NORTH DAKOTA LEGISLATIVE COUNCIL

Minutes of the

BUDGET COMMITTEE ON HUMAN SