# BUDGET COMMITTEE ON HEALTH CARE

The Budget Committee on Health Care was assigned the following study responsibilities:

1. Section 11 of 2005 House Bill No. 1010 directed a study of the need for a comprehensive long-range study of the state's current and future health care needs in order to address issues, such as the aging population of the state, the phenomenon of health care cost-shifting to the private sector, the trend of uncompensated health care services, shortages in the number of health care professionals, duplication of technology and facilities, and any other factors that might affect the health care system in North Dakota in the year 2020.
2. Section 6 of 2005 House Bill No. 1280 directed a study of the feasibility and desirability of creating an allied health professions board to regulate the practice of members of allied health professions, including the feasibility and desirability of a North Dakota allied health professions board entering joint professional licensure agreements with neighboring states.
3. Section 2 of 2005 Senate Bill No. 2269 directed a study of the feasibility and desirability of establishing an umbrella licensing organization for a group consisting of counselors, psychologists, marriage and family therapists, and social workers.
4. Section 1 of 2005 Senate Bill No. 2171 directed a study of the licensure and regulation of acupuncturists practicing in the state as well as the possibility of multistate joint licensure and regulation programs.
5. To make a recommendation of a private entity, after receiving a recommendation from the Insurance Commissioner, for the Legislative Council to contract with to provide a cost-benefit analysis for legislative measures mandating health insurance coverage of services or payment for specified providers of services, or an amendment that mandates such coverage or payment, pursuant to North Dakota Century Code (NDCC) Section 54-03-28.

The committee was also assigned the responsibility to receive reports from:

- The Board of Nursing on its study of the nursing educational requirements in this state and the nursing shortage in this state and its implications for rural communities, pursuant to NDCC Section 43-12.1-08.2.
- The Department of Human Services describing enrollment statistics and costs associated with the children's health insurance program state plan, pursuant to NDCC Section 50-29-02.
- The State Department of Health regarding the department's basic care survey pilot project, including a recommendation of whether the unannounced survey process should continue for all basic care facilities, pursuant to Section 26 of 2005 Senate Bill No. 2004.

Committee members were Senators Aaron Krauter (Chairman), John M. Andrist, Richard L. Brown, Ralph L. Kilzer, Judy Lee, Tim Mathern, Carolyn Nelson, and Russell T. Thane and Representatives William R. Devlin, Lee Kaldor, Gary Kreidt, Shirley Meyer, Vonnie Pietsch, Todd Porter, Louise Potter, Clara Sue Price, Robin Weisz, and Alon C. Wieland.

The committee submitted this report to the Legislative Council at the biennial meeting of the Council in November 2006. The Council accepted the report for submission to the 60th Legislative Assembly.

## COMPREHENSIVE STUDY OF NORTH DAKOTA HEALTH CARE NEEDS

Section 11 of 2005 House Bill No. 1010, the appropriation bill for the Insurance Commissioner's office, directed a study of the desirability of proposing a comprehensive health care and health insurance study to be performed during the 2007-08 interim. The 2005-06 interim study was to include consideration of whether there is a need for a comprehensive long-range study of the state's current and future health care needs in order to address the following issues:

- The aging population in the state;
- The phenomenon of health care cost-shifting to the private sector;
- The trend of uncompensated health care services;
- Shortages in the number of health care professionals;
- Duplication of technology and facilities; and
- Any other factors that might affect the health care system in North Dakota in the year 2020.

If the study results in a recommendation for a comprehensive health care and health insurance study, the proposal is to address the parameters of the proposed study and how the proposed study will be designed in order to allow for significant consumer input. The Legislative Council assigned this responsibility to the Budget Committee on Health Care.

### North Dakota Health Care Issues

The committee learned that it is expected that the state's current population over age 65 will increase from the current population of 97,800 to approximately 149,600 by 2020. The state's population over age 85 is expected to increase from the current population of 15,300 to approximately 24,300 by 2020. Because of the anticipated increases in the number of elderly, there may be a need to relocate or add skilled nursing home beds. In addition, future demand for Alzheimer's and dementia-related services will greatly depend on the availability of new treatment options.

The committee learned that:

- North Dakota's elderly receive high-quality care despite the fact that Medicare spends considerably less on care for North Dakota

beneficiaries. Medicare in certain areas of the country is implementing a new model of linking payment to quality of care delivered referred to as "paying for performance." This model has resulted in substantial improvements in the quality of care provided.

- Total personal health care expenditures in North Dakota in 2000 were approximately $2.9 billion, or 16.2 percent of the gross state product, an increase from the 1990 total personal health care expenditures of $1.7 billion, or 14.4 percent of the gross state product.
- Approximately 58 percent of North Dakotans travel 5 miles or less to receive health care; approximately 9 percent travel 21 to 50 miles; and approximately 20 percent travel more than 50 miles to access health care services. Studies have shown that greater distances people must travel to receive health care services result in underutilization of health care services.
- Between 1994 and 2003 there were 789 identified suicides in North Dakota. Suicide rates among American Indians on reservations is anywhere from 2 to 10 times higher than the rest of the state's population.

The committee heard testimony from a representative of the University of North Dakota School of Medicine and Health Sciences Center for Rural Health regarding North Dakota health care needs. North Dakota is 1 of 13 states that does not participate in the healthcare cost and utilization project (HCUP), which is a federal data base for patient-level health care data relating to a broad range of health policy issues, including cost and quality of health services, medical practice patterns, and access to health care programs. The Center for Rural Health uses the HCUP national data to determine key rural health trends across the states; however, the data does not reflect findings associated with North Dakota. Participation would require North Dakota to obtain data from third-party payers, including purchasing Medicare data. It is estimated that it would cost approximately $50,000 per year to update the Medicare data set.

## Governor's Health Insurance Advisory Committee

The committee learned the Governor's Health Insurance Advisory Committee managed the Health Resources and Services Administration federal grant program to study health insurance coverage in North Dakota. The State Department of Health received a total of $1,151,702 from the Health Resources and Services Administration over a three-year period for the study. Research related to the study, which was completed in August 2006, was conducted by the University of North Dakota School of Medicine and Health Sciences Center for Rural Health. Based on the study findings, approximately 8.2 percent of North Dakota's population does not have health insurance, compared to the national rate of 15.2 percent. The North Dakota percentage represents about 52,000 residents of the state, including approximately 11,000 children under age 18. American Indians are far more likely to be uninsured (31.7 percent) compared to Caucasians (6.9 percent). Residents living in a household with an annual income of less than $10,000 are twice as likely to be uninsured (16.6 percent), compared to the overall state rate of 8.2 percent.

## Blue Cross Blue Shield of North Dakota

A representative of Blue Cross Blue Shield of North Dakota provided testimony regarding a potential comprehensive long-range study of the state's current and future health care needs. Blue Cross Blue Shield of North Dakota supports a study of future health care needs in North Dakota and is willing to provide funding to assist with the study.

## University of North Dakota School of Medicine and Health Sciences

The committee heard testimony from representatives of the University of North Dakota regarding the status of the medical school. The committee learned there are 1,461 licensed physicians in North Dakota. Of the state's 328 practicing family medicine physicians, approximately 68 percent graduated from the University of North Dakota with a medical degree, residency training, or both. Family medicine physicians provide the majority of patient care in rural areas. However, in North Dakota and throughout the United States, the number of medical student graduates choosing a residency in family medicine is decreasing. This decrease in the number of family medicine physicians is primarily due to lower salaries and more "on-call" hours as compared to specialty practice physicians.

The committee reviewed information for the period 1990 through 2000 regarding University of North Dakota School of Medicine and Health Sciences graduates who continue to reside in North Dakota:

| | Number of Graduates Remaining in North Dakota/Total Graduates | Percentage of Graduates Remaining in North Dakota |
|---|---|---|
| Medical school graduates | 182/497 | 37% |
| Residency training graduates | 161/409 | 39% |
| Combined medical school and residency training graduates | 343/906 | 38% |

In comparison, approximately 25 percent of all University of North Dakota graduates (all majors) continue to reside in state after graduation. The committee reviewed a historical comparison of federal, state, tuition, and other funding sources received by the University of North Dakota School of Medicine and Health Sciences and an overview of the utilization of state funding. The state funding is primarily used for educational purposes, and research is supported with federal and private grants.

The committee toured the University of North Dakota School of Medicine and Health Sciences, including the federal research laboratory, classrooms, and study

group sections. Approximately 62 students are accepted into the doctor of medicine (M.D.) program each year.

The committee learned that students at the University of North Dakota School of Medicine and Health Sciences generally receive their M.D. degree after four years of successful study. The students generally complete the first two years at the Grand Forks campus. For the third year, the majority of the students are assigned to do clerkship rotations within clinical settings. Approximately six to eight third-year students are chosen to participate in the rural opportunities in medical education (ROME) program. In the fourth year, students complete internships designed to teach students how to function in a hospital setting.

The University of North Dakota School of Medicine and Health Sciences has developed a curriculum that focuses on patient-centered learning. Patient-centered learning curriculum allows first- and second-year medical students to interact with actual patients, allowing them to learn the dynamics of doctor/patient relationships, how to interview patients, and how to conduct physical examinations. The University of North Dakota School of Medicine has received national acclaim for its patient-centered learning curriculum, which has been copied by many other prestigious medical schools.

The small group learning sessions for first- and second-year medical students are designed to facilitate the integration of the basic sciences with clinically relevant cases. The medical students are separated into small groups for 8- to 10-week periods to study various sections of basic sciences and clinical medicine curriculum. The small group sessions stress independent learning to strengthen individual problem-solving skills.

The ROME program allows third-year medical students to live and train in a nonmetropolitan community under the supervision of physician preceptors. A goal of the ROME program is to expose students to practicing medicine in rural areas throughout North Dakota.

### Physician Loan Repayment Program

The committee reviewed information regarding the physician loan repayment program. The physician loan repayment program provides funding for educational loan repayments incurred while recipients were attending an accredited four-year medical program in exchange for a commitment to serve a community. Pursuant to NDCC Chapter 43-17.2, each physician is limited to a $45,000 maximum loan repayment from the state paid over a two-year period. Additional funding for the loan repayment is to be provided by the selected community in an amount that equals or exceeds the amount of loan repayment provided by the state. Senate Bill No. 2266 (2005) increased the maximum amount of state match from $40,000 to $45,000 and provided the loan be repaid over two years rather than four years. The total 2005-07 biennium appropriation for this program is $75,000 from the general fund.

In order to receive funding from the physician loan repayment program, physicians must commit to practice in the sponsoring community for a two-year period. Historically, approximately 80 percent of the physicians have remained in the community after completing their commitment. Individuals are not "turned down" for the program but go on a "waiting list" until additional funding is available.

The committee learned that all available 2005-07 biennium physician loan repayment funding has been committed. Currently, four medical doctors and two physician assistants are participating in the program.

### Other Reports and Testimony

The committee heard other reports and testimony regarding:

- Blue Cross Blue Shield of North Dakota's decision to decrease payment rates to pharmacies for prescription drugs.
- Health care technology and legal and marketing issues.
- Healthy North Dakota worksite wellness programs.

### Recommendation

The committee recommends that the 60th Legislative Assembly consider providing for a comprehensive Legislative Council study of health care and health insurance during the 2007-08 interim and that a consultant be hired, as necessary, to assist with the study.

## ALLIED HEALTH PROFESSIONS BOARD STUDY

Section 6 of 2005 House Bill No. 1280 directed a study of the feasibility and desirability of creating an allied health professions board to regulate the practice of members of allied health professions, including the feasibility and desirability of a North Dakota allied health professions board entering joint professional licensure agreements with neighboring states. The Legislative Council assigned this responsibility to the Budget Committee on Health Care.

Allied health professions are boards and commissions involved with delivery of health care or related services pertaining to identification, evaluation, and prevention of diseases and disorders; dietary and nutrition services; and rehabilitation and health systems management. Allied health professions may include professions, such as dental hygienists, dieticians, medical technologists, occupational therapists, polysomnographic technologists, respiratory therapists, speech-language pathologists, and radiologic technologists.

Pursuant to NDCC Section 43-51-07, a board may establish, by administrative rule, conditions and procedures for foreign practitioners to practice in this state pursuant to written compacts or agreements between the board and one or more other states or jurisdictions or pursuant to any other method of license recognition that ensures the health, safety, and welfare of the public. An example of a multistate licensure agreement is the Nurse Licensure Compact, which allows a nurse to have one license (in the nurse's state

of residence) and to practice in other states as long as that nurse acknowledges that he or she is subject to each state's practice laws and discipline.

## North Dakota's Health-Related Boards and Commissions

The committee received information on 23 state health-related boards and commissions, including the number of individuals licensed, education and training requirements, examination requirements, and continuing education requirements. Each of these health boards and commissions are provided for in the North Dakota Century Code; however, licensure and regulation requirements for each board are not consistently provided for in statute. The state health-related boards include:

| Board/Commission | Professions or Groups Licensed (and Number Licensed) | Education and Training Requirements | Examination Requirements | Continuing Education Requirements |
|---|---|---|---|---|
| Board of Addiction Counseling Examiners | Licensed addiction counselors (308) | Bachelor's degree in addiction studies or a closely related field and complete 1,400 hours of clinical training in a board-approved clinical training program | National Association of Alcoholism and Drug Abuse Counselor exam or International Certification and Reciprocity Consortium exam and the Board of Addiction Counseling Examiners oral exam | 60 hours of continuing education every three years |
| Board of Athletic Trainers | Certified athletic trainers (124) | Bachelor's degree (based on requirements of certification established by the National Athletic Trainers' Association Board of Certification (NATABOC)) | NATABOC exam | 80 hours over a three-year period as required by NATABOC |
| Board of Examiners on Audiology and Speech-Language Pathology | Speech-language pathologists and audiologists (405) | Master's degree in speech-language pathology or audiology | Praxis exam | 10 hours per year of training directly related to profession |
| State Board of Chiropractic Examiners | Doctors of chiropractic (312) | Doctor of chiropractic degree from an accredited college of chiropractic | National Board of Chiropractic Examiners exam (5 parts) and a jurisprudence exam | 20 hours per year, including 4 hours of boundary issues every three years |
| Board of Clinical Laboratory Practice | Clinical laboratory scientists/medical technologists (CLS/MTs), clinical laboratory technicians/medical laboratory technicians (CLT/MLTs), and clinical laboratory specialists (915) | CLS/MTs are required to obtain a bachelor's degree in a science-related discipline; specialists are required to obtain a bachelor's or higher degree with a major in chemical, physical, or biological sciences; and CLT/MLTs must successfully complete a two-year academic program recognized by the board | Licensees are required to pass one of four board-approved national exams | 20 hours of continuing education every two years |
| Board of Counselor Examiners | Licensed professional counselors (LPCs) and licensed professional clinical counselors (LPCCs) (336) | Licensed professional counselors must obtain a master's degree from an accredited institution in guidance and counseling, an LPCC must also complete an additional 12 semester hours in clinical courses | The National Counseling exam; LPCCs must also pass the National Clinical Mental Health Counseling exam | LPCs are required to earn 30 hours of continuing education every two years; LPCCs are required to earn 40 hours of continuing education every two years |
| Board of Dental Examiners | Dentists, registered dental hygienists, registered dental assistants, and qualified dental assistants (1,450) | Dentists are required to have a doctor of dental surgery or doctor of dental medicine degree from a dental college recognized by the board; | Dentists and dental hygienists are required to pass a written National Board Dental exam and a jurisprudence exam; | Dentists are required to complete 32 hours of continuing education every two years; dental hygienists are required to complete 16 hours |

| Board/Commission | Professions or Groups Licensed (and Number Licensed) | Education and Training Requirements | Examination Requirements | Continuing Education Requirements |
|---|---|---|---|---|
| | | dental hygienists must hold a bachelor's or associate degree from a school of dental hygiene which is approved by the American Dental Association; a registered dental assistant must attend an accredited assisting program or successfully "challenge" the Dental Assisting National exam; a qualified dental assistant is required to be registered by the state but because of less training is limited to performing less expanded functions | certified dental assistants must successfully complete an accredited dental assisting program or pass an exam administered by the Dental Assistants National Board | every two years; dental assistants are required to complete 8 hours of continuing education every year; all dentists, hygienists, and assistants are required to have 2 hours of infection control and 2 hours of CPR every two years |
| Board of Dietetic Practice | Licensed registered dietitians (LRDs) and licensed nutritionists (LNs) (312) | LRDs are required to have a bachelor of science degree plus be registered by the Commission on Dietetic Registration of the American Dietetic Association; and LNs are required to have a degree which includes advanced nutrition requirement | LRDs must complete the registered dietitian exam sponsored by the Commission on Dietetic Registration | 75 continuing education hours in a five-year period |
| Board of Hearing Aid Specialists | Audiologists who hold hearing instrument dispensing licenses and hearing instrument dispensers (68) | High school diploma and pass written and practical exams (no formal training program) | A written exam administered by the National Institute of Hearing Instrument Specialists and a practical exam administered by the State Board of Examiners for Hearing Instrument Dispensers | 10 continuing education hours per year |
| Marriage and Family Therapy Licensure Board | Marriage and family therapists (The 2005 Legislative Assembly approved Senate Bill No. 2269 creating NDCC Chapter 43-53 and provided for the Governor to appoint a North Dakota Marriage and Family Therapy Licensure Board.) | Master's degree or a doctoral degree in marriage and family therapy from a recognized educational institution or a graduate degree in an allied field from a recognized educational institution and graduate level coursework which is equivalent to a master's degree in marriage and family therapy and two calendar years of work experience in marriage and family therapy under qualified supervision | A national exam administered by the board | To be established by the board |

| Board/Commission | Professions or Groups Licensed (and Number Licensed) | Education and Training Requirements | Examination Requirements | Continuing Education Requirements |
|---|---|---|---|---|
| State Board of Medical Examiners | Doctor of medicine (MD), doctor of osteopathy (DO), and physician assistants (2,941) | Doctor of medicine or doctor of osteopathy degree from a medical school approved by the board or by an accrediting body approved by the board; physician assistants are required to have a bachelor's degree, be certified by the National Commission on Certification of Physician Assistants, and be under contract to provide patient services under the supervision of an MD or DO | Physicians must pass the United States Medical Licensing Exam, the Comprehensive Osteopathic Medical Licensing Exam, or the Medical Council of Canada Evaluating Exam; physician assistants must pass the National Commission on Certification of Physician Assistants exam | Physicians are required to earn 60 hours of continuing medical education every three years; physician assistants are required to earn 100 continuing education units every two years |
| Board of Nursing | Registered nurses (RNs), licensed practical nurses (LPNs), advanced practice registered nurses (APRNs), unlicensed assistive persons, and medication assistants I, II, and III (16,309) | RNs - Minimum two-year associate degree; LPNs - Minimum one-year certificate; APRNs - Bachelor of science and master's degrees; medication assistant I - Completion of a training module and clinical component; medication assistant II - 40 hours of theory, 8 hours of lab, and 32 hours of clinical training; medication assistant III - Associate degree and completion of training program; unlicensed assistive person - Trained by employer | The NCLEX-RN and NCLEX-PN exams administered by the National Council of State Boards of Nursing, Inc. | Registered nurses and licensed practical nurses are required to obtain 12 contact (continuing education) hours within the previous two years; advanced practice registered nurses with prescriptive authority are required to have 15 contact hours within the previous two years; the Board of Nursing requires 400 practice hours within the previous four years for license renewal |
| State Board of Examiners for Nursing Home Administrators | Nursing home administrators (151) | Bachelor's degree from an accredited college or university and completion of a 480-hour administrator in training program | The Nursing Home Administrator exam | 20 hours per year by a recognized sponsor |
| Board of Occupational Therapy Practice | Occupational therapists (OTs) and occupational therapy assistants (OTAs) (488) | OTs are required to have a bachelor's degree or higher and OTAs are required to have a certificate or associate degree for occupational therapy assistant | The National Board of Certification for Occupational Therapy exam (both OTs and OTAs exams are provided) | 20 hours of continuing education every two years |
| State Board of Optometry | Optometrists (213) | Doctorate of optometry | National Board of Examiners exam (3 parts) and the state jurisprudence exam | 50 hours every three years |
| State Board of Pharmacy | Pharmacists, technicians, interns, pharmacies, and wholesalers (4,934) | Pharmacists must have a doctor of pharmacy degree from an Accreditation on Council Pharmacy Education-approved school; technicians must successfully complete | Pharmacists must complete the North American Pharmacists Licensure exam or the Foreign Pharmacists Equivalence Exams and the multistate jurisprudence exam | Pharmacists must complete 15 hours of continuing education per year/30 hours in a two-year renewal cycle; technicians must complete 10 hours of continuing education per |

| Board/Commission | Professions or Groups Licensed (and Number Licensed) | Education and Training Requirements | Examination Requirements | Continuing Education Requirements |
|---|---|---|---|---|
| | | either a two-year associate of applied science degree program, a one-year pharmacy technician certificate program, or a noncredit certificate of completion in pharmacy technology program; in addition the State Board of Pharmacy offers the only accredited on-the-job pharmacy technician training program in the country | | year/20 hours in a two-year renewal cycle |
| State Examining Committee for Physical Therapists | Physical therapists (PTs) and physical therapist assistants (PTAs) (796) | PTs must have a master of arts degree and PTAs must complete a two-year degree | National Physical Therapists exam (PTs and PTAs exams) | 25 hours every two years |
| Board of Podiatric Medicine | Podiatrists (26) | Doctorate degree from an accredited school and minimum one year of surgical residency | Three-part National Board exam covering basic science, clinical, and the licensing exam | 20 hours per year or 60 hours over three years |
| State Board of Psychologist Examiners | Psychologists (186) | Doctorate degree in psychology from an accredited school or college and two full years of supervised professional experience, 2,000 hours predoctoral and 2,000 hours postdoctoral | A written exam for the professional practice of psychology and an oral exam by the State Board of Psychologist Examiners that focuses on ethical and legal issues in the practice of psychology in North Dakota | 40 continuing education credits every two years in categories specified by the board in its rules |
| Board of Reflexology | Reflexologists (76) | Minimum 100 hours of training, including 40 hours of classroom training and 25 hours of hands-on practice | A 100-question written exam and a practical exam administered by the Board of Reflexology | 12 continuing education hours over three years |
| State Board of Respiratory Care | Temporary, certified, and registered respiratory therapists (currently in the process of adopting rules for licensure and regulation of polysomnographic technologists, pursuant to 2005 House Bill No. 1280) (404 - Number is anticipated to increase in 2006 with addition of polysomnographic technologists) | Successful completion of an accredited four-year respiratory care training program | National Board of Respiratory Care exam | 10 continuing education units per year |
| Board of Social Work Examiners | Licensed social workers (LSWs), licensed certified social workers (LCSWs), and licensed independent clinical social workers (LICSWs) (2,251) | An LSW must have a bachelor's degree in social work from a college or university; an LCSW must obtain a doctorate or master's degree in social work from a college or university; an LICSW must obtain a doctorate or master's degree in social work from a | Association of Social Work Boards exam | 30 continuing education hours every two years |

| Board/Commission | Professions or Groups Licensed (and Number Licensed) | Education and Training Requirements | Examination Requirements | Continuing Education Requirements |
|---|---|---|---|---|
| | | college or university and successfully complete within four years, 3,000 hours of supervised post-master's clinical social work experience | | |
| State Board of Veterinary Medical Examiners | Veterinarians and veterinary technicians (661) | Veterinarians must have a doctor of veterinarian degree from an accredited or approved college of veterinary medicine and veterinarian technicians are required to complete a two-year accredited program in veterinary technology | Veterinarians must successfully complete the North American Veterinary Licensing exam and a state written exam and veterinary technicians must successfully complete the Veterinary Technician National exam | 24 hours every two years for veterinarians and 8 hours every two years for veterinary technicians |

## Consolidation Efforts in Other States

The committee received information regarding recent efforts to consolidate professional boards in other states, including California, Montana, Nebraska, Texas, and Minnesota. The committee learned that often centralization efforts involve boards and commissions that are interdisciplinary in nature and deal with related occupations. In some states, boards have maintained all of their regulatory authority and a central agency merely performs "housekeeping" duties, such as payroll and printing. In other states, boards merely serve in an advisory capacity to the directors of the umbrella agencies.

## Autonomous Boards Versus Central Agencies - Comparison

The committee reviewed information regarding various perceived benefits of autonomous boards and perceived benefits of central agencies as identified by the Council on Licensure, Enforcement and Regulation. The Council on Licensure, Enforcement and Regulation is a resource organization based in Kentucky for groups and individuals involved in licensure or registration of regulated occupations and professions. The benefits of autonomous boards may include:

1. Need for professional expertise - Assures appropriate peer review of professional practice standards, qualified personnel to investigate complaints, and professional perspective of the public interest.
2. Administrative efficiency - Provides for efficient decisionmaking capabilities, greater visibility to the public, and a deterrent to potential violators.
3. Accountability - Provides for greater controls over allocation of funds and clearer levels of accountability.

The benefits of central agencies may include:

1. Administrative efficiency - Provides for consolidation of staff, space, time, and equipment and the capability to hire more professional staff to assist the boards.
2. Coordination - Provides executive and legislative branches with a single point of contact for consumer questions and complaints.
3. Oversight - Increases equity through uniform application of criteria for board decisions.

The committee considered a bill draft that would have required an interim Legislative Council study of any new allied health profession wanting to be established. Each study would have to consider the feasibility and desirability of having an agency or existing occupational or professional board regulate the new allied health profession.

## Recommendation

The committee recommends Senate Bill No. 2026 establishing an allied health professions board. The bill:

1. Defines "allied health professions" as clinical health care professions distinct from the medical and nursing professions.
2. Provides that board membership includes three to five individuals who are licensed members from each allied health profession regulated by the board. The members are appointed by the Governor for three-year terms.
3. Provides the duties of the board include regulating each of the allied health professions the board is directed to regulate, including the issuances of licenses and the regulation of licensees. The board is to meet at least once a year and annually select a president, vice president, and any other officers from its members.
4. Provides an option for existing allied health professions that choose not to be "stand-alone" boards to petition for membership in the allied health professions board. The allied health professions board and the entity submitting the petition are required to prepare and request introduction of a bill during the next legislative session to accomplish the request for inclusion.
5. Provides that a "new" allied health profession that is not regulated by an existing occupational

or professional board of the state or by a state agency will be required to submit a petition to the allied health professions board requesting inclusion as a profession regulated by the board. The allied health professions board will be required to determine whether to prepare and request introduction of a bill to accomplish the requested inclusion.

6. Provides a general fund appropriation of $4,000 for related costs of the board, including per diem costs and legal fees. The board will not have any other revenue source until an allied health profession is approved by the Legislative Assembly for inclusion in the allied health professions board. The board's primary revenue source will be from member dues.

## STUDY OF ESTABLISHING AN UMBRELLA LICENSING ORGANIZATION FOR COUNSELORS, PSYCHOLOGISTS, MARRIAGE AND FAMILY THERAPISTS, AND SOCIAL WORKERS

Section 2 of 2005 Senate Bill No. 2269 directed a study of the fiscal impact and the feasibility and desirability of establishing an umbrella licensing organization for a group consisting of counselors, psychologists, marriage and family therapists, and social workers. The Legislative Council assigned this responsibility to the Budget Committee on Health Care.

Counselors, psychologists, marriage and family therapists, and social workers provide the following services:

- Counseling is an application of human development and mental health principles in a therapeutic process and professional relationship to assist individuals, couples, families, and groups in achieving more effective emotional, mental, marital, family, and social or educational development and adjustment.
- Psychology is the observation, description, evaluation, interpretation, or modification of human behavior by the application of psychological principles, methods, and procedures for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior and enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health, and mental health.
- Marriage and family therapy is the diagnosis and treatment of mental and emotional disorders, whether cognitive, effective, or behavioral, within the context of marriage and family systems.
- Social work practice consists of the professional application of social work values, principles, and techniques in helping people obtain tangible services, counseling, psychotherapy, and providing social casework, social work education, social work research, or any combination of these.

The committee considered a bill draft that would have consolidated the Board of Addiction Counseling Examiners, Board of Counselor Examiners, Board of Social Work Examiners, and the North Dakota Marriage and Family Therapy Licensure Board into a single board--the allied council professionals board.

The committee received testimony from representatives of the counseling professions opposing consolidation, including:

1. A consolidated board could result in one profession subsidizing the cost of another profession.
2. Individual professionals and consumer representatives of the existing boards are familiar only with their own laws, rules and regulations, and professional codes of ethics.
3. Complaints can be multifaceted in content and often require a full-day meeting to address. As a result, a consolidated board could require meetings that extend for several days.
4. Decisions made by an umbrella board relating to adjudication of complaints would be more vulnerable to legal challenges.
5. Each of the professions differ widely in regard to ethical codes, education and training requirements, licensing examinations and procedures, and general practices.

### Recommendation

The committee makes no recommendation relating to its study of the fiscal impact and the feasibility and desirability of establishing an umbrella licensing organization for a group consisting of counselors, psychologists, marriage and family therapists, and social workers.

## LICENSURE AND REGULATION OF ACUPUNCTURISTS STUDY

Section 1 of 2005 Senate Bill No. 2171 directed a study of the licensure and regulation of acupuncturists practicing in the state as well as the possibility of multistate joint licensure and regulation programs. The Legislative Council assigned this responsibility to the Budget Committee on Health Care. Senate Bill No. 2171, as introduced, provided for the State Board of Medical Examiners to license acupuncturists. The bill would have provided for similar licensing requirements as are required in Minnesota.

Acupuncture practice is a comprehensive system of health care using Oriental medical theory and its unique methods of diagnosis and treatment. Its treatment techniques include the insertion of acupuncture needles through the skin and the use of other biophysical methods of acupuncture point stimulation.

The committee learned that the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) was established in 1982 to develop and administer a national certification process based on the nationally recognized standards of competence and education. The NCCAOM is the only nationally recognized certification available to qualified practitioners of acupuncture and Oriental medicine. Certification is granted to those who meet the eligibility and education criteria and pass an examination of an

individual's knowledge and skills necessary for safe and effective acupuncture practice. In addition, individuals must agree to follow "clean needle techniques" and the NCCAOM code of ethics and disciplinary process. The education component, which is a three-year program, includes training on the theory of Chinese medicine, "point location," "needling" techniques, and Western medicine.

The committee learned that according to the NCCAOM, 44 of 50 states license traditional acupuncturists. Approximately 97 percent of these states require completion of the NCCAOM test as part of their licensure process for acupuncturists and approximately one-half of these states require NCCAOM certification for licensure.

### "Traditional" Acupuncturists

The committee learned that there are approximately three individuals practicing traditional acupuncture in North Dakota who are not chiropractors or medical doctors. Traditional acupuncture is significantly different from acupuncture services provided by chiropractors or medical doctors. It is not illegal to practice traditional acupuncture in North Dakota; however, other than the State Department of Health requirement for the use of sterilized disposable needles, the profession is not regulated.

### Chiropractors and Medical Doctors Practicing Acupuncture

Acupuncture services offered by chiropractors and medical doctors are regulated by the State Board of Chiropractic Examiners and the State Board of Medical Examiners, respectively.

The committee learned that the State Board of Chiropractic Examiners requires a chiropractor to complete a minimum of 100 hours of training and education in order to provide acupuncture services. All licensed chiropractors are required to complete 20 hours of continuing education per year. There are many continuing education courses relating to acupuncture services available to chiropractors; however, there are no additional requirements for chiropractors to receive continuing education specifically related to acupuncture. A total of 72 of the 261 chiropractors practicing in North Dakota also provide acupuncture services.

The committee learned that the State Board of Medical Examiners does not regulate individual procedures; however, all physicians are required to meet certain "standards of care." If the board determines that these "standards of care" are not being met, the physician would be subject to disciplinary action. Based on a survey of 11 large hospitals in North Dakota, conducted by the State Board of Medical Examiners, there are approximately four physicians in North Dakota who provide acupuncture services.

### Options for Regulating Acupuncture

The committee reviewed various options for regulation of acupuncture, including:

- Licensure is the most restrictive form of state regulation. Under licensure laws, it is illegal for a person to practice a profession without first meeting the standards imposed by the state. It is illegal for unlicensed individuals to perform acts within the statutorily defined scope of practice.
- Certification under which title protection is granted to persons who have met the predetermined qualifications. Those not certified may perform the services of the profession or occupation but may not use the title.
- Registration is the least restrictive form of state regulation, usually consisting of requiring individuals to file their name, address, and qualifications with a government agency before practicing the profession.

The committee reviewed information regarding licensure options. The committee learned that licensure is the only method that provides for a system under which professional standards are set and an individual is prohibited from practicing unless those standards are met. Licensure of a profession in North Dakota is typically conducted by a legislatively created board; however, there are examples of executive state agencies performing this function. The degree of expertise required of an agency charged with regulating a profession would in large part depend on the standards required.

The committee heard testimony from an acupuncturist practicing in Grand Forks who indicated the primary reason for regulation should be to identify those acupuncturists who have obtained the proper training and to prevent unqualified people from practicing in the state. The committee was told that because acupuncturists are not licensed in North Dakota, self-funded insurance plans cannot include acupuncture services as a benefit.

The committee learned the State Department of Health would incur one-time startup costs of approximately $18,000 to $20,000 for development and implementation of a licensure program for acupuncturists. Licensure fees generated by three acupuncturists would not be sufficient to cover possible complaint investigations and the costs related to a hearing process if needed. The department does not have qualified staff to conduct onsite investigations of complaints related to the quality of care of services provided by acupuncturists.

The committee reviewed information regarding registration options. The committee learned that with registration an individual could be prohibited from practicing acupuncture unless that individual registered with the identified state agency. It appears very little expertise would be required to regulate acupuncture through a registry. Failure to register is a relatively basic issue to prove and enforce.

The committee reviewed information regarding reciprocity. The committee learned that reciprocity addresses the mutual exchange, recognition or enforcement of licenses, privileges, or obligations between states. In order to establish reciprocity agreements with another state, both states are required to establish some method of regulation.

The committee considered a bill draft that would have required all individuals practicing acupuncture in North Dakota, including those who practice within a scope of a profession in which they are licensed, to register with the State Department of Health.

### Recommendation

The committee recommends Senate Bill No. 2027 to require individuals practicing acupuncture in North Dakota, excluding those individuals who practice acupuncture under the scope of a profession for which they are licensed, to register with the State Department of Health. The bill:

1. Provides that a person may not practice acupuncture or hold oneself out as practicing acupuncture in North Dakota unless that person holds a valid certification of registration issued by the State Department of Health. The regulation requirement exempts from registration those individuals who practice acupuncture under the scope of a profession for which they are licensed, such as physicians and chiropractors.
2. Defines "acupuncture" as the insertion and manipulation of needles to an individual's body for the prevention, cure, or correction of any disease, illness, injury, pain, or other condition. The term does not include the insertion and manipulation of needles to an animal's body.
3. Provides that any person who fails to obtain a certificate of registration as required is guilty of a Class B misdemeanor.
4. Provides that the State Department of Health is to designate on the certificate of registration whether the registrant is a diplomat in good standing of the National Certification Commission for Acupuncture and Oriental Medicine, its successor organization, or a comparable organization as may be determined by the registrar.
5. Provides for an annual registration fee of $100.
6. Provides that registration does not exempt a person who practices acupuncture from the regulatory provisions of any other profession for which that person is licensed.

## MANDATED HEALTH INSURANCE COVERAGE

North Dakota Century Code Section 54-03-28 provides that the Legislative Council is to contract with a private entity, after receiving one or more recommendations from the Insurance Commissioner, to provide a cost-benefit analysis of every legislative measure or amendment mandating health insurance coverage of services or payment for specified providers of services. The committee was assigned the responsibility to make a recommendation regarding this contract.

Pursuant to NDCC Section 54-03-28, a legislative measure mandating health insurance coverage may not be acted on by any committee of the Legislative Assembly unless accompanied by a cost-benefit analysis. The Insurance Commissioner is to pay the cost of the contracted services, and the cost-benefit analysis must include:

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

### 59th Legislative Assembly Cost-Benefit Analyses

During the 2005 legislative session, a total of $13,929 was paid to Milliman and Associates for conducting cost-benefit analyses relating to two bills--House Bill No. 1381 ($6,598) and Senate Bill No. 2169 ($1,725) and for general project work ($5,606). House Bill No. 1381, which was not approved by the Legislative Assembly, would have created a new section to NDCC Chapter 54-52.1 providing for insurance coverage of prescription drugs for outpatient hormone replacement therapy, contraceptives, infertility therapy, and osteoporosis treatment. Senate Bill No. 2169, which was not approved by the Legislative Assembly, would have created a new section to Chapter 54-52.1 providing for colorectal cancer screenings. The 59th Legislative Assembly authorized $55,000 from the insurance regulatory trust fund, the same as the 2003-05 biennium appropriation, for payment of cost-benefit analyses of the 2007 Legislative Assembly measures mandating health insurance coverage.

### Insurance Commissioner Recommendations

The Insurance Commissioner recommended that based on the work done during the 59th Legislative Assembly, the Legislative Council contract with Milliman and Associates for cost-benefit analyses during the 60th Legislative Assembly.

### Recommendations

The committee recommends that the Legislative Council contract with Milliman and Associates for cost-benefit analyses of future legislative measures mandating health insurance coverage, pursuant to NDCC Section 54-03-28.

## BOARD OF NURSING REPORT

North Dakota Century Code Section 43-12.1-08.2, which is effective through September 30, 2006, provides that the Board of Nursing may review and study the nursing educational requirements and the nursing shortage in this state and the implications for rural communities. The Board of Nursing is to report annually on the progress of the study, if undertaken, to the Legislative Council. The Legislative Council assigned this responsibility to the Budget Committee on Health Care.

### Nursing Shortage Study

The committee learned that the Board of Nursing contracted with the University of North Dakota Center for Rural Health in 2002 for a study of nursing education requirements, the nursing shortage in North Dakota, and implications for rural communities. The Board of Nursing approved a 10-year timeline for the study which began in 2002. The Board of Nursing approved $54,850 of funding for the nursing needs study for the fiscal year ended June 30, 2006. The study findings include:

1. Based on a survey of 568 North Dakota high school students, 38 percent of the students indicated an interest in pursuing a career in the health care profession; however, 46 percent of the students indicated an interest in more than one profession.
2. Of the students interested in the health care profession, 38 percent indicated an interest in nursing, 30 percent indicated an interest in medicine, and 25 percent indicated an interest in physical therapy.
3. The 2006 statewide vacancy rate for licensed practical nurses (LPNs) was 7 percent, which is an increase from the 2005 vacancy rate of 5 percent.
4. The 2006 statewide vacancy rate for registered nurses (RNs) is 7 percent, which is a decrease from the 2005 vacancy rate of 11 percent.
5. The 2006 statewide employee turnover rate for LPNs is 12 percent, compared to the 2005 turnover rate of 21 percent.
6. The 2006 statewide employee turnover rate for RNs is 17 percent, compared to the 2005 turnover rate of 20 percent.
7. Based on the 2006 employee turnover and vacancy rates, it appears that the shortage of RNs may be lessening; however, there is some indication of an increasing shortage of LPNs.
8. There are approximately 632 advanced practice registered nurses (APRNs), 8,468 RNs, and 3,365 LPNs in North Dakota.
9. The average age of North Dakota RNs is 45, the same as the national average, and the average age of North Dakota LPNs is 41, which is slightly younger than the national average of 43.
10. In 2005 North Dakota RNs were paid an average of $19 per hour, compared to the national average of approximately $27 per hour.
11. In 2005 LPNs were paid an average of $14 per hour, compared to the national average of approximately $17 per hour.

### Out-of-State Nursing Employment Agencies

The committee learned there are numerous reasons hospitals use employment agencies or "registries" for short-term personnel needs, including sudden disease outbreaks, short-term staff vacancies, and position vacancies that require a specific professional skill-set. Sometimes hospitals cannot meet personnel needs locally and, in those instances, employment agencies or "registries" are a valued resource.

### Nursing Education Licensure Requirements

The committee reviewed information regarding nursing licensure requirements. Pursuant to NDCC Section 43-12.1-09, the Board of Nursing is to license and register nursing applicants. North Dakota Administrative Code (NDAC) Section 54-02-05-05.1 requires a minimum of 400 hours in clinical practice within the preceding four years for licensure renewal of RNs, LPNs, and APRNs. North Dakota Administrative Code Section 54-02-05-08 requires RNs, LPNs, and APRNs to complete a minimum of 12 contract or continuing education hours within the previous two years for licensure renewal.

### Nursing Education Loan Program

The committee reviewed information regarding the nursing education loan program. The Board of Nursing maintains a nursing education loan program funded through licensure fees of $10 for each RN and LPN biennial renewal fee or $5 for each RN and LPN annual renewal fee. The loans may be provided to students accepted into nondegree LPN programs, associate degree LPN or RN programs, baccalaureate RN programs, and master's or doctoral nursing programs and for LPNs or RNs to take board-approved refresher courses. The committee received information regarding the total amount and number of nursing education loans provided:

| | 2001-02 | 2002-03 | 2003-04 | 2004-05 |
|---|---|---|---|---|
| Total amount of loans (number of loans) | $57,350 (35) | $59,410 (35) | $48,575 (30) | $64,100 (67) |

### Nursing Programs

The committee received information regarding the approval process of the two-year registered nurse and one-year certificate practical nurse programs. The Board of Nursing granted conditional approval for the Dakota Nurse practical nurse program (Bismarck State College, Williston State College, Lake Region State College, and Minot State University - Bottineau) and continued initial approval for the Dakota Nurse registered nurse program through November 2007. The Board of Nursing granted initial approval of the State College of Science registered nurse program through March 2007.

## CHILDREN'S HEALTH INSURANCE PROGRAM REPORT

North Dakota Century Code Section 50-29-02 requires the Department of Human Services to report annually to the Legislative Council regarding enrollment statistics and costs associated with the Healthy Steps program (children's health insurance program). The Legislative Council assigned this responsibility to the Budget Committee on Health Care.

The committee learned that the Legislative Assembly provided funding of $12.1 million, of which $2.9 million is from the general fund and $9.2 million is from federal funds for Healthy Steps for the 2005-07 biennium.

Compared to the 2003-05 legislative appropriation, the funding provided is a $2.6 million increase, $768,000 of which is from the general fund and $1.8 million of which is from federal funds. The Legislative Assembly continued eligibility requirements for the program at 140 percent of poverty level and anticipated an insurance premium rate of $181.87 per child per month, an increase of 17.5 percent compared to the 2003-05 premium rate of $154.78. The Legislative Assembly provided funding to serve an average of 2,971 children per month.

The committee learned that due primarily to outreach efforts conducted by the Dakota Medical Foundation, the June 2006 enrollment in Healthy Steps was 3,547 children, which is an increase of 1,127 children since July 1, 2005, and 576 more children than the 2,971 used to calculate the 2005-07 biennium appropriation. The premium rate is $181.71 per non-Native American child and $183.35 per Native American child. Based on the current enrollment and premium, the total estimated expenditures for Healthy Steps will be $14.9 million. The total estimated expenditures are $2.8 million more than the total appropriation, including $700,000 from the general fund. The Department of Human Services anticipates "covering" the $700,000 budget shortfall within its existing total appropriation authority.

### Recommendations

The committee makes no recommendations regarding the children's health insurance program state plan.

## ANNOUNCED BASIC CARE SURVEYS PILOT PROJECT

Section 26 of 2005 Senate Bill No. 2004, the appropriation bill for the State Department of Health, provides that the State Department of Health is to develop a pilot project to test an announced basic care survey process. Previously, all basic care surveys were unannounced. The pilot project is to begin with 50 percent of the state-licensed basic care providers surveyed receiving an unannounced survey. The State Department of Health is to evaluate the results of the pilot project and provide a report to the Legislative Council during the 2005-06 interim. The Legislative Council assigned this responsibility to the Budget Committee on Health Care.

The committee learned that the State Department of Health is responsible for establishing standards and rules for basic care facilities. The department is required to inspect all places and grant annual licenses to basic care facilities that conform to the standards established and the rules prescribed. It is illegal for a basic care facility to operate without a license. The licenses are issued by the State Department of Health and each license is not valid for more than one year. Any license may be revoked by the department for violations of standards and rules adopted by the department.

Pursuant to NDAC Section 33-03-24.1-03, the State Department of Health may, at any time, inspect a facility that the department determines meets the definition of a basic care facility. The department is to perform, as deemed necessary, unannounced onsite surveys to determine compliance with established rules and regulations.

The committee learned that a workgroup was formed to develop this pilot project consisting of representation of the North Dakota Long Term Care Association, basic care providers, AARP, Protection and Advocacy Project, the Department of Human Services, including Medicaid and the ombudsman program, and the State Department of Health. Before initiation of the pilot project, a basic care survey pilot project plan was developed by the State Department of Health and reviewed and agreed upon by the workgroup. The guidelines for announcing surveys consisted of sending a fax to the basic care facility one week prior to the announced survey which was then followed up with a telephone call to make sure the facility received the message.

The pilot project covered the period July 1, 2005, through May 31, 2006. The committee reviewed the State Department of Health study findings, including:

1. Both providers and surveyors indicated that information is more readily available in most cases when the survey is announced.
2. Both providers and surveyors reported some improvement in communications with announced surveys.
3. Surveyors reported no increase in communication or contact initiated by family, residents, or staff resulting from announcing the surveys.
4. Providers indicated that in their opinion the results of the announced surveys are the same as if the surveys were unannounced.
5. Review of deficiency statements reveals that approximately twice as many deficiencies result from unannounced surveys as from announced surveys.

| Number of Surveys Completed | Average Number of Citations |
|---|---|
| 13 announced program surveys | 4.4 |
| 10 unannounced program surveys | 9.1 |
| 11 announced Life Safety Code surveys | 3.8 |
| 11 unannounced Life Safety Code surveys | 5.8 |

The committee also received information regarding the impact of additional federal health care facility regulations on the Department of Human Services and the Medicaid budget.

### State Department of Health Recommendation

The State Department of Health recommendation to the committee was that basic care surveys continue to be unannounced. The reasons for supporting unannounced surveys include:

1. The national standard is for surveys to be conducted unannounced to get a true picture of the day-to-day care and services provided to residents.
2. Announcing surveys allows facilities to make changes that have the potential to alter survey findings.
3. The greater number of findings with unannounced surveys indicates that facilities are

possibly fixing problems for the announced survey visits rather than developing a system to ensure continued compliance.

4. Citation of a deficient practice and the resulting plan of correction have a more significant impact on a facility's ability to deliver services in an improved manner over a longer period of time.
5. During announced surveys certain deficiencies can be missed. For example, the absence of staff in a facility would be missed if the survey were announced.

### North Dakota Long Term Care Association Response

The committee learned that the North Dakota Long Term Care Association surveyed basic care facilities regarding their experience with the announced basic care pilot project. The survey findings indicate that all the facilities that have experienced the announced survey process encouraged its continuation based on the following:

1. Residents and families have an opportunity for more meaningful involvement.
2. Assures essential staff will be present and available for announced surveys.
3. Paperwork was efficiently delivered to surveyors for announced surveys.
4. Facility staff was more comfortable and better able to perform routine work during announced surveys.
5. Review of past payroll records could identify attempts to manipulate staffing during announced surveys.
6. Various methods of gathering data makes it difficult to cover up a long- or short-time facility practice.

### Recommendation

The committee makes no recommendation regarding the pilot project to test an announced basic care survey process.

## BUDGET TOURS

During the interim, the Budget Committee on Health Care functioned as a budget tour group of the Budget Section and visited North Dakota Vision Services - School for the Blind, Mill and Elevator, School for the Deaf, East Laboratory, Crime Laboratory, Fraine Barracks, International Peace Garden, and State Fair Association. The committee received testimony regarding facility programs, overviews of clients or individuals served, and problems that facilities may be encountering during the interim. The tour group minutes are available in the Legislative Council office and will be submitted in report form to the Appropriations Committees during the 60th Legislative Assembly.

The committee learned that the International Peace Garden does not have sufficient funding for operating and maintenance costs. In addition, the International Peace Garden can only offer minimum wages and cannot maintain a consistent workforce because of the competitive job marketplace. The International Peace Garden plans to submit a request for an additional appropriation of $1,317,000 from the 2007 Legislative Assembly, of which $384,000 is for salaries and operating costs and $933,000 is for needed repairs to existing infrastructure.

## OTHER REPORTS

### Pharmacy Payment Policy and Medicaid

The Budget Committee on Health Care met with the Budget Committee on Human Services to receive information from Dr. Stephen Schondelmeyer, Professor of Pharmaceutical Economics, University of Minnesota, regarding the cost of dispensing pharmaceuticals and the Medicaid program. The committee learned that the cost of prescription drugs as a percentage of total United States Medicaid expenditures increased from 5.5 percent in 1990 to 14.1 percent in 2005. The average United States Medicaid drug product cost has increased from $17.72 in 1990 to $67.68 in 2004, while the average dispensing fee payment has only increased from $3.81 to $4.15 for the same period.

The committee learned the Deficit Reduction Act of 2005, which is scheduled to go into effect January 1, 2007, will change the formula that determines the payment to pharmacies for prescription drugs under the Medicaid program. The new formula, which will be based on the average manufacturer's price, has not yet been finalized. However, it is anticipated that payments to pharmacies for prescription drugs will be less under the new formula.

North Dakota's Medicaid prescription drug dispensing fee paid to pharmacists is $5.60 per generic drug and $4.60 per brand name drug. The current rate, which was implemented in August 2003, was negotiated between the Department of Human Services and representatives of pharmacies to provide a "fair" prescription drug dispensing fee. However, according to a report on the cost of dispensing pharmaceuticals prepared by PharmAccounts, the average cost of dispensing medications for 80 percent of the community pharmacies is $11.73.

The percentage of a pharmacy's total revenues from Medicaid prescriptions averages between 12 to 15 percent throughout the United States. The percentage of revenues from Medicaid prescriptions averages between 20 to 25 percent for independent pharmacies. Depending on the location of a pharmacy, the percentage of revenues can vary significantly.

### Children With Special Health Care Needs

The Budget Committee on Health Care met with the Budget Committee on Human Services to receive reports from the Department of Human Services regarding options for providing Medicaid services for children with special health care needs, on waivers surrounding states have submitted for programs for children with special health care needs, and on the status of the department's waiver request.