HUMAN SERVICES COMMITTEE

The Human Services Committee was assigned the following responsibilities:

- Section 33 of Senate Bill No. 2015 (2019) directed a study of issues relating to the North Dakota Olmstead Commission, including consideration of the implementation of the new Olmstead Commission structure and any emerging Olmstead issues related to services for elderly individuals and individuals with behavioral health issues, physical disabilities, or intellectual disabilities.
- Senate Concurrent Resolution No. 4014 (2019) directed a study of the implementation of the recommendations of the Human Services Research Institute's study of North Dakota's behavioral health system.

The Legislative Management delegated to the committee the responsibility to:

- Receive annual reports from the Autism Spectrum Disorder (ASD) task force. (North Dakota Century Code (NDCC) Section 50-06-32)
- Receive a report from the Department of Human Services (DHS) regarding the ASD program pilot project. (Section 50-06-32.1)
- Receive a report from DHS and the steering committee for the developmental disabilities system reimbursement project on development activities and status information for the project. (Section 50-06-37)
- Receive a report from DHS before August 1 of each even-numbered year regarding provider reimbursement rates under the medical assistance expansion program. (Section 50-24.1-37)
- Receive a biennial report before August of each even-numbered year from DHS on the tribal health care coordination fund and tribal government use of money distributed from the fund. (Section 50-24.1-40(4))
- Receive annual reports from DHS describing enrollment statistics and costs associated with the children's health insurance program state plan. (Section 50-29-02)
- Receive a report from DHS on the system of services for individuals with an intellectual or developmental disability. (Section 5 of House Bill No. 1517 (2019))
- Receive a report prior to July 1, 2020, from DHS on the acute psychiatric and residential care statewide needs plan. (Section 18 of Senate Bill No. 2012 (2019))
- Receive a report prior to October 1, 2020, from DHS on the plan to implement the revised payment methodology for nursing facility services. (Section 19 of Senate Bill No. 2012 (2019))
- Receive a report during the 2019-20 interim from DHS and permanent housing program grant recipients regarding the services provided by the programs, the nonidentifiable demographics of the individuals receiving services, and the other funding or reimbursement being used to support the programs. (Section 22 of Senate Bill No. 2012 (2019))
- Receive a report from DHS on the ongoing work of the department to improve community provider capacity, together with any barriers encountered and a report regarding the system of services for individuals with an intellectual or developmental disability, including a review of the existing service system, funding, and unmet needs. (Section 3 of Senate Bill No. 2247 (2019))
- Receive periodic reports from DHS on the status of the department's administration of county social services programs, including the establishment of human service zones, human service zone budgets, and the indirect cost allocation plan; program changes and any "family first" legislation initiatives; formula payments, and any county employees transferred to the department. (Legislative Management Directive)

Committee members were Representatives Karen M. Rohr (Chairman), Jeff A. Hoverson, Dwight Kiefert, Lisa Meier, Matthew Ruby, Mary Schneider, Kathy Skroch, Bill Tveit, and Greg Westlind and Senators JoNell A. Bakke, Dick Dever, Kathy Hogan, Judy Lee, Tim Mathern, Jessica Unruh-Bell.

STUDY OF THE OLMSTEAD COMMISSION

Section 33 of Senate Bill No. 2015 (2019) directed a study of issues relating to the North Dakota Olmstead Commission. The study was to include consideration of the implementation of the new Olmstead Commission structure and any emerging Olmstead issues related to services for elderly individuals and individuals with behavioral health issues, physical disabilities, or intellectual disabilities.

Previous Study

The 2017-18 interim Health Services Committee studied state and federal laws and regulations relating to the care and treatment of individuals with developmental disabilities or behavioral health needs. As part of the study, the

committee received information regarding the Olmstead decision and state efforts to comply with the decision. The committee also received updates regarding the restructuring of the Olmstead Commission.

Background

Olmstead v. L.C. 527 U.S. 581 (1999) (*Olmstead*) is a United States Supreme Court case regarding discrimination against people with mental disabilities. In *Olmstead*, the Court found mental illness is a form of disability and unjustified isolation of a person with a disability is a form of discrimination under Title II of the federal Americans with Disabilities Act (ADA). The Court held community placement is required and appropriate only if "[a] the State's treatment professionals have determined that community placement is appropriate, [b] the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and [c] the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." Since this 1999 decision, there has been litigation in each of the 12 United States Circuit Courts of Appeal. In addition to enforcement of the Olmstead decision through the court system or through agreements, the United States Attorney General published regulations for implementing the requirements of the ADA, including requirements from *Olmstead*, such as Title II, regarding state and local government services, and Title III, regarding public accommodations and commercial facilities.

Creation of Commission and Development of State Plan

The Olmstead Commission was created in 2001 through an executive order issued by Governor John Hoeven. The order provided the commission was to develop a plan to implement the Olmstead decision by providing appropriate community-based placement for individuals with disabilities in a manner consistent with the needs and resources of the state.

