with effective supervision. The program will focus on addressing gaps in recovery services not currently being provided by public or private providers. Participating providers will be paid a base rate per participant, per month, for providing care coordination and recovery services. The program includes funding that will focus on addressing local community needs such as housing and transportation.

The committee received information regarding outcomes of the free through recovery program. From January 10, 2018, through April 18, 2018, there were 328 referrals to the program which resulted in 289 participants. Program providers began recording the following outcome metrics:

- Is the participant living in a residence that is supportive of their recovery;
- Is the participant actively seeking or participating in employment;
- Is the participant demonstrating effort to reduce their substance use or the harm associated with their use or improving their mental health functioning; and
- Did the participant avoid law enforcement involvement resulting in arrest, criminal charges, or probation violations?

In March 2018, 78 percent of program participants achieved at least three of the four outcome measurements. Approximately 22 percent of program participants achieved fewer than three of the measurement outcomes.

Other Information Received

The committee also received information regarding:

- Changes to the payment methodology for developmental disabilities services to allow individuals to request "outlier" funding to receive additional services.
- The implementation of legislation enacted by the 2017 Legislative Assembly which affects DHS.
- The status of the children's prevention and early intervention behavioral services pilot project.
- The activities of the children's behavioral health task force.
- The role of the State Department of Health in delivering behavioral health services.

Committee Recommendations

The committee recommends the following bill drafts:

- Senate Bill No. 2028 to provide a general fund appropriation of $600,000 to DHS for behavioral health prevention and early intervention services, of which DHS must allocate $300,000 for substance abuse prevention and early intervention services and the remaining $300,000 for other mental health prevention and early intervention efforts.
- Senate Bill No. 2029 to direct DHS to implement a community behavioral health program to provide services to individuals outside the correctional system who have serious behavioral health conditions. The bill provides a $7 million appropriation to DHS for the program, of which $5.25 million is from the general fund and $1.75 million is from other funds. The bill also authorizes 6 FTE positions for the program.
- Senate Bill No. 2030 to provide an appropriation of $408,000 from the general fund to DHS to coordinate the implementation of recommendations of the Human Services Research Institute's study of the state's behavioral health system. The bill also authorizes 1.5 FTE positions to coordinate the implementation of recommendations.
- Senate Bill No. 2031 to provide an appropriation to DHS for targeted case management. The bill appropriates $12,196,834 from the general fund and $12,196,834 from other funds and authorizes 1 FTE position.
- Senate Bill No. 2032 to implement a peer support services certification program within DHS. The bill appropriates $275,000 from the general fund and $275,000 from other funds, and authorizes 1 FTE position for the program.

STUDY OF THE TOMPKINS REHABILITATION AND CORRECTIONS CENTER

Section 12 of Senate Bill No. 2015 (2017) provided for a study of TRCC. The study was to review the operation, management, conditions, caseload, and physical plant of the center. The study also was to review the potential transition of the center, including the transfer of the building, employees, and supervision and management of all operations and caseload of the center from DHS and the State Hospital to DOCR.

Tompkins Rehabilitation and Corrections Center Overview

The Tompkins Rehabilitation and Corrections Center is located at the State Hospital and operated by DHS in collaboration with DOCR. The center, which began operations in 1999, has 60 beds for men and 30 beds for women. The center is a residential facility providing substance abuse treatment services 24 hours a day, 7 days a week.

The Department of Corrections and Rehabilitation contracts with the center to provide treatment to offenders with substance abuse issues. Programs at the center provide diagnosis, evaluation, and treatment planning. Individuals may receive group and individual therapy, cognitive restructuring, structured social environment therapy, and aftercare planning services.

Number of Individuals Served

The Tompkins Rehabilitation and Corrections Center program is a joint commission accredited residential addiction treatment program providing comprehensive services to high-risk individuals with substance use disorders. The program serves individuals who will soon be released from incarceration and have been identified as a high risk for recidivism.

The schedule below details the number of individuals served at the TRCC since state fiscal year 2014.

	Fiscal Year			
	2014	**2015**	**2016**	**2017 (Estimated)**
Individuals served	342	365	396	426

Facilities

The Tompkins Rehabilitation and Corrections Center program is located in two buildings on the State Hospital grounds. The men's program is located in the TRCC building which contains 34,660 square feet. The women's program is located in the New Horizons building. The New Horizons building, which consists of 75,485 square feet, also houses other State Hospital programming.

Shortly after the TRCC program began operations, a total of 90 residential beds were available. In 2015 DHS expanded the center to provide an additional 16 beds.

As part of the study, the committee conducted a tour of the TRCC program facilities.

Staff

The Tompkins Rehabilitation and Corrections Center program employs 49 staff members, which includes a program director, nursing staff supervisor, nursing staff, and rehabilitation staff. There are positions that provide services to the entire State Hospital that also provide services to the TRCC program, including security, records, admissions, medical, and administration.

Tompkins Rehabilitation and Corrections Center Program Budget and Contract Payments

The committee received the following schedule detailing the estimated amount of funding and FTE employees included in DHS's budget for the TRCC program since the 2013-15 biennium:

	2013-15 Biennium	2015-17 Biennium	2017-19 Biennium (Estimated)
Estimated TRCC program funding	$6,091,172	$8,582,804	$8,601,457
FTE employees	43.95	54.60	54.60

The committee received the following schedule detailing the current biennium budgeted expenses of the TRCC program:

Estimated Biennial Budget - Tompkins Rehabilitation and Corrections Center Program	
Salaries	$7,431,464
Operating	36,993
Medical, pharmacy, dental	304,000
Physical plant	55,000
Custodial	120,000
Chaplaincy	44,000
Other capital and maintenance	610,000
Total	$8,601,457

The source of funding for the TRCC program is contract payments from DOCR. The following schedule details contract payments and the number of beds provided through the TRCC program since the 2009-11 biennium:

Biennium	Contract Payments	Number of Beds
2009-11	$4,764,035	90
2011-13	$5,127,300	90
2013-15	$5,651,247	90
2015-17	$7,985,926	106[1]
2017-19	$8,607,462	106

[1]Sixteen beds were added in December 2015.

The contract payments do not include services provided directly to the program by DOCR which include laundry service, meal service, education services, and nonroutine medical services, and 4 FTE case and program management staff.

Recommendations for Program Changes

The committee was informed representatives of DHS, DOCR, and the Governor's office have been meeting to review potential changes to the TRCC program. A representative of the Governor's office reported to the committee the agencies have developed the following proposal for operational changes to the program:

- DOCR would utilize the TRCC building to provide 60 beds for substance abuse and mental health treatment of DOCR inmates. Treatment services would be provided by DOCR staff.
- The remaining 46 beds would be operated by DHS and be dedicated to intensive residential treatment services for individuals with mental health and substance abuse disorders. It is anticipated that most of the beds would be contracted on a per-diem basis to DOCR to treat individuals housed in DOCR facilities or individuals on probation resulting from substance-related offenses. Treatment services would be provided by DHS staff.

Representatives of DHS and DOCR also reviewed the following recommended changes to the treatment services of the program:

- Accept participants who have serious mental health conditions, have a more challenging transition process than the average prison resident, or are under community supervision and are having difficulty meeting the expectations of the supervision term due to behavioral health concerns;
- Provide individualized assessment and recovery support plans for participants who enter the program from community settings;
- Coordinate services with free through recovery program providers;
- Implement medication-assisted treatment;
- Emphasize emotion regulation skills; and
- Build import-model services for employment development and educational and leisure opportunities.

Representatives of DHS and DOCR anticipate any necessary funding adjustments needed to implement the recommended program changes will be included in each department's 2019-21 biennium budget request.

Committee Recommendations

The committee makes no recommendation regarding the study of the TRCC.

STUDY OF REFUGEE RESETTLEMENT

House Bill No. 1427 (2017) directed a study of the refugee resettlement process in the state. The scope of the study was revised by the Legislative Management to provide for a review of the impact of refugee resettlement on workforce, government services (particularly law enforcement), human services, education, and health care. The study was to include recommendations to improve or modify the resettlement process.

Previous Study

The 1995-96 interim Budget Committee on Human Services studied refugee resettlements in the state and the net fiscal effects of refugees and other limited English proficient or language minority students on school districts and the providers of social services. The committee received information regarding estimated costs to resettle refugees, the sources of funds for resettlement costs, support services for refugees, negative impacts of resettlement, and the costs to school districts for serving students with limited language proficiency.

The committee recommended Senate Bill No. 2055 (1997), which was approved by the Legislative Assembly, to provide school districts with additional payments for each student in the school district that had limited English proficiency.

Background

Federal Refugee Act of 1980

The federal Refugee Act of 1980 (Pub. L. 96-212), which became effective April 1, 1980, was an amendment to the earlier Immigration and Nationality Act and the Migration and Refugee Assistance Act. The Refugee Act of 1980 was enacted to provide a permanent and systematic procedure for the admission to the United States of refugees of special humanitarian concern to the United States and to provide comprehensive and uniform provisions for the effective resettlement and absorption of those refugees who are admitted.

The Act defines a refugee as "any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion."

The main objectives of the Act were to:

- Create a new definition of refugee based on the definition created at the United Nations Convention and Protocol on the Status of Refugees;
- Establish the Office of United States Coordinator for Refugee Affairs and the Office of Refugee Resettlement (ORR); and
- Establish explicit procedures on how to deal with refugees in the United States by creating a uniform and effective resettlement and absorption policy.

The Refugee Act of 1980 requires the President, in consultation with the United States Congress, to determine the maximum number of refugees to be admitted to the country each year. The federal Bureau of Population, Refugees, and Migration (PRM) screens refugees to determine eligibility for resettlement in the United States. Once the PRM accepts a refugee for resettlement, it works with ORR, which is a division of the United States Department of Health and Human Services, and national volunteer agencies to provide services to the refugee in an American community. The Bureau of Population, Refugees, and Migration places refugees according to plans it develops with input from national volunteer agencies and state and local government representatives. The plans aim to avoid resettlement in areas already highly impacted by the presence of refugees to the extent practicable. When the PRM decides to place a refugee in a state, the bureau must consider the recommendations of the state regarding the appropriate community for placement. The ultimate decision regarding placement; however, is with the federal government.

State Refugee Resettlement Plan

The Refugee Act of 1980 requires each state to submit a refugee resettlement plan to ORR and obtain ORR's approval of the plan before the state may receive refugee resettlement assistance funds. When a state wishes to amend its plan, the Governor of the state must approve the amended plan and submit it to ORR for final approval. To receive

approval, a plan must include all the elements required under federal law, and the state must agree to comply with all federal laws, regulations, and official issuances of the Director of ORR. Since the enactment of the Refugee Act of 1980, DHS, in consultation with Lutheran Social Services of North Dakota, has prepared and submitted the state's refugee resettlement plan to ORR. In preparing the state plan, the department also receives information and recommendations from the local refugee advisory committees located in Fargo, Grand Forks, and Bismarck.

Refugee Resettlement Program

Information provided to the committee indicated there are three different types of programs utilized by states for refugee resettlement--state-administered programs, public-private partnerships, and the alternative Wilson-Fish program. North Dakota is 1 of 14 states that use the Wilson-Fish program for refugee resettlement. The Wilson-Fish program provides for ORR to contract with a nonprofit organization to provide refugee resettlement services. The program emphasizes early employment and economic self-sufficiency.

Section 50-06-01.4 assigns responsibility for refugee services to DHS. Until 2010, the department employed a part-time refugee coordinator and administered the Refugee Resettlement program. The department acted as a fiscal passthrough agent for federal refugee services funding and played a larger role overall in the state's involvement in refugee resettlement. In October 2010, as the result of a memorandum of understanding between the department and Lutheran Social Services, the department transitioned most refugee-related services to Lutheran Social Services. The decision to transition refugee resettlement services was an executive branch decision by the Governor. The transition shifted the responsibility for securing federal grant funding, providing services, and fulfilling required reporting requirements to Lutheran Social Services, the only federally recognized and approved refugee resettlement organization in the state.

As part of the transition, ORR required DHS to retain responsibility for the Unaccompanied Refugee Minor program, which provides foster care for federally designated refugee children, and the Refugee Medical Assistance program, which provides up to 8 months of medical assistance coverage for legally admitted refugees. These two programs are funded with federal funds.

Funding for Refugee Resettlement Program

Federal resettlement assistance to refugees is provided primarily through the state's Refugee Resettlement program, which is administered by Lutheran Social Services. The Refugee Resettlement program is 100 percent federally funded. The following schedule provides information regarding legislative appropriations for the Refugee Resettlement program from the 2009-11 biennium through the 2017-19 biennium.

	2009-11 Biennium	2011-13 Biennium	2013-15 Biennium	2015-17 Biennium	2017-19 Biennium
Department of Human Services	$4,095,632	$2,731,279	$2,848,472	$4,206,208	$2,756,113

Number of Refugees Resettled

The following schedule provides a summary of the total refugees resettled into North Dakota for federal fiscal years 2003 through 2016:

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Number of annual refugee resettlements	111	223	225	182	202	403	438	470	354	555	449	590	506	558

The following schedule details the locations of refugee resettlements since federal fiscal year 1997:

Primary Refugee Arrivals to North Dakota					
Federal Fiscal Years	Total Number of Refugees Resettled	Percentage of Refugees Resettled by Location			Main Ethnicities
		Fargo/ West Fargo	Grand Forks	Bismarck	
1997-2001	2,646	80%	4%	16%	Bosnian, Somali
2002-2006	792	89%	11%	0%	Somali, Liberian
2007-2011	1,867	78%	20%	2%	Bhutanese, Iraqi
2012-2017	3,084	74%	20%	6%	Bhutanese, Iraqi, and Somali
Total 1997-2017	8,389	78%	14%	8%	

NOTE: Includes primary refugee arrivals only.
In federal fiscal year 2017, 95 percent of refugee individuals resettled in the state had family ties in their resettlement locations.

In the first 6 months of federal fiscal year 2018, 97 percent of the refugee individuals admitted had family ties in North Dakota and 70 percent were either women or children and had spent an average of 19.2 years in refugee camps before arrival. The refugees who were resettled identified themselves as Hindu/Buddhist/Kirat (49 percent), followed by Christians (39 percent), and Muslims (13 percent).

Programs Assisting Refugees

Economic Assistance Programs

The committee received the following information regarding the number of refugees utilizing DHS economic assistance programs and related expenditures:

Refugees Utilizing Economic Assistance Programs			
	State Fiscal Year 2015	**State Fiscal Year 2016**	**State Fiscal Year 2017**
Traditional Medicaid			
Individuals served	2,684	2,630	2,983
Amount paid	$11,991,012	$11,849,449	$14,419,630
Supplemental nutrition assistance program			
Individuals served	4,275	4,354	4,295
Amount paid	$5,552,366	$5,690,768	$5,630,104
Temporary assistance for needy families			
Individuals served	355	299	260
Amount paid	$284,789	$254,596	$200,327

NOTE: The number of individuals served is a **cumulative** total which includes new refugees, individuals who have been in the country for more than 1 year, and individuals who no longer have refugee status. The funding amounts listed are a combination of state and federal funds.

Refugees also may be receive benefits through the child care assistance program and low-income home energy assistance program. However, DHS' information management programs do not capture data regarding citizenship or refugee status.

Unaccompanied Refugee Minor Program

The Unaccompanied Refugee Minor program provides assistance to eligible unaccompanied refugee minors settled in the state. The program provides the same level of assistance as is available to foster children in the state. When an unaccompanied refugee minor arrives in the state, Lutheran Social Services obtains guardianship of the child and places the child in a licensed foster home.

The committee received the following data regarding the Unaccompanied Refugee Minor program:

Unaccompanied Refugee Minor Program			
	Minors Served	**Payments to Lutheran Social Services of North Dakota for Administrative Expenses**	**Direct Payments for Support of Minor**[1]
Federal fiscal year 2015	72	$627,285	$1,130,996
Federal fiscal year 2016	75	$741,019	$1,117,146
Federal fiscal year 2017 (through June 2017)	76	$527,003	$1,311,396

[1]Includes maintenance payments to foster homes, funds for extraordinary clothing needs, independent living preparation programming, education and training vouchers, and emergency funding.

NOTE: The number of minors served is a **cumulative** total which includes new refugees and children and youth who have been in the country for more than 1 year and no longer have refugee status. Funding for the program is provided from federal funds.

Refugee Medical Assistance Program

The Refugee Medical Assistance program provides funding for medical expenses for unaccompanied minors and other legally admitted refugees. When a refugee arrives in the country it is determined whether the refugee is eligible to enroll in the traditional Medicaid program, Expanded Medicaid program, or children's health insurance program. If a refugee is not eligible to enroll in any of the Medicaid programs, the refugee may be enrolled in the Refugee Medical Assistance program. The medical assistance program is available for the first 8 months a refugee is in the country, or until the age of 21 for an unaccompanied minor.

The committee received the following information regarding the number of individuals receiving assistance under the program and the amount of program payments made since state fiscal year 2013:

Refugee Medical Assistance Program Recipients and Payments (State Fiscal Year)					
	2013	**2014**	**2015**[1]	**2016**[1]	**2017**[1,2]
Number of recipients	267	166	33	18	17
Amount of payments	$617,738	$495,069	$18,970	$9,799	$12,928

[1]The reduction in recipients is due in part to individuals enrolling in the Medicaid Expansion program rather than the Refugee Medical Assistance program.

[2]Additional claims may be incurred for services provided in state fiscal year 2017.

NOTE: The Refugee Medical Assistance program is 100 percent federally funded.

Elementary and Secondary Education

The state definition of an English learner (EL) is an individual who is aged 5 to 21, is enrolled in a North Dakota school district, has a primary language other than English or comes from an environment in which a language other than English significantly impacts the individual's level of English proficiency, and has difficulty speaking, reading, writing, and understanding English as determined by assessment results. Federal law requires states to provide EL programs that meet specific standards.

English learner programs provide instruction to refugees, immigrants, and other individuals. During academic year 2017-18, 3,885 students were enrolled in EL programs. A total of 1,111 of the 3,885 EL students had refugee status. Some refugee students have achieved English proficiency and are not enrolled in EL programs. The committee received the following schedule which details total EL program enrollment at school districts, the number of EL students in the programs that are refugees, and the number of refugee students not enrolled in EL programs.

2017-18 EL Program Enrollment			
School District	**Total EL Program Enrollment**	**Number of Refugee Students Enrolled in EL Programs[1]**	**Number of Refugee Students Not Enrolled in EL Programs[1]**
Bismarck	277	38	32
Fargo	969	432	148
Dickinson	127	0	0
Dunseith	47	0	0
Grafton	49	0	0
Grand Forks	396	255	84
Mandan	112	0	0
McKenzie County (Watford City)	98	0	0
Minot	163	0	0
New Town	51	0	0
West Fargo	875	375	130
Williston	240	0	0
Other districts/not listed	481	11[2]	6[2]
Total	3,885	1,111	400

[1]Includes new refugees and individuals who have been in the country for more than 1 year and no longer have refugee status.

[2]Includes students that are not listed for specific school districts due to the small number of refugee students enrolled in the school district.

Funding for EL programs is provided from state and other sources. State funding through the education funding formula is based on average daily membership (ADM). In addition to receiving general ADM funding for students, additional funding is provided for students enrolled in EL programs. The committee received the following schedule that details the general and weighted funding received by school districts for EL students:

2017-18 Funding Formula Payments for EL Students		
General ADM Payments for EL Students	**Weighted EL Payment**	**Total Funding for EL Students**
$26,738,616	$3,963,252	$30,701,868

State EL grants provide additional funding for instruction of EL students. The 2017-18 school year grants were awarded to the four school districts in the state with the highest populations of EL students in specified proficiency levels. The following schedule details grant awards:

School District	EL Grant Funding Awarded
Fargo	$104,635
West Fargo	83,480
Grand Forks	34,984
Bismarck	26,901
Total	$250,000

Benefits of Refugee Resettlement

Fargo-Moorhead Metropolitan Area Economic Impact

The New American Economy organization reported the following economic impact of new Americans in the Fargo-Moorhead metropolitan area during 2014:

- Paid $13.8 million in state and local taxes.

- Paid $23.5 million in Social Security taxes.
- Paid $5.9 million in Medicare taxes.
- Contributed $542.8 million to the metropolitan area's gross domestic product.

Grand Forks Region Economic Impact

The New American Economy organization reported the following economic impact of new Americans in the Grand Forks region during 2015:

- Paid $14.4 million in state and local taxes.
- Paid $20.4 million in Social Security taxes.
- Paid $5 million in Medicare taxes.
- Contributed $353.7 million to the region's gross domestic product.

Statewide Economic Impact

The New American Economy organization reported the following economic impact of new Americans in North Dakota during 2014:

- Paid $36.4 million in state and local taxes.
- Paid $66.9 million in Social Security taxes.
- Paid $16.2 million in Medicare taxes.
- Earned $559.6 million of income.

Workforce

The committee received testimony from representatives of private businesses and others regarding contributions of refugees and other new Americans to meet workforce needs. Comments included:

- At Cardinal Glass Industries in Fargo, 69 percent of the plant's 268 employees are new Americans, many of whom are resettled refugees. Seventy one percent of team leaders at the plant are new Americans and 85 percent of new hires in 2017 were new Americans.
- Of the new Americans living in the state, 8.1 percent are employed in manufacturing compared to the overall state rate of 7.7 percent.
- New Americans help meet the workforce needs at Bethany Retirement Living in Fargo. Many certified nurse assistants and many housekeeping positions at the facility are filled by individuals originally from Liberia.

The New American Economy organization reported new Americans, in 2015, represented 3.8 percent of the employed labor force in the Grand Forks region. The industries with the largest percentages of new Americans in the labor force included health care (6.8 percent), education (6.0 percent), professional services (5.1 percent), manufacturing (4.7 percent), and recreation and accommodation (4.3 percent).

Committee Recommendations

The committee makes no recommendation regarding the study of refugee resettlement.

AUTISM SPECTRUM DISORDER TASK FORCE

Senate Bill No. 2174 (2009), codified as Section 50-06-32, established an Autism Spectrum Disorder Task Force consisting of the State Health Officer, the Executive Director of the Department of Human Services, the Superintendent of Public Instruction, the Executive Director of the Protection and Advocacy Project, and the following members appointed by the Governor:

- A pediatrician with expertise in the area of autism spectrum disorder (ASD);
- A psychologist with expertise in the area of ASD;
- A college of education faculty member with expertise in the area of ASD;
- A licensed teacher with expertise in the area of ASD;
- An occupational therapist;
- A representative of a health insurance company doing business in the state;

- A representative of a licensed residential care facility for individuals with ASD;
- A parent of a child with ASD;
- A family member of an adult with ASD; and
- A member of the Legislative Assembly.

The purpose of the task force is to examine early intervention and family support services that would enable an individual with ASD to remain in the least restrictive home- or community-based setting, programs transitioning an individual with ASD from a school-based setting to adult day programs and workforce development programs, the cost of providing services, and the nature and extent of federal resources that can be directed to the provision of services for individuals with ASD.

The task force is required to develop a state ASD plan and continue to review and periodically update or amend the plan to serve the needs of individuals with ASD. The task force is required to provide an annual report to the Governor and the Legislative Council regarding the status of the state ASD plan.

Report

The report of the task force stated the task force is working to update the ASD plan to integrate the collective impact design. The collective impact design is a framework that facilitates a collaborative process between multiple organizations and agencies to strengthen available resources. The task force is in the second of three phases of implementing the design.

The task force identified the following draft goals for children from birth through age 18:

- Assure individuals with suspected ASD receive an appropriate diagnosis as soon as possible;
- Review and provide recommendations on the centralized locations for information on ASD; and
- Establish a model identifying training and education opportunities available that address the needs of diverse stakeholders.

The task force also identified the following draft goals for adults age 18 and over:

- Identify the needs and services gaps for adults with ASD;
- Strengthen supports for transitions from adolescent to adult services; and
- Develop more opportunities for adults with ASD to be valued, contributing members of their communities based on their unique strengths, differences, and challenges.

AUTISM SPECTRUM DISORDER VOUCHER PROGRAM PILOT PROJECT

House Bill No. 1038 (2013), codified as Section 50-06-32.1, requires DHS to establish a voucher program pilot project beginning July 1, 2014, to assist in funding equipment and general educational needs related to ASD for individuals below 200 percent of the federal poverty level from age 3 to under age 18 who have been diagnosed with ASD. In addition, the department is required to adopt rules addressing management of the voucher program pilot project and to establish eligibility requirements and exclusions for the voucher program pilot project. The 2015 Legislative Assembly provided funding for 53 voucher slots for the 2015-17 biennium. However, funding for 10 of the slots was removed due to the August 2016 general fund budget reductions. The 2017 Legislative Assembly restored funding for the voucher slots to provide for 53 voucher slots for the 2017-19 biennium. The department is required to provide a report to the Legislative Management regarding the ASD program pilot project. Section 13 of Senate Bill No. 2012 (2015) provided for the continuation of Section 50-06-32.1 to require DHS to continue the ASD voucher program pilot project and to report to the Legislative Management regarding the ASD program pilot project.

Report

The Department of Human Services reported the ASD voucher program began on July 1, 2014, to assist in funding equipment and general educational needs for individuals with incomes below 200 percent of the federal poverty level from age 3 to under age 18 who have been diagnosed with ASD. The voucher may not exceed $12,500 for a fiscal year and any unused funds are returned to the program.

The report indicated 126 children have participated in the program since it began. During state fiscal year 2017, 50 children were served with an average expenditure of $4,398 per child. Items purchased for eligible children include electronic tablets, swimming lessons, activity center memberships, tutoring, and stress-relieving and safety-related items. There are 53 voucher slots available and DHS has received applications from 63 individuals.

CHILDREN'S HEALTH INSURANCE PROGRAM

Section 50-29-02 requires DHS to prepare, submit, and implement a children's health insurance program state plan and report annually to the Legislative Management and describe enrollment statistics and costs associated with the plan. Healthy Steps--North Dakota's children's health insurance plan--provides premium-free health coverage to uninsured children in qualifying families. It is intended to help meet the health care needs of children from working families that earn too much to qualify for full Medicaid coverage but not enough to afford private insurance. To be eligible for the program, a family's net income may not exceed 175 percent of the federal poverty level.

Legislative Appropriations

The schedule below summarizes legislative appropriations for the Healthy Steps program since the 2011-13 biennium.

Biennium	General Fund	Federal Funds	Total
2011-13	$8,517,391	$19,007,011	$27,524,402
2013-15	$11,400,407	$21,293,663	$32,694,070
2015-17	$2,831,220	$17,643,704	$20,474,924
2017-19	$1,870,086	$13,712,891	$15,582,977

Federal Medical Assistance Percentage and North Dakota's Allocation

The schedule below summarizes the federal medical assistance percentage (FMAP) and North Dakota's allocation of federal funds for the Healthy Steps program.

Federal Fiscal Year Ending	FMAP	North Dakota Allocation
September 30, 2012	68.78%	$16,063,553
September 30, 2013	66.59%	$17,311,376
September 30, 2014	65.00%	$18,787,251
September 30, 2015	65.00%	$20,997,498
September 30, 2016	88.00%	$21,240,226
September 30, 2017	88.00%	$21,886,855
September 30, 2018 (estimate)	88.00%	$21,200,000
September 30, 2019 (estimate)	88.00%	$21,200,000

Children Enrolled and Premium Rates

The schedule below summarizes the average annual recipients and premium rates in effect for the majority of the year for the majority of children covered.

State Fiscal Year Ending	Average Annual Recipients	Monthly Average Premium Rates
June 30, 2012	3,872	$272.69
June 30, 2013	4,046	$272.67
June 30, 2014	3,879	$280.52
June 30, 2015	2,591	$287.56
June 30, 2016	2,298	$273.12
June 30, 2017	2,154	$263.16
June 30, 2018	2,156	$310.00
June 30, 2019 (estimate)	2,200	$299.00

MEDICAID EXPANSION PROVIDER REIMBURSEMENT RATES

Section 38 of House Bill No. 1012 (2017) continued the medical assistance expansion program through June 30, 2019. The section provided the contract between DHS and the insurance carrier must include a provision for the carrier to provide DHS with provider reimbursement rate information when selecting a carrier. The section also required DHS to provide the Legislative Management a report regarding provider reimbursement rates under the medial assistance expansion program. The report may include trend data but may not disclose identifiable provider reimbursement rates.

Report

Representatives of DHS presented the following schedule detailing the estimated payment rates under the Medicaid Expansion program compared to Medicare and traditional Medicaid rates as of July 1, 2017:

Type of Service	Estimated Percentage of Medicare	Estimated Percentage of Traditional Medicaid
Professional	179%	179%
Inpatient	184%	173%
Outpatient	190%	264%
Overall	183%	202%

The committee also received the following schedule detailing the minimum reimbursement rates available to North Dakota pharmacy providers under the Medicaid Expansion program:

	Floor Rate	Pricing Methodology
Ingredient cost - Brand	Average wholesale price minus 14%	Lower of submitted ingredient cost, contracted average wholesale price discount or maximum allowable cost, or usual and customary
Ingredient cost - Generic	Maximum allowable cost	Lower of submitted ingredient cost, maximum allowable cost, or usual and customary
Dispensing fee	$1.50	Fee does not apply to usual and customary claims

NURSING HOME AND HOME- AND COMMUNITY-BASED SERVICES

Section 3 of House Bill No. 1038 (2017) requires DHS to review services and related funding provided within its long-term care division for the 2015-17 and 2017-19 bienniums. The department is required to report to the Legislative Management during the 2017-18 interim on the levels of funding provided for and spent on nursing home services and home- and community-based services by program during these time periods and to provide recommendations for options to increase the number and level of services and funding provided for home- and community-based services for the 2019-21 biennium.

Report

Representatives of DHS reported home- and community-based programs administered by the DHS Long-Term Care Division include SPED, expanded SPED, personal care, targeted case management, Medicaid home- and community-based services waiver, children's medically fragile waiver, Medicaid technology-dependent waiver, program for all-inclusive care for the elderly (PACE), children's hospice waiver, money follows the person sustainability grant, Medicaid children's autism waiver, and the state autism voucher. The department's budget for the 2017-19 biennium includes $693.8 million for long-term care services, of which $91.4 million is for home- and community-based services.

The committee reviewed the following schedule detailing home- and community-based services expenditures and persons served since state fiscal year 2012:

Home- and Community-Based Services Funding and Persons Served								
	2012	2013	2014	2015	2016	2017	2018 (Estimated)	2019 (Estimated)
Expenditures	$13,559,588	$14,139,128	$30,661,463	$32,050,512	$36,767,469	$36,293,650	$41,356,324	$43,012,056
Monthly average persons served	1,709	1,690	2,278	2,263	2,124	2,157	2,225	2,582

The committee received the following schedule detailing the average cost per year per person for individuals receiving care through nursing home facilities, basic care facilities, and home- and community-based services:

Average Cost Per Person Per Year for Care Services			
Year	Home- and Community-Based Services	Basic Care Facilities	Nursing Home Facilities
2012	$7,935	$23,460	$67,755
2013	$8,365	$23,473	$70,415
2014	$13,460	$25,811	$74,912
2015	$14,165	$26,682	$77,927
2016	$17,313	$32,521	$88,638
2017	$16,823	$30,590	$87,467
2018 (estimated)	$17,561	$31,176	$88,784
2019 (estimated)	$17,933	$32,878	$89,832

Representatives of DHS reviewed the following proposals to increase the use of home- and community-based services:

- Add additional service options to the Medicaid home- and community-based waiver for aged and disabled individuals similar to the Medicaid intellectual and developmental disability waiver;
- Develop agency adult foster care to increase provider capacity and residential services options; and
- Address medication administration issues for aged and disabled individuals.

The committee also received information regarding the SPED and expanded SPED programs. The programs provide services for individuals who are older or physically disabled to allow the individuals to live independently. Examples of services provided include chore services, homemaker services, and home-delivered meals. County social services offices are required to provide case management services for the programs.

To qualify for the SPED program, an individual must have less than $50,000 of available liquid assets. An individual must also meet functional assessment requirements that are based on impairments in activities of daily living. As of September 2018, 1,161 individuals were receiving services through the SPED program.

To qualify for the expanded SPED program, an individual must be Medicaid eligible and have income below specified levels. An individual also must meet functional assessment requirements based on impairments in activities of daily living. As of September 2018, 186 individuals were receiving services through the expanded SPED program.

The service payments for elderly and disabled program uses an income limit level sliding fee schedule to determine a recipient's copayment for services received under the program. Since 2003, the Legislative Assembly has adjusted the SPED sliding fee schedule twice. In 2003, legislative intent provided for reductions in the fee schedule income limit levels and divided the fee schedule into two separate schedules with the use of each schedule dependent upon whether an individual has over $25,000 of liquid assets. In 2009, the Legislative Assembly appropriated additional funding to increase the income limit levels of the sliding fee schedules based on cost of living increases.

Committee Recommendations

The committee recommends:

- House Bill No. 1032 to require DHS to establish and revise a sliding fee schedule biennially for the SPED program;
- House Bill No. 1033 to direct DHS to create a pilot program for independent home- and community-based services case managers for the SPED and expanded SPED programs; and
- House Bill No. 1034 to require DHS to establish guidelines for long-term care services providers to deliver home- and community-based services.

MEDICAID FRAUD CONTROL UNIT STUDY

Section 1 of House Bill No. 1226 (2017) requires DHS, with the cooperation of the Governor and Attorney General, to study the feasibility and desirability of establishing a Medicaid fraud control unit. The department was required to provide a report to the Legislative Management prior to August 1, 2018, regarding the results of the study.

Background

Section 1902(a)(61) of the federal Social Security Act requires states to operate a Medicaid fraud and abuse control unit unless the state demonstrates the operation of a unit would not be cost-effective and beneficiaries of the plan will be protected from abuse and neglect in connection with the provision of medical assistance without the control unit. North Dakota has received an exemption since 1994 from the requirement to operate a Medicaid fraud control unit. In January 2017, the Centers for Medicare and Medicaid Services (CMS) notified the Governor the state's exemption would not be continued and requested the state to provide a plan to implement a Medicaid fraud control unit.

Report

Representatives of DHS and Attorney General's office presented the report regarding the feasibility and desirability of establishing a Medicaid fraud control unit. The committee was informed the primary function of a Medicaid fraud control unit is to investigate provider fraud, including billing for services not performed, billing for a more expensive process, billing twice for the same service, and billing for services that should be combined into one billing. A fraud control unit also may investigate nursing home neglect and abuse complaints and theft of nursing home resident personal funds.

The committee received information regarding Medicaid fraud control units operated by Montana, South Dakota, and Wyoming. The number of staff members assigned to the fraud control units ranged from four staff in Wyoming to nine staff in Montana. Unit staff generally consist of a combination of attorneys, investigators, auditors, administrative assistants, legal assistants, and unit directors.

The report indicated the state has the option to establish a Medicaid fraud control unit using qui tam provisions. Qui tam is a whistleblower law that allows private citizens to sue any individuals, companies, or other entities defrauding the state and recover damages and penalties on the state's behalf. To initiate a qui tam action, a private citizen, also known as a "realtor", must file a civil complaint with the court and serve a copy of the complaint and relevant evidence to the Attorney General. The state must decide whether to take over the case or allow the private citizen to litigate the case. The private citizen may be eligible to receive a portion of any proceeds recovered in the case.

The Medicaid fraud control unit workgroup recommended the following staffing levels for a North Dakota fraud control unit based on whether qui tam provisions are utilized:

Recommended Staffing Levels	
Qui Tam Provisions Not Utilized	**Qui Tam Provisions Utilized**
1 Attorney/Director (criminal focus) 1 Attorney (civil focus) 2 Investigators 2 Auditors 1 Support staff	1 Attorney/Director (assist with criminal focus) 1 Attorney (criminal focus) 1 Attorney (civil focus) 2 Investigators 2 Auditors 1 Criminal analyst 1 Support staff
7 Total staff positions	9 Total staff positions

The following are estimated 2019-21 and 2021-23 biennium budgets for a North Dakota fraud control unit based on whether qui tam provisions are utilized:

	Qui Tam Provisions Not Utilized		Qui Tam Provisions Utilized	
	2019-21 Biennium	**2021-23 Biennium**	**2019-21 Biennium**	**2021-23 Biennium**
Estimated expenses				
Salaries and wages	$1,333,716	$1,412,965	$1,716,394	$1,819,328
Operating expenses	398,809	361,900	511,496	413,432
Equipment	84,800	0	84,800	0
Total	$1,817,325	$1,774,865	$2,312,690	$2,232,760
Funding sources				
General fund	$181,733	$310,601	$231,269	$390,733
Federal funds	1,635,592	1,464,264	2,081,421	1,842,027
Total funding	$1,817,325	$1,774,865	$2,312,690	$2,232,760

The Medicaid fraud control unit would be funded 90 percent from federal funds the first 3 years after being established and would be funded 75 percent from federal funds after 3 years.

DEVELOPMENTAL DISABILITY MEDICAID WAIVER STUDY

Section 2 of Senate Bill No. 2041 (2017) required DHS to study the current eligibility requirements for the developmental disability Medicaid waiver. The study must include an analysis of whether the current developmental disability waiver eligibility determination protocol uses age-appropriate assessment methods, uses assessment tools reliable and valid in nature for level of need determinations, and utilizes assessment information that may already be available in an individual's record. The study also must include an evaluation of the feasibility and desirability of including in the eligibility determination consideration of related conditions and the possible use of certain medical conditions, such as Down syndrome. The department was required to report to the Legislative Management prior to August 1, 2018, regarding the result of the study.

Background

In March 2014, CMS established a new rule relating to the requirements for the qualities of settings eligible for reimbursement for Medicaid home- and community-based services, which are provided by the federal 1915(c) home- and community-based services waivers. The Department of Human Services completed a review of services, which included site visits and work with CMS, consumers, and providers to assure compliance with new rules. Section 1 of Senate Bill No. 2234 (2015) required DHS to study eligibility for developmental disability waivers and to provide a report to the Legislative Management regarding the eligibility for developmental disability waivers.

The Department of Human Services created an internal eligibility workgroup in October 2014 to review the new *Diagnostic and Statistical Manual of Mental Disorders*, American Psychiatric Association, 5th edition, text revision (2013), and its impact on developmental disability eligibility. Initial recommendations provided by the workgroup include:

- If cognitive testing has been completed and is still valid, it will be considered in eligibility determination, but will not hold as much weight in the eligibility formula as it currently does.
- If cognitive testing has not been completed or it is no longer valid, it will not be required, but cognitive screening will be required.
- Adaptive functioning testing will be required and will hold more weight in the eligibility formula than intellectual functioning.
- Individuals with related conditions must have an intellectual disability or adaptive functioning disability.

The Department of Human Services requested guidance from CMS regarding eligibility of developmental disabilities case management services. An individual must qualify as needing an institutional level of care to be eligible for the

developmental disabilities waiver. Even though an individual may meet certain criteria to be eligible for services, that individual may not qualify for any services because the individual does not meet the institutional level of care requirement. A state may choose its level of care for determining eligibility for developmental disabilities waivers, which includes hospitalization, intermediate care facility, or nursing facility. Various tools are available to help states make a determination and a state must receive approval from CMS for its level of care. North Dakota chose an institutional level of care.

Report

Representatives of DHS reported the department requested technical assistance from the CMS home- and community-based services technical assistance project. The goals of receiving the assistance were to conduct a comprehensive review of the state's existing Medicaid waiver programs to identify potential paths for eligibility for individuals without an intellectual or developmental disability, to provide the department with strategies to improve and maintain consistency in the application of criteria, to assist the department in identifying strategies to address gaps in service, to provide technical assistance relating to mitigating conflict of interest in case management structures, and to provide information and strategies related to person-centered practices and planning.

The Department of Human Services received several recommendations through the home- and community-based services technical assistance project which the department is reviewing.