NORTH DAKOTA LEGISLATIVE COUNCIL

Minutes of the

BUDGET COMMITTEE ON HUMAN SERVICES

Tuesday and Wednesday, September 12-13, 2006
Roughrider Room, State Capitol
Bismarck, North Dakota

Senator Dick Dever, Chairman, called the meeting to order at 1:00 p.m. on Tuesday, September 12, 2006.

Members present: Senators Dick Dever, Richard L. Brown, Aaron Krauter, Judy Lee; Representatives Jeff Delzer, William R. Devlin, Lee Kaldor, James Kerzman, Gary Kreidt, Ralph Metcalf, Vonnie Pietsch, Chet Pollert, Todd Porter, Louise Potter, Clara Sue Price, Sally M. Sandvig, Gerald Uglem, Alon C. Wieland

Members absent: Senators Tom Fischer, Russell T. Thane, John M. Warner; Representatives Jon O. Nelson, Ken Svedjan

Others present: See attached appendix for additional persons present.

Senator David O'Connell, member of the Legislative Council, was also in attendance.

It was moved by Representative Kreidt, seconded by Senator Brown, and carried on a voice vote that the minutes of the previous meeting be approved as distributed.

JOINT MEETING WITH THE BUDGET COMMITTEE ON HEALTH CARE

The committee began its joint meeting with the Budget Committee on Health Care, Senator Aaron Krauter, Chairman.

Dr. Patricia A. Hill, Executive Vice President, North Dakota Pharmacists Association, Bismarck, provided information regarding North Dakota pharmacies. A copy of the information presented is on file in the Legislative Council office. She said two research projects relating to the economic impact of pharmacies on the state's economy and the cost of dispensing prescription drugs have been recently completed.

Dr. Hill said according to the economic impact study completed by the North Dakota State University Department of Agribusiness and Applied Economics, the economic activity generated by community pharmacies supports approximately 10,158 full-time equivalent jobs and generates approximately $907 million annually throughout various sectors of North Dakota's economy. She said more than 107,000 prescriptions are dispensed weekly in North Dakota, divided almost evenly between rural and urban communities. She said North Dakota community pharmacies clearly have a critical role in the health care delivery system, especially for rural communities.

Dr. Hill said 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, which does not include the cost of the product. She said the dispensing cost is specific to the cost of operating a community pharmacy, including expenses for salaries, rent, technology and software, accounts receivable, etc. She said the dispensing fee rate paid pharmacies under the Medicaid program is $4.60 for brand name drugs and $5.60 for generic drugs.

Chairman Dever called on Dr. Stephen Schondelmeyer, Professor of Pharmaceutical Economics, University of Minnesota. A copy of the information presented is on file in the Legislative Council office. Dr. Schondelmeyer said 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. He said 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 increased from $3.81 to $4.15 for the same period.

Dr. Schondelmeyer said total United States Medicaid drug expenditures have increased by 303 percent, or 215 percent as adjusted for inflation, during the 10-year period from 1992 to 2002. He said the primary factors contributing to the change in drug expenditures are increases in utilization and the drug manufacturer's product price.

Dr. Schondelmeyer said the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established a drug payment program for Medicare recipients. He said the Act requires the Medicare program to pay for dual-eligible recipients, or individuals who receive Medicare, and also some form of Medicaid assistance. As a result, he said, approximately one-half of the prescriptions previously paid for under the Medicaid program are now covered under Medicare.

Dr. Schondelmeyer said North Dakota's Medicaid pharmaceutical reimbursement rates are based on the lowest cost as determined by several formulas, including the average wholesale price less 10 percent, the federal upper limit, the maximum allowable cost, or the usual and customary price to the public. He said 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. He said the new formula, which will be based on the average manufacturers price (AMP), has not yet been finalized. However, he said, it is anticipated that payments to pharmacies for prescription drugs will be less under the new formula. He said inadequate payments for prescription drugs will force many pharmacies to close. He said rural and inner city pharmacies will be the hardest hit by the changes.

Dr. Schondelmeyer said the dispensing fee paid to pharmacies is not addressed in the Deficit Reduction Act of 2005. He said dispensing fees should be based on actual costs incurred by the pharmacy and should increase each year for inflation. He said in 2005 the actual cost of dispensing medications for North Dakota pharmacies was between $6.44 and $11.73.

In response to a question from Senator Mathern, Dr. Schondelmeyer said the actual cost of dispensing medications for North Dakota pharmacies is similar to the cost for pharmacies in other states.

In response to a question from Representative Kaldor, Dr. Schondelmeyer said the percentage of a pharmacy's total revenues from Medicaid prescriptions averages between 12 to 15 percent throughout the United States. He said the percentage of revenues from Medicaid prescriptions averages between 20 to 25 percent for independent pharmacies. Depending on the location of the pharmacy, he said, the percentage of revenues from Medicaid can vary significantly.

Senator Lee said it is important to determine the actual cost paid by pharmacies for prescription drugs in order to establish a fair reimbursement rate.

In response to a question from Senator Mathern, Dr. Schondelmeyer said Medicaid does not prohibit states from implementing a payment scale to pharmacies based on the number of Medicaid recipients served or for providing payments to pharmacies for counseling services.

In response to a question from Senator Krauter, Dr. Schondelmeyer said other states have implemented various incentives and programs, such as preferred drug lists and utilization management programs, to control Medicaid prescription drug costs.

In response to a question from Representative Kaldor, Dr. Schondelmeyer said private insurers have adopted various prescription drug price reimbursement limitations, many of which are similar to Medicaid. However, he said, many private insurers also provide financial incentives relating to utilization of lower cost drugs.

In response to a question from Representative Kerzman, Dr. Schondelmeyer said the Canadian government evaluates drug prices to determine if they are "excessive." He said the cost of pharmaceuticals can vary significantly from one country to the next. He said drug manufacturers often base the drug prices on the average personal purchasing power of the citizens within each country.

In response to a question from Senator Lee, Dr. Schondelmeyer said the province of British Columbia uses "referenced based pricing," which provides that the price of new drugs cannot be more than the cost of a similar drug already on the market.

In response to a question from Senator Dever, Dr. Schondelmeyer said payments to pharmacies for prescription drugs are inadequate under both the Medicare and Medicaid programs; however, pharmacies are "less worse off" under the Medicaid program.

In response to a question from Representative Price, Dr. Schondelmeyer said the majority of Medicare prescription drug programs allow 90 days' worth of medication to be issued by a mail order pharmacy, while community pharmacies may only issue 30 days' worth of medication.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS STUDY

Ms. Maggie Anderson, Medical Services Director, Department of Human Services, provided information on 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.

Ms. Anderson said the department is completing its waiver application for providing in-home services to children with extraordinary medical needs and anticipates the draft of the application to be available for public comment later this fall. She said the waiver application will be submitted with a July 1, 2007, effective date and will be contingent upon legislative appropriations to operate the waiver.

Ms. Anderson said Montana does not have a waiver for providing in-home services to children with special health care needs, South Dakota has a family support waiver that provides in-home services for children with mental retardation, and Minnesota has a community alternatives waiver for disabled individuals that provides in-home services for disabled individuals under the age of 65.

Ms. Anderson provided information on the various options under federal law for states to provide Medicaid services to children with special health care needs as follows:

	Waiver	Medicaid Buy-In	Katie Beckett Eligibility Option
Description	A home and community-based waiver is designed to reduce extended hospitalizations and prevent skilled nursing facility placements for children who are medically fragile by providing assistance for families who require long-term support and services to maintain their child at home while meeting the child's medical needs.	The Family Opportunity Act, authorized by Congress in 2006 as part of the Deficit Reduction Act, allows states to create Medicaid buy-in programs for children who meet the Social Security standard for disability, but whose family income is above standard Medicaid eligibility limits. States need legislative approval and Centers for Medicare and Medicaid Services approval.	The Katie Beckett eligibility option is an optional eligibility category that allows children with long-term disabilities or complex medical needs, living at home, to access Medicaid services.
Covered population	Medically fragile children aged 2 to 18. Medically fragile children are at times medically stable but still may require skilled nursing care, specialized therapy, and specialized medical equipment and supplies to enhance or sustain their lives.	Disabled children aged 18 and under whose family income does not exceed 300 percent of poverty (could be lower at state option). In 2006 for a family of four, this amount would be $6,668 per month (**net income**). Assets are not considered. Eligibility will be phased in starting in October 2007 for children aged 6 and under, in October 2008 for children aged 7 to 13, and October 2009 for children aged 12 to 18.	Children aged 18 and under who do not have income or assets in their name in excess of the current standards for a child living in an institution. Without the Katie Beckett eligibility option, the income of legally liable relatives is counted when the individual is cared for at home.
Medical conditions of group	Children must meet institutional (hospital or nursing facility) level-of-care criteria in order to qualify for waiver services. If not for the waiver, the child would require services in a hospital or nursing facility. Initial enrollment will be based on the greatest need.	Children must be determined to be disabled under Social Security Act guidelines.	Children must be determined to be disabled under Social Security Act guidelines and require a level of care at home that is typically provided in an institution.
Number of children covered	Limited to 15	Estimated 778 (includes about 31 that would switch from medically needy)	Not available
Estimated cost per year	The estimated cost per year would be $44,769 per child ($671,535 total for 15 children). This includes both the Medicaid state plan and waiver services.	$2,066,245 per biennium. This includes an offset of premiums estimated to be $800,000.	Not available
Services offered	All Medicaid services Proposed waiver services include: • In-home support • Respite care • Excess medical-related expenses not covered by the state plan • Case management (Medicaid waivers are required to be cost-neutral. The overall cost of the waiver services may not exceed the cost of institutionalization.)	All Medicaid services	The cost to Medicaid cannot exceed the cost Medicaid would pay if the child were in an institution.
Cost to family	The family will not incur a Medicaid recipient liability because family income and assets will not be an eligibility consideration.	Premium equal to 5 percent of the family's gross income. The law requires participating families to first take advantage of available employer-sponsored health insurance options. These premiums would be offset by the family's private insurance premiums. Recipient liability would not apply.	Premiums and/or recipient liability would not apply.
Program caps/limits	Waivers allow a cap on enrollment. States may also determine the individual cost limit at less than institutional costs or have no individual cost limit. The Department of Human Services is proposing a waiver that caps the number of individuals enrolled and the amount of waiver services each individual may obtain per year.	All who meet program requirements would be allowed to buy in. Limits within the Medicaid program would apply.	All who meet eligibility requirements would access Medicaid. Limits within the Medicaid program would apply.

In response to a question from Representative Meyer, Ms. Anderson said although the department will limit the number of children accepted for waiver services to 15, the department anticipates as many as 100 may meet the waiver guidelines. She said the department will develop criteria to evaluate which children are accepted for waiver program services.

Mr. Bruce Murry, Protection and Advocacy Project staff attorney, commented on services to children with special health care needs. Mr. Murry said he believes the draft application for the waiver project being prepared by the Department of Human Services is in accordance with the provisions of Senate Bill No. 2395. He expressed support for the department's efforts in preparing the waiver application.

Mr. Murry said although a number of medically fragile children are served in intermediate care facilities for people with mental retardation, the waiver being developed will focus on children who are currently not receiving services in these types of facilities but would qualify for either nursing facility or hospital levels of care. A copy of the testimony is on file in the Legislative Council office.

The joint meeting with the Budget Committee on Health Care concluded. The committee recessed at 3:40 p.m. and reconvened at 9:00 a.m. on Wednesday, September 13, 2006.

Ms. Roxane Romanick, Family Voices of North Dakota, Bismarck, presented testimony on behalf of Ms. Donene Feist, Family Voices of North Dakota. Ms. Romanick said while the committee has reviewed the Department of Human Services children's special health services program, additional information should be reviewed relating to the programs and services provided to children under developmental disabilities, medical services, and other programs. She said a variety of services are available to these children delivered by various agencies with different missions, different eligibility requirements, and varying budgets. She said additional study is needed to consider the entire system of services for these children.

Ms. Romanick said Family Voices of North Dakota has conducted a survey of families raising children with special health care needs about the services they receive, their perceptions regarding the quality, gaps in services, and unmet needs. She said that while the waiver request being developed by the Department of Human Services will benefit a limited number of families, many others will not be included. She suggested the state develop a Medicaid buy-in program to assist more of these families to access Medicaid services for their children.

Ms. Romanick said creative development of waivers and other programs allowing families to receive assistance for caring for their children with special health care needs is needed in order for these families to survive and not result in bankruptcy, divorce, or leaving the state. Ms. Romanick provided the following suggestions and recommendations based on the survey responses:

1. Coordination of care and communication among providers are essential and must be improved to ensure quality of care for children with special needs and to reduce health care costs.
2. Families with children with special health care needs require access to more information and assistance in order to ensure a health system that works for their child and family.
3. Additional opportunities should be made available for family involvement at the state policy level.

Copies of the testimony and survey responses are on file in the Legislative Council office.

Ms. Jennifer Restemayer, parent of a child with special health care needs, commented on the study. Ms. Restemayer said her child qualified for early intervention services until she was three years old. Since that time, she said, the family no longer qualifies for assistance to pay for her treatment costs and the Medicaid recipient liability is too much for the family to afford. She suggested the committee consider identifying children that are not accessing the state's current system of services and to identify services that are lacking to assist families with children with special health care needs. A copy of the testimony is on file in the Legislative Council office.

In response to a question from Senator Lee, Ms. Anderson said the Department of Human Services will attempt to identify and review a Minnesota Medicaid waiver that is providing services for children with exceptional medical needs and provide the information to the committee.

MEDICAID STUDY AND REPORTS

Ms. Anderson presented the biennial medical assistance report as required by House Bill No. 1460. Ms. Anderson said the department contracted with Milliman, Inc., for actuarial services for completing the report at a cost of $100,000, $50,000 of which is from the general fund and $50,000 of federal Medicaid administrative funding.

Ms. Anderson said the report includes information on medical-related costs of the Medicaid program but does not include information on long-term care or developmental disabilities services. Ms. Anderson said the report includes schedules comparing North Dakota medical assistance funding to South Dakota, Minnesota, and Montana and information on the unduplicated number of recipients and eligibility categories.

Ms. Anderson presented the following schedule comparing selected North Dakota payment rates to South Dakota, Minnesota, and Montana:

Service Category	Ratio of South Dakota to North Dakota Department of Human Services	Ratio of Minnesota to North Dakota Department of Human Services	Ratio of Montana to North Dakota Department of Human Services
Dental*	NA	103.5%	110.4%
Laboratory	96.6%	95.2%	100.6%
Mental health	53.2%	127.0%	98.0%
Outpatient hospital	97.8%	110.0%	99.9%
Physical therapy	77.0%	153.6%	146.8%
Physician	85.3%	81.8%	103.4%
Radiology	100.1%	141.8%	99.9%
Speech therapy	82.1%	144.3%	141.7%

*Minnesota figures are relative to 2005 fee-for-service experience. Dental services in South Dakota are provided through a capitated, managed care program.

Ms. Anderson presented the following schedule comparing North Dakota payment rates to payment rates of Medicare, Workforce Safety and Insurance, and Blue Cross Blue Shield of North Dakota:

Service Category	Ratio of Medicare to North Dakota Department of Human Services	Ratio of North Dakota Workforce Safety and Insurance to North Dakota Department of Human Services	Ratio of Blue Cross Blue Shield (BCBS) of North Dakota to North Dakota Department of Human Services
Dental*	N/A	167.2%	222.9%
Inpatient hospital	107.0%	130.6%	134.7%
Laboratory	100.0%	203.8%	169.8%
Mental health**	106.4%	124.0%	N/A
Outpatient hospital	113.9%	252.4%	236.4%
Patient therapy**	135.0%	175.8%	N/A
Physician	113.5%	156.3%	168.8%
Radiology	110.6%	185.3%	180.6%
Speech therapy**	105.6%	162.1%	N/A

*Medicare does not cover dental services.

**Mental health care, physical therapy, and speech therapy (BCBS) - Fee schedule not provided by BCBS.

Ms. Anderson presented the actuary's baseline forecast for Medicaid expenditures through fiscal year 2011. She said current projected expenditures for the 2005-07 biennium are $378 million and projections for the 2007-09 biennium total $417.7 million, an increase of 10 percent. She said factoring in a 1 percent inflationary rate, 2007-09 projected expenditures would total $422 million. The following schedule presents Milliman's baseline forecast for the North Dakota Medicaid program:

State Fiscal Year	Expenditures	Percentage of Growth
2005	$184,923,700	
2006	$193,360,600	4.6%
2007	$184,238,300	(4.7%)
2008	$198,860,300	7.9%
2009	$218,831,300	10.0%
2010	$230,488,200	5.3%
2011	$247,337,100	7.3%

NOTES: The lower growth rates in state fiscal years 2006 and 2007 correspond to implementation of Medicare Part D pharmacy benefits effective January 1, 2006.

The increased growth rate for paid state fiscal year 2009 corresponds to a 53-week payment pattern (i.e., 53 Tuesdays) for the fiscal year.

In response to questions from Representative Price and Senator Brown, Ms. Anderson said the department will discuss with Milliman, Inc., the reasons why the number of aged individuals eligible for Medicare identified in the report is not increasing at a greater rate since North Dakota's average age is increasing.

Ms. Anderson presented information on the estimated cost for the North Dakota Medicaid program if it would pay based on the Medicare fee schedule rather than the Medicaid fee schedule. Ms. Anderson said for the 2007-09 biennium, Milliman, Inc., projects that North Dakota Medicaid expenditures would total $438.3 million if it paid claims based on the Medicare fee schedule compared to the North Dakota Medicaid baseline forecast for the same period of $417.7 million. She said the estimated additional cost if North Dakota Medicaid payments were based on the Medicare fee schedule would total $20.6 million for the 2007-09 biennium, of which $7.5 million would be from the general fund.

Representative Delzer asked for the cost of providing a 1 percent provider rate increase for each year of the 2007-09 biennium for all providers within the department's budget. Ms. Anderson said the department will calculate that information and provide it to the committee members.

In response to a question from Representative Price, Ms. Anderson said the department has not had any discussions regarding the possibility of including funding in its 2007-09 budget request to continue purchasing actuarial services to update the biennial medical assistance report during the next biennium.

In response to a question from Representative Delzer, Ms. Anderson said the department does not anticipate using the Milliman, Inc., projections as it prepares its 2007-09 biennium budget request. It plans to use the same methodology it has used for previous budget requests.

A copy of the biennial medical assistance report is on file in the Legislative Council office.

Ms. Anderson reported on the status of the prescription drug monitoring workgroup and implementation of a prescription drug monitoring

program. Ms. Anderson said the department has received a $372,315 grant from the federal Department of Justice for the implementation of a prescription drug monitoring program. The department and the State Board of Pharmacy are releasing a request for proposal to secure a vendor to develop and operate the necessary computer and data services for the program. She said the program will be administered by the State Board of Pharmacy.

Ms. Anderson provided an update on the status of the Medicaid management information system (MMIS) replacement project. She said the department has begun Phase 1 of the project and has established a stakeholder committee to gather input regarding the development of the new system and to provide communications regarding the design and operations of the new system. A copy of the report is on file in the Legislative Council office.

Ms. Nancy McKenzie, Statewide Human Service Center Director, Department of Human Services, provided information on the impact of addiction counselor vacancies at the human service centers. Ms. McKenzie said a number of human service centers are experiencing sustained vacancies in licensed addiction counselor positions. In order to meet critical client needs and maintain a basic level of service, she said, the department is:

1. Hiring part-time temporary addiction counselors, where available.
2. Supporting existing mental health clinicians to complete required coursework and internships to meet addiction licensure requirements.
3. Underfilling vacant positions with trainees who commit to employment in the center after receiving licensure.
4. Discussing the critical shortage impact with the Board of Addiction Counseling Examiners and others to encourage growth in the profession.

Ms. McKenzie said the Board of Addiction Counseling Examiners is planning to request statutory changes during the 2007 Legislative Assembly to allow more flexibility in administrative rules regarding the licensing of addiction counselors.

Ms. McKenzie said the department continues to recruit additional counselors at six of the eight human service centers. She said at the North Central Human Service Center and South Central Human Service Center, approximately 50 percent of the licensed addiction counselor positions are vacant. As a result, she said, some programs have had to be modified. She said service changes include:

1. A reduction in some levels of care.
2. Utilization of peer support and case aide services to assist clients who are waiting for services.
3. Utilization of call lists to inform clients on short notice if an appointment time opens.

Ms. McKenzie said the department continues to provide emergency services for priority populations; however, the position vacancies are resulting in delays for regular services.

Ms. McKenzie said client travel is also impacted as a result of these centers reducing some of their outreach services. She said some clients must travel further than in the past for services. A copy of the report is on file in the Legislative Council office.

Mr. Howard C. Anderson, Executive Director, State Board of Pharmacy, Bismarck, commented on the Medicaid study and reports. Mr. Anderson said the point-of-sale system for purchasing prescription drugs for Medicaid clients is working well for pharmacies and clients. He said the prescription drug monitoring program is being developed and the working group plans to ask the Governor to approve emergency rules to expedite the development and implementation of the program.

Representative Devlin expressed concern that the prescription drug monitoring workgroup is asking the Governor to approve emergency rules for the program, thereby bypassing the administrative rules process that involves the Administrative Rules Committee.

Representative Devlin asked for information on the number of pharmacies that opened during the past year. Mr. Anderson said he would provide that information to the committee.

Representative Devlin asked for information on the implementation of the Georgia Medicaid management information system and the process Georgia used to convert to a fiscal agent system. In addition, he asked for information on other states that have recently made changes to their Medicaid management information systems. Chairman Dever asked the Legislative Council staff to provide this information to the committee members and other interested persons.

It was moved by Representative Porter, seconded by Representative Price, and carried that the committee recommends that the 2007 Legislative Assembly consider the value of the biennial medical assistance report and the importance of continuing funding for the report for the actuarial analysis and other information that may be useful for the Legislative Assembly and specifically the Appropriations Committees in the development of the Department of Human Services appropriation. Senators Dever, Brown, Krauter, and Lee and Representatives Delzer, Devlin, Kaldor, Kreidt, Metcalf, Pietsch, Pollert, Porter, Price, Sandvig, Uglem, and Wieland voted "aye." No negative votes were cast.

FOSTER CARE FACILITY PAYMENT STUDY

Mr. Don Snyder, Foster Care Program Administrator, Department of Human Services, provided information on the number of children in foster care and on the status of changes in payment procedures for foster care facilities.

Mr. Snyder presented the following schedule showing the number of children in foster care by placement type since federal fiscal year (FFY) 2000:

Placement Type	FFY 2000	FFY 2001	FFY 2002	FFY 2003	FFY 2004	FFY 2005
Preadoptive home	154	166	157	160	207	228
Relative placement	237	240	276	328	383	507
Family foster care	875	835	824	932	912	896
Group home	125	109	127	125	120	96
Facility (RTC and RCCF)	577	540	619	604	555	552
Total	1,968	1,890	2,003	2,149	2,177	2,279
Children aging out of foster care	43	45	56	66	60	65

Mr. Snyder said currently 72 children are placed in out-of-state facilities. Of these, he said, 58 are in residential care and 14 are in family foster homes or relative care.

In response to a question from Representative Porter, Mr. Snyder said of the 58 children placed in residential care out of state, 39 are in these facilities for treatment services, 9 because of a lack of bed space in an in-state facility, and 10 due to the close proximity to family members.

Since July 1, 2006, Mr. Snyder said residential child care facilities and therapeutic foster care homes began billing Medicaid under the new federally required methodology for dates and services. He said the department will be monitoring payments each quarter to ensure that providers do not receive less than $15 per child per day for rehabilitation costs. A copy of the report is on file in the Legislative Council office.

The committee recessed for lunch at 11:20 a.m. and reconvened at 12:30 p.m.

HEALTHY NORTH DAKOTA STUDY

Ms. Melissa Olson, Healthy North Dakota Director, State Department of Health, provided information on the status of the Healthy North Dakota program and on the development of a worksite wellness program.

Ms. Olson said Healthy North Dakota has completed its strategic assessment process and identified the following recommendations:

1. Designate focus areas for Healthy North Dakota and prioritize Healthy North Dakota resources accordingly.
2. Develop written rule and function descriptions for coordinating, advisory, and executive committees.
3. Develop legislative priorities for the 2007-09 biennium.
4. Determine the appropriate legal identity for Healthy North Dakota.

Regarding funding for Healthy North Dakota, Ms. Olson said the State Department of Health has requested funding for the 2007-09 biennium from the community health trust fund to provide a more consistent funding source for the program.

Ms. Olson reported on the status of the focus areas of Healthy North Dakota, including:

1. Healthy weight - Healthy North Dakota is involving more than 500 state, local, and county government employees to take part in the "five-a-day challenge" program designed to increase the amount of fruits and vegetables eaten daily. In addition, she said, 17 community coalitions promote healthy eating and physical activity with the potential to reach more than 70 percent of the state's population.
2. Health disparities - The Health Disparities Committee has received a grant to establish an office of special populations within the State Department of Health. She said the Tribal/State Health Task Force was formed at the request of the Indian Affairs Commission to identify the common health needs of North Dakota's American Indian population. Key issues identified include:
   a. Little public health infrastructure exists on the reservations.
   b. State/tribal communications are problematic.
   c. Access to health care is poor.
3. Tobacco use - The tobacco quitline began in September 2004 and is demonstrating high rates of success in assisting people to quit smoking. She said the 6-month quitrate is 36 percent and the 12-month quitrate is 27 percent.
4. Cancer - The cancer coalition is developing a cancer control plan for the state. She said the plan provides a starting point to improve cancer care.
5. Early childhood - The Early Childhood Alliance recently completed its early childhood comprehensive systems state plan. She said the key areas of the plan include access to health insurance and medical home, mental health and social/emotional development, early care and education/child care, parent education, and family support.
6. Oral health - The oral health coalition has completed its state plan. She said the plan is important for establishing the vision to improve the oral health and well-being of North Dakota citizens. She said an oral health conference is scheduled for September.
7. Injury - Healthy North Dakota assisted in the formation of the North Dakota injury prevention coalition. The coalition works to address prevention or intervention of intentional injuries, such as domestic violence, sexual assault, and suicide, and unintentional injuries, such as motor vehicle accidents and playground injuries.
8. Environmental quality - Environmental health partners provided expertise needed to