In 2002, the Olmstead Commission held public meetings across the state to gather information on how to serve individuals with disabilities. The commission developed a working plan that included historical information regarding efforts to serve individuals in less restrictive settings and a record of state actions to comply with the Olmstead decision.

Executive orders issued by the Governor in 2010 and 2018 continued the Olmstead Commission and adjusted the membership of the commission. The 2018 executive order also allowed the commission to create subgroups for purposes of seeking expertise and input on community services and supports, health care, housing employment, education, and transportation.

Olmstead Commission Membership

The 2001 executive order establishing the Olmstead Commission provided for the commission to consist of 13 voting members and for a representative of the Governor's office and the executive director of the Department of Human Services to co-chair the commission. The 2010 executive order adjusted the commission by adding representatives of the Indian Affairs Commission and State Council on Developmental Disabilities and removing representatives from the Office of Management and Budget and Attorney General's office. The 2018 executive order provides for the commission to consist of 10 voting members and 8 nonvoting members with a representative of the Governor's office and a member representing the public to serve as co-chairs. The following schedule summarizes the membership of the commission under each executive order:

Voting Members		
2001 Executive Order	**2010 Executive Order**	**2018 Executive Order**
Representative of the Governor's office (co-chair)	Representative of the Governor's office (co-chair)	Representative of the Governor's office (co-chair)
Executive director of the Department of Human Services, or designee (co-chair)	Executive director of the Department of Human Services, or designee (co-chair)	One member of the Senate
One member of the Senate	One member of the Senate	One member of the House of Representatives
Two members of the House of Representatives	Two members of the House of Representatives	Representative of Mental Health America of North Dakota
Representative of Mental Health Association of North Dakota	Representative of Mental Health Association of North Dakota	Representative of the Protection and Advocacy Project
Representative of The Arc of North Dakota	Representative of The Arc of North Dakota	Representative of the Statewide Independent Living Council
Representative of the Protection and Advocacy Project	Representative of the Protection and Advocacy Project	Two representatives of the public (one to serve as co-chair)
Representative of the American Association of Retired Person (AARP) of North Dakota	Representative of the AARP of North Dakota	Representative of the State Council on Developmental Disabilities
Representative of the Statewide Independent Living Council	Representative of the Statewide Independent Living Council	Representative of the judicial branch

Voting Members		
2001 Executive Order	**2010 Executive Order**	**2018 Executive Order**
Representative of the public	Representative of the public	
Attorney General, or designee	Representative of the Indian Affairs Commission	
Director of the Office of Management and Budget, or designee	Representative of the State Council on Developmental Disabilities	
Nonvoting Members		
2001 Executive Order	**2010 Executive Order**	**2018 Executive Order**
None	None	Executive director of the Department of Human Services, or designee
		State health officer, or designee
		Superintendent of Public Instruction, or designee
		Commissioner of the Department of Commerce, or designee
		Executive director of Job Service North Dakota, or designee
		Director of the Department of Transportation, or designee
		Indian Affairs Commissioner, or designee
		Executive director of the Housing Finance Agency, or designee

Agency Administration

From the creation of the Olmstead Commission until June 30, 2019, DHS provided staff services for the commission; however, the department did not receive additional funding or positions for support of the commission. In 2018, an informal advisory group reviewed the structure and operations of the Olmstead Commission and recommended a centralized point of contact be established for the commission. The group determined the Protection and Advocacy Project had the appropriate structure and organization to respond to inquiries, make referrals, and provide education about the Olmstead decision. As a result, the Protection and Advocacy Project requested additional funding in its 2019-21 biennium budget request for a staff person to assist in Olmstead Commission duties. The Legislative Assembly, in Senate Bill No. 2014 (2019), added 1 full-time equivalent (FTE) position and related funding to the budget for the Protection and Advocacy Project for support of the Olmstead Commission. Total funding added was $238,929, $164,314 of which is from the general fund.

Department of Justice Lawsuit

The committee was informed that in 2015 the federal Department of Justice (DOJ) received complaints from North Dakota Medicaid recipients residing in skilled nursing facilities who no longer needed skilled care and would prefer to reside at home. The DOJ is continuing to investigate the complaints and has identified certain deficits in services to individuals with physical disabilities. The deficits include an imbalance of state funding provided to skilled nursing facilities compared to home- and community-based services, a lack of providers for community-based services, and a lack of awareness regarding the availability of home- and community-based services. DHS and the Governor's office are negotiating a settlement with the DOJ. Statutory and regulatory changes may be needed as a result of the DOJ settlement.

Commission Actions

The committee was informed prior to the Coronavirus (COVID-19) pandemic, the Olmstead Commission was meeting quarterly and three subcommittees were established to review and define:

1. Commission governance;
2. Availability of and deficits in services for individuals with disabilities; and
3. Scope of commission and work plan.

The commission scheduled community meetings across the state to gather input from individuals regarding their experiences and concerns with services provided to individuals with a disability. However, the community meetings were postponed due to COVID-19. The commission also worked with the Information Technology Department to develop a website to provide information regarding the rights and responsibilities related to the Olmstead decision and services available to individuals with a disability.