develop objectives in the prevention section of North Dakota's cancer control plan and further collaboration opportunities have been identified.

Regarding worksite wellness programs, Ms. Olson said the goal of a worksite wellness program is to create an environment that meets the health improvement needs of both the employee and the employer. She said a 2001 study by Winkleman Consulting indicated that more than 80 percent of North Dakota businesses believe that healthier employees have lower insurance costs, better morale, fewer sick days, and better productivity. At the time, fewer than 10 percent of the businesses had conducted a worksite needs assessment or prepared a worksite wellness plan. She said a similar survey has been conducted this year and preliminary results will be available in October.

Ms. Olson said the Healthy North Dakota Worksite Wellness Committee has developed a state-level framework to provide technical assistance and resources to businesses interested in implementing worksite wellness programs.

Ms. Olson said Healthy North Dakota has provided two worksite training programs to expand the pool of trained consultants who have expertise to assist businesses in development of worksite wellness programs. She said Healthy North Dakota has recently contracted with North Dakota State University to evaluate current worksite wellness programs that are being piloted in the state. Pilot programs being evaluated include three programs funded by the Dakota Medical Foundation as well as programs implemented by schools in the Hettinger area, North Dakota Farmers Union, North Dakota Public Employees Retirement System, and North Dakota Vision Services - School for the Blind. A copy of the report is on file in the Legislative Council office.

In response to a question from Representative Devlin, Ms. Olson said the State Department of Health is requesting between $200,000 and $300,000 for the 2007-09 biennium from the community health trust fund for the Healthy North Dakota program. She said this request is not expected to affect other programs receiving funding from the fund.

PUBLIC HEALTH STUDY

Ms. Kelly Nagel, Local Public Health Liaison, State Department of Health, said the task force reviewing public health services has conducted a survey reviewing the options and possibilities of further developing joint powers agreements and other methods of sharing services between public health units in the state.

Dr. Chandice Covington, Dean, College of Nursing, University of North Dakota, commented on the nursing program at the University of North Dakota.

Dr. Covington discussed health issues affecting North Dakota. Dr. Covington said North Dakota has the highest proportion of population 85 years of age and older in the nation. She said the leading causes of death in North Dakota include heart disease, stroke, and cancers.

Dr. Covington said there are currently 3,400 licensed practical nurses, 8,500 registered nurses, and 600 advanced practice nurses in North Dakota. She said of the 8,500 registered nurses in North Dakota, 14 percent are University of North Dakota graduates.

Dr. Covington discussed the increasing number of nurses that will be retiring in the upcoming years. She said it is important to encourage young people to enter nursing and to be able to retain those nursing graduates in North Dakota. She said many nursing graduates begin their nursing career in North Dakota but after gaining experience move to other states primarily due to the higher salaries available in other states.

Dr. Covington discussed future plans for the University of North Dakota College of Nursing to recruit more individuals into the nursing profession and to enhance their educational experience at the University of North Dakota. A copy of the report is on file in the Legislative Council office.

In response to a question from Representative Metcalf, Dr. Covington said because of the increasing number of nurses who will be retiring in upcoming years, the state needs to increase the number of nurses being educated each year by 10 to 15 percent.

It was moved by Representative Devlin, seconded by Senator Lee, and carried that the chairman and the staff of the Legislative Council be requested to prepare the report of the committee and to present the report to the Legislative Council.

It was moved by Senator Krauter, seconded by Senator Brown, and carried that the meeting be adjourned sine die.

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Allen H. Knudson
Assistant Legislative Budget Analyst and Auditor

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Jim W. Smith
Legislative Budget Analyst and Auditor

ATTACH:1