The commission is reviewing the process for an individual to submit a complaint. When a complaint is received, commission staff will gather information and conduct an initial screening assessment. A commission subcommittee will determine if additional information is needed from individuals, providers, or others. After all information is gathered, the Olmstead Commission will meet and an appropriate resolution to the situation will be determined.

Home- and Community-Based Services

The committee received an update regarding home- and community-based services. There is a range of home- and community-based services available to older adults and individuals with physical disabilities. Services are available through the Service Payments for the Elderly and Disabled (SPED) Program, Expanded SPED program, federal Medicaid 1915(c) waiver, and Medicaid state plan for personal care services. The 2019 Legislative Assembly provided for the expansion of the Aging and Disability Resource Link (ADRL) to include a centralized intake system. The ADRL is used to process and receive home- and community-based referrals and to determine if it is appropriate to assign a case manager to complete a home visit.

Committee Recommendations

The committee makes no recommendations regarding the study of the Olmstead Commission.

STUDY OF THE IMPLEMENTATION OF RECOMMENDATIONS OF THE HUMAN SERVICES RESEARCH INSTITUTE'S STUDY OF THE STATE'S BEHAVIORAL HEALTH SYSTEM

Senate Concurrent Resolution No. 4014 (2019) directed a study of the implementation of the recommendations of the Human Services Research Institute's (HSRI) study of North Dakota's behavioral health system. In conducting the study, the committee was to:

1. Receive regular updates on each of the major recommendation areas from the report;
2. Identify the availability, access, and delivery of behavioral health services;
3. Seek input from stakeholders, including law enforcement, social and clinical service providers, medical providers, mental health advocacy organizations, emergency medical service providers, juvenile court personnel, educators, tribal governments, and state and local agencies; and
4. Consider options for improving access and the availability for behavioral health care.

Additionally, Section 47 of Senate Bill No. 2012 (2019) provided for the Legislative Management to receive a report before August 1, 2020, from DHS regarding the implementation of the HSRI report recommendations.

Human Services Research Institute Study and Report

In 2017, DHS contracted with HSRI 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.

As a result of the study, the final HSRI report identified 13 recommendations and 65 specific strategies to direct future behavioral health policy and services in the state. The following are the recommendations and strategies included in the report:

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 (LEAD) 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
	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

Recommendation	Strategy
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
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	Collaborate 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

Recommendation	Strategy
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

Legislative Action Relating to the Final Report

The 2017-18 interim Human Services Committee received updates from DHS and HSRI regarding the study of the state's behavioral health system. The committee recommended Senate Bill No. 2030 (2019) which included a general fund appropriation of $408,000 and 1.5 FTE positions for the purpose of coordinating the implementation of recommendations of the study of the state's behavioral health system. The bill was not approved but Senate Bill No. 2012 (2019), which was approved by the Legislative Assembly, included a $300,000 general fund appropriation for the implementation of study recommendations.

Behavioral Health Funding and Programs

The Legislative Assembly appropriated $72.4 million to DHS for behavioral health programs for the 2019-21 biennium. This represents an increase in funding of $28.6 million compared to the 2017-19 biennium appropriations for behavioral health programs as detailed in the schedule below.

	2017-19 Biennium Appropriation	2019-21 Biennium Appropriation	Increase (Decrease)
Behavioral health			
General fund	$7,975,380	$21,981,044	$14,005,664
Other funds	35,853,789	50,420,587	14,566,798
Total	$43,829,169	$72,401,631	$28,572,462

The committee received updates regarding behavioral health programs administered by DHS. DHS has submitted an application for a federal Medicaid 1915(i) state plan amendment. The amendment proposes to provide home- and community-based services to individuals who have a mental illness, a brain injury, or a substance use disorder. Selected services included in the amendment are care coordination, community transitional services, and training for caregivers.

The substance use disorder treatment voucher program began serving individuals in 2016. The program allows individuals to receive substance use disorder treatment services from participating private providers. The 2019-21 biennium appropriation for the program is $7,997,294. However, as of August 3, 2020, $7,149,152 has been expended for the program. As a result, the department is not accepting new applications to participate in the program.

The 2019 Legislative Assembly authorized DHS to draft administrative rules for the certification of peer support specialists. The rules were drafted and the department received public comment regarding the rules. The rules provide for the certification of peer support specialists and peer support specialist supervisors.

Telehealth Services

The committee received information regarding the use of telehealth to provide behavioral health services. A study was conducted in 2017 by the University of North Dakota Center for Rural Health to determine the extent to which telehealth was used to provide behavioral health services. The study determined at least 10 facilities in the state provided telehealth services for behavioral health and 44 facilities received telehealth services. Most respondents reported providing or receiving services for adults rather than children and adolescents.

The Abound Counseling program administered by Lutheran Social Services uses telehealth to provide remote services to individuals in their homes or at partnership locations. Partnerships have been established with school districts, human service centers, and churches to house telehealth equipment. There are 27 partner telehealth locations providing services and 4 additional locations are pending.

Representatives of the State Hospital testified telehealth improves the patient experience by reducing the need to travel, and telehealth can be more cost-effective. The regional human service centers provide more than 700 telebehavioral health services per month. DHS is expanding behavioral health emergency services by offering emergency telehealth options through critical access hospitals and mobile crisis response teams.

Testimony Received

The committee received testimony and comments from the following stakeholders and providers regarding behavioral health and the implementation of recommendations included in the study of the state's behavioral health system:

- Representatives of the North Dakota Association of Counties expressed support for the continued development of local behavioral health treatment programs. County social services and correctional programs are affected by the lack of local behavioral health services. Some county correctional facilities screen inmates for substance use

and mental health issues when entering the facility. Upon completion of the assessment, a specialist visits with the inmate about services needed and referrals are made to the appropriate entities.

- Representatives of the Indian Affairs Commission reported tribal governments are experiencing behavioral health issues and many tribal communities are located in rural areas which affects the recruitment and retention of behavioral health personnel. Some tribes have been developing plans to improve access to services, including the Three Affiliated Tribes of the Fort Berthold Reservation, which recently opened a treatment center in Bismarck.
- Representatives of emergency medical services providers reported 85 percent of first responders have experienced mental health symptoms. They suggested the state develop a program to address the mental health needs of first responders. Testimony indicated some states allow an individual who has behavioral health needs relating to work experiences to receive services without informing the individual's employer.
- Representatives of the North Dakota Medical Association expressed support for the recommendation in the report on the state's behavioral health system to expand outpatient and community-based services. They argued the report recommendation to ensure all citizens have timely access to behavioral health services, including crisis response services, is an important part of the behavioral health system.
- Representatives of the North Dakota Hospital Association stressed the critical role of hospitals across the state in providing mental health and substance use disorder services. Hospital emergency departments often are the primary source of acute care services for people with mental illness and substance abuse issues. Some hospitals have embedded behavioral health specialists within its primary-care practice. Many of the state's hospitals also are using telehealth to provide behavioral health services.
- Representatives of the North Dakota Juvenile Justice State Advisory Group reviewed its contract with the Council of State Governments to conduct a study of the state's juvenile justice system. Although no formal recommendations have been made, initial findings indicate the state uses a punitive approach to unruly youth. The initial findings suggest additional services are needed for these youth earlier so they do not become involved with the juvenile justice system.
- Representatives of the Department of Veterans' Affairs reviewed behavioral health services available for veterans at the Fargo Veterans' Affairs clinic and at eight community-based outreach clinics. Services are provided by psychiatrists, psychologists, advanced practice nurses, social workers, and licensed professional mental health counselors. Veteran centers are located in Bismarck, Fargo, Grand Forks, and Minot, and provide community-based counseling services. The centers provide a wide range of social and psychological services to eligible veterans, active duty service members, and their families. Counseling services also are provided through telehealth to veterans in rural areas of the state. A virtual veterans court was established to identify veterans in the court system and connect them with services. A veterans' affairs justice outreach coordinator will work with prosecutors and judges as a veteran proceeds through the court process. Some approaches to assist the veteran include allowing the veteran to receive treatment while waiting for a court date or having a veteran's criminal charges removed after pleading guilty and receiving treatment. Testimony indicated the services provided to veterans in the court system are designed to identify if military service has contributed to the veteran's involvement in the justice system. Conditions caused by military service, such as post-traumatic stress disorder, may be a factor in the veteran's actions.
- Representatives of the Department of Public Instruction reviewed the department's strategic plan for elementary and secondary education, which identified behavioral health as having a significant impact on student learning. At the time there were increasing challenges with student behavioral health outbursts that were starting to occur at younger ages. Surveys determined student suicide idealization has increased along with suicide attempts. As a result, the Department of Public Instruction chose to partner with DHS to improve behavioral health services in schools. The departments continue to work together to improve school behavioral health services.

Implementation of Recommendations

The committee received updates regarding the status of implementation of recommendations included in the HSRI study of the state's behavioral health system. The Behavioral Health Planning Council, in conjunction with behavioral health stakeholders, is coordinating the development of a strategic plan to implement the recommendations. In December 2018, 570 individuals completed a survey to prioritize the implementation of strategies included in the HSRI report. The top five strategies ranked in the survey were included in the 2019 behavioral health strategic plan.

The top five strategies are:

1. To implement training on trauma-informed approaches for criminal justice staff;
2. To expand in-home community supports;
3. To implement crisis intervention team training for law enforcement officers and emergency medical responders;

4. To review behavioral health treatment capacity in jails and develop a plan to address needs; and
5. To expand school-based mental health and substance use disorder treatment services for youth.

The strategic planning process identified an implementation plan with four phases:

1. Strategic planning.
2. Prioritization and refinement of goals and objectives.
3. Initiate the implementation of goals and objectives.
4. Monitor and sustain the implemented efforts.

The state is in Phases 3 and 4 of the implementation plan. Dashboards are being developed to allow the public to view the implementation progress. The dashboards will be updated quarterly.

Committee Recommendations

The committee makes no recommendations regarding the study of the implementation of recommendations included in the HSRI report on the state's behavioral health system.

AUTISM SPECTRUM DISORDER TASK FORCE

Senate Bill No. 2174 (2009), codified as Section 50-06-32, established an ASD 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 ASD;
- A psychologist with expertise in the area of ASD;
- A college of education faculty member with expertise in the area of ASD;
- A behavioral specialist;
- 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;
- An enrolled member of a federally recognized Indian tribe;
- An adult advocate 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-based or community 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 also 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, required 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 section further provides the department is to report to the Legislative Management regarding the pilot project. When enacted, the section included an expiration date of June 30, 2015; however, Section 13 of Senate Bill No. 2012 (2015) provided for the continuation of Section 50-06-32.1.

The 2015 Legislative Assembly provided funding for 53 voucher slots for the 2015-17 biennium; however, funding for 10 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 2019 Legislative Assembly also provided funding for 53 voucher slots for the 2019-21 biennium. Funding of $1,075,088 from the general fund was appropriated for the program for each of the 2017-19 and 2019-21 bienniums. Section 46 of Senate Bill No. 2012 (2019) provides DHS is to propose changes to North Dakota Administrative Code to increase program flexibility to serve more families within existing appropriations. The section provides the proposed rules should consider changes that include a voucher solely for technology support and one for in-home supports, adding case management or parent-to-parent support as an allowable service for voucher funds, and reducing the amount of time during which a household may use approved voucher funds.

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 2020, there was an average expenditure of $3,187 per child.

During the 2017-19 biennium, approximately 30 percent of the program appropriation was expended. The 2019 Legislative Assembly authorized DHS to consider administrative code changes that included adding a voucher solely for technology support, adding a voucher for in-home supports, adding case management or parent-to-parent support as an allowed service, and reducing the amount of time during which a household may use approved voucher funds. The Department of Human Services consulted with the ASD task force on the proposed administrative code changes and the changes became effective April 1, 2020.

DEVELOPMENTAL DISABILITIES SYSTEM REIMBURSEMENT PROJECT

Section 50-06-37, as enacted by Senate Bill No. 2043 (2011), required DHS, in conjunction with developmental disabilities providers, to develop a prospective developmental disabilities payment system based on the support intensity scale. A steering committee was created to guide DHS on the development of the new payment system. The new payment system was implemented on April 1, 2018. The new system is based on a needs assessment for each individual served and rates that are standardized for all providers.

Section 50-06-37 was amended by Senate Bill No. 2247 (2019) to provide DHS maintain the payment system based on a state-approved assessment. A steering committee of no more than 18 individuals is to be used to provide guidance for the system. The steering committee must include no more than two clients, no more than one family member of a client, a representative of DHS, and a representative of the Protection and Advocacy Project. The steering committee is to analyze appropriate data and recommend to DHS any rate adjustments, resource allocation modifications, or process assumptions. The department and the steering committee are to report developmental activities and state information to the Legislative Management.

Report

A representative of DHS serving on the steering committee reported DHS contracted with a vendor in April 2019 to review the new payment rate structure and methodology to determine the appropriateness of assumptions and to recommend potential adjustments to the system. Key findings of the review include:

- Increase the program support component of medically fragile residential habilitation rates to represent the hours of nursing relative to the hours of direct support professionals for each acuity tier;
- Remove the 4 percent absences factor applied to every base residential rate and replace it with a 30-day personal assistance retainer policy;
- Add a 2 percent vacancy factor to the residential and intermediate care facility rate to account to vacancy costs; and
- Provide for systemwide changes in support intensity scales and overall rate changes to mitigate support intensity scales for day services, residential habilitation services, and intermediate care facility services.

MEDICAID EXPANSION PROVIDER REIMBURSEMENT RATES

Section 7 of Senate Bill No. 2012 (2019) continues the Medicaid Expansion program through June 30, 2021. The section provides for the contract between DHS and the insurance carrier to include a provision for the carrier to provide DHS with provider reimbursement rate information when selecting a carrier. The section also requires DHS to provide the Legislative Management a report regarding provider reimbursement rates under the medical assistance expansion program. The report may include trend data, but may not disclose identifiable provider reimbursement rates.

Report

Representatives of DHS reported Medicaid Expansion provider service rates in 2018 were 65.8 to 108 percent higher than provider rates under the traditional Medicaid program and rates overall were 77.8 percent higher. The following schedule details the percentage for each service that Medicaid Expansion rates were above traditional Medicaid rates in 2018.

Service	Percentage Medicaid Expansion Rates Exceeded Traditional Medicaid Rates
Inpatient	65.8%
Outpatient	108.0%
Professional	68.2%
Overall	77.8%

TRIBAL HEALTH CARE COORDINATION FUND

Section 50-24.1-40, as enacted in House Bill No. 1194 (2019), provides for DHS to facilitate care coordination agreements between health care providers and tribal health care organizations that will result in 100 percent federal funding for eligible medical assistance provided to an American Indian. The section created a tribal health care coordination fund and provided any funding received in excess of the state's regular share of federal medical assistance funding due to a care coordination agreement is to be deposited 60 percent in the tribal health care coordination fund and 40 percent in the general fund. Money in the tribal health care coordination fund is appropriated on a continuing basis for distribution to tribal governments in accordance with agreements between DHS and the tribal governments. The agreements must require the tribal governments to use funding distributed from the tribal health care coordination fund for health-related purposes, which may include population health programs or services, marketing or education-related to health programs or services, and developing or enhancing community health representative programs or services. Funding may not be used for capital construction, stipends to individuals for services, or services covered by the federal Indian Health Services, Medicaid, or other third-party payers or programs. The agreements between DHS and tribal governments also must require tribal governments to submit annual reports to DHS regarding the use of money distributed from the tribal health care coordination fund. Tribal governments also must submit an audit report to DHS every 2 years which relates to the use of funding distributed from the tribal health care coordination fund.

The Department of Human Services is to provide to the Legislative Management before August 1 of each even-numbered year a report regarding the tribal health care coordination fund including how participating tribal governments used funding distributed from the fund.

Report

The Department of Human Services reported the department entered health care coordination agreements with two tribes; however, the agreements are inactive due to concerns from tribal governments.

Representatives of the Indian Affairs Commission reported tribal governments have expressed concern the percentage of funding deposited in the tribal health care coordination fund is too low. There also are concerns increased

staffing would be needed at tribal health care facilities to administer the agreements. Another concern is funding distributed from the tribal health care coordination fund is not allowed to be used for construction purposes.

CHILDREN'S HEALTH INSURANCE PROGRAM

Section 50-29-02 provides DHS is to prepare, submit, and implement a children's health insurance program state plan and report annually to the Legislative Management. The report must include 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. The program is intended to help meet the health care needs of children from working families that earn too much income to qualify for full Medicaid coverage, but not enough to afford private insurance. To be eligible for the program, the family's net income may not exceed 175 percent of the federal poverty level.

The 2019 Legislative Assembly appropriated $12,821,689, of which $3,225,725 is from the general fund, for the Healthy Steps program for the 2019-21 biennium. This level of appropriation is based on an estimated average annual enrollment of 2,154 the 1st year of the biennium and an estimated average annual enrollment of 2,180 the 2nd year of the biennium.

Report

Representatives of DHS reported through June 2020, the program has spent $5,552,235, or 43 percent, of its budget. Monthly enrollment in the program has increased from 2,071 in December 2019 to 2,398 in June 2020.

The committee was informed Senate Bill No. 2106 (2019) allowed DHS to transfer the children's health insurance program (CHIP) from a managed care program to a fee-for-service arrangement. The transition date was January 1, 2020. The change to a fee-for-service arrangement is estimated to save the state $6.1 million per biennium, of which $1.9 million is from the general fund. The Department of Human Services reduced 1 FTE position for the administration of the CHIP program by transferring the program to a fee-for-service arrangement and savings also were realized by not contracting for actuarial services required under the managed care arrangement.

SYSTEM OF SERVICES AND PROVIDER CAPACITY FOR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

House Bill No. 1517 (2019) directs DHS to establish regional crisis support services for individuals with an intellectual or developmental disability. The bill also directs the department to conduct the standardized assessment of eligible individuals residing at the Life Skills and Transition Center. Section 5 of the bill requires DHS to provide a report to the Legislative Management regarding services for individuals with an intellectual or developmental disability. The report is to include:

1. The ongoing work of the department to improve community provider capacity, including any barriers encountered and policy review; and
2. The system of services for individuals with an intellectual or developmental disability, including a review of the existing service system, funding, and unmet needs.

Section 3 of Senate Bill No. 2247 (2019) provides legislative intent that DHS continue to work with community providers to continuously improve community provider capacity to serve clients in the least restrictive appropriate setting. The department is to provide the Legislative Management a status report on the ongoing work of the department to improve community provider capacity, together with any barriers encountered. The department also is to provide a report to Legislative Management regarding the system of services for individuals with an intellectual or developmental disability, including a review of the existing service system, funding, and unmet needs.

Report

Representatives of DHS presented an overview of services available for individuals with an intellectual or developmental disability. The regional human service centers provide services to approximately 5,800 individuals with an intellectual or developmental disability. Individuals also may receive services through 38 providers currently licensed by DHS. The Life Skills and Transition Center provides intermediate care services and statewide crisis services.

The Department of Human Services' Clinical Assistance Resource and Evaluation Service (CARES) located at the Life Skills and Transition Center provides resources across the state to allow individuals with disabilities to reside in their preferred community. The CARES program also provides crisis services statewide.

The Department of Human Services' Developmental Disabilities Division administers several programs to assist individuals with an intellectual or developmental disability. Programs include:

Service Area	Programs
Infants and toddlers	• Birth review program • Right track program • Early intervention services
Family support	• In-home support • Self-directed services • Extended home health care
Children and adult services	• Residential • Employment • Day habilitation • Corporate guardianship • Intermediate care facilities

The department did not identify any barriers relating to community provider capacity or any unment service needs.

ACUTE PSYCHIATRIC AND RESIDENTIAL CARE STATEWIDE NEEDS PLAN

Section 18 of Senate Bill No. 2012 (2019) (which was further amended by Section 30 of Senate Bill No. 2015 (2019)) requires DHS to develop a statewide plan to address acute psychiatric and residential care needs. The plan must address the following:

1. The size and use of the State Hospital;
2. The potential need for state-operated or private acute facilities in areas of the state outside the city of Jamestown;
3. The potential to expand private providers' offering of acute psychiatric care and residential care to fulfill the identified need, including how the implementation of services authorized by the 2019 Legislative Assembly affects the balance of inpatient, residential, and community-based services;
4. The impact of department efforts to adjust crisis services and other behavioral health services provided by the regional human service centers; and
5. The potential use of available Medicaid authorities, including waivers or plan amendments.

The Department of Human Services was required to provide a report to the Legislative Management before July 1, 2020, regarding the plan and any legislation necessary to implement the plan.

Report

The Department of Human Services contracted with the HSRI to conduct the study and to analyze the condition of State Hospital facilities and options to construct a new State Hospital facility. The study focused on the size and use of the State Hospital, the need for psychiatric facilities outside the city of Jamestown, the ability for private providers to offer additional psychiatric services, the effect of the DHS efforts to increase crisis and other behavioral health services at regional human service centers, and the potential use of available Medicaid waivers and state plan amendments.

The following are the recommendations that resulted from the HSRI study of the state's acute psychiatric and residential care statewide needs:

Study Area	Key Recommendations
Size and use of the State Hospital	1. A new 75- to 85-bed facility should be constructed. 2. Demand for the rehabilitation function of the State Hospital may be alleviated by expanding the availability of partial hospital programs. 3. Problems with access to behavioral health services reported by critical access hospitals should be investigated.
Need for state-operated or private acute facilities outside the city of Jamestown	Options should be explored to establish a small number of beds to serve a combination of adults and youth in the northwestern part of the state. Options to contract with an existing inpatient facility for the beds should be reviewed.
Expansion of private providers offering of acute psychiatric and residential care needs	1. Expansion efforts should focus on increased capacity for outpatient treatment that reduces the demand for inpatient treatment. 2. Expansion of services should be accompanied by the goal of increased efficiency. 3. Federally qualified health clinics and critical access hospitals may provide increased access in less populated areas. 4. Assessment of geographic distribution is needed along with expansion.

Study Area	Key Recommendations
Effect of DHS efforts to expand crisis and other behavioral health services at regional human service centers	1. Offering additional and enhanced behavioral health services should be accompanied by thorough data collection and monitoring to assess the impact on emergency department and hospital diversion. 2. Consideration should be given to contracting for residential beds until the effects of service changes are known. 3. Care criteria should be reviewed and utilization management processes enhanced to ensure appropriate level of care assignment. 4. Community stability should be monitored when transferring individuals from residential programs to less intensive settings. 5. Permanent housing supports should be maximized. 6. Service utilization should be monitored across the entire behavioral health system. 7. A comprehensive and integrated crisis response system could monitor individuals through care transitions and more efficiently identify available capacity.
Potential use of Medicaid waivers and plan amendments	A Medicaid Institution for Mental Disease waiver should not be sought by the state which may increase inpatient capacity and is counter to the report recommendations of increased community-based services.

NURSING FACILITY SERVICE PAYMENT METHODOLOGY

Section 19 of Senate Bill No. 2012 (2019) requires DHS to develop and implement a plan for a revised payment methodology for nursing facility services. The plan must include recommendations for:

1. Methods of reimbursement for nursing facility cost categories, including direct patient care, administrative expenses, and capital assets;
2. Considerations regarding establishing peer groups for payments based on factors such as geographical location or nursing facility size;
3. The feasibility and desirability of equalizing payments for nursing facilities in the same peer group, including the time frame for equalization; and
4. Payment incentives related to care quality or operational efficiency.

The executive director of DHS and representatives of the nursing facility industry must appoint a committee to advise the department in developing the revised payment methodology. The department was required to provide a report to the Legislative Management before October 1, 2020, regarding the plan to implement the revised payment methodology. The estimated costs related to the implementation of the revised payment methodology must be included in the department's 2021-23 biennium budget request submitted to the Legislative Assembly.

Report

Representatives of DHS reported the department, with advice from representatives of the nursing facility industry, developed an implementation plan for a revised payment methodology for nursing facility services. The report stated the goals of the new payment methodology are to incentivize operating efficiency, promote building improvements, reduce variation in rates, and decrease the state's financial liability.

The recommended payment methodology for nursing care costs is price-based. Rates in a price-based system are set prospectively using historical costs adjusted to the rate year. Nursing facilities that operate below the set price retain the differential up to a margin cap. Nursing facilities that operate above the set price would realize a loss. The recommended payment methodology would set a margin cap of 3.46 percent and provide hold harmless funding payments until nursing facility rates are rebased. The total estimated cost of the hold harmless payments is $4.1 million for the 2021-23 biennium.

The recommended payment methodology would use a fair rental value calculation to determine property rates. A daily fair rental value rate would be set prospectively based on the facility replacement cost less depreciation. The net facility cost would be multiplied times a rental rate. The total estimated 2021-23 biennium cost of the proposed property model is $3.1 million.

PERMANENT HOUSING PROGRAM GRANTS

Section 22 of Senate Bill No. 2012 (2019) identifies $925,000 from the general fund included in the DHS budget for grants to entities to provide housing services to individuals in the northeast and southeast human service regions. The department is to develop and implement standardized processes for the distribution of the permanent housing grants. Grant funds may be used only for services not reimbursed by other funding sources. The department, along with entities receiving the grants, were required to provide reports to the Legislative Management regarding services provided by the

programs, demographics of individuals receiving services, and other funding or reimbursement being used to support the programs.

Report

Representatives of the Grand Forks Housing Authority reviewed its permanent housing support program at the LaGrave on First apartment complex in Grand Forks. The grant funds are used to pay for housing support specialist staff at the complex. The staff are mental health technicians who provide continuous mental health and tenancy services at the complex. From September 1, 2019, through March 12, 2020, 43 individuals have been served through the program. Of those served, 14 had mental health concerns, 17 had alcohol dependency issues, 7 had drug abuse issues, 5 had a chronic health condition, 5 had a developmental disability, and 6 had a physical disability.

Representatives of the Dacotah Foundation reviewed the services it provides at the Cooper House permanent supportive housing facility in Fargo. Services provided include crisis intervention, emergency management, de-escalation, tenant support, and safety monitoring. From September 1, 2019, through March 12, 2020, 44 individuals have been served through the program. Of those served, 29 had mental health concerns, 26 had alcohol dependency issues, 13 had a chronic health condition, 1 had a developmental disability, and 14 had a physical disability.

COUNTY SOCIAL AND HUMAN SERVICES PROJECT

In Senate Bill No. 2124 (2019), the Legislative Assembly approved a new social and human service delivery system. Key components of the system include:

- Up to 19 multicounty zones may be established for the delivery of human services. Counties with a population over 60,000 may be a single county zone.
- A human service zone board, comprised of county commissioners and other local officials, govern each zone. The board may not exceed 15 members appointed by county commissioners with at least one commissioner from each county serving on the board.
- Each human service zone board must hire a human service zone director to serve as presiding officer of the board and to oversee the operations of the human service zone.
- Funding formula payments for direct costs will be provided to each zone which are based on fiscal year 2018 data.
- Up to 33 full-time equivalent employees may be transferred from counties to DHS if one or more human service zones transfer duties to the department. Funding formula payments may be withheld from a zone for any duties transferred to the department.
- Up to 107 FTE employees may be transferred from counties to DHS for specific positions that provide services to the zones.

Pursuant to a Legislative Management directive, the committee was to receive periodic reports from DHS on the status of the department's administration of county social service programs, including the establishment of human service zones, human service zone budgets, and the indirect cost allocation plan; program changes and any "family first" legislation initiatives; formula payments, and any county employees transferred to the department.

Report

Representatives of DHS reported on the collaboration with counties to form human service zones effective January 1, 2020. Zone directors were to be hired by March 31, 2020, and each zone was to complete an operations plan by June 30, 2020. The first payment to human service zones was made in January 2020, and the second zone payment was made in June 2020. Payments made in 2020 are estimated to total $91.6 million and 2021 payments are estimated to total $91.4 million. The total estimated payments are $9.3 million more than the amount appropriated for the program; however, DHS estimates $10.3 million of payments will be offset due to zone fund balances exceeding allowable amounts. The department anticipates salaries and benefits costs will exceed estimates by $13.9 million, indirect costs will exceed estimates by $6.3 million, and operating expenses will be $10.8 million less than estimated. A total of 112 positions have been transferred from counties to DHS to date. The positions relate to early childhood services (22), home- and community-based services case management (60), long-term care eligibility (16), child welfare quality control (10), and administration of zone activities (4).

Representatives of the North Dakota Association of Counties informed the committee one major issue is the employee benefit packages offered by various counties. Benefit packages vary by county and zone employee benefits will be administered by the host county. This may affect an employee's benefit coverage level as well as how much counties pay for employee benefits. Additionally, they suggested indirect costs for items such as travel and office costs will be an issue that needs to be addressed by the 2021 Legislative Assembly.

Representatives of DHS also provided updates regarding the federal Family First Prevention Services Act. The Act adjusts how states may use federal Title IV-E funds for programs such as foster care and kinship care. The Act also allows funding to be used for preventative services. The Department of Human Services is partnering with law enforcement agencies, tribal governments, states' attorneys, schools, hospitals, and providers to implement the new program requirements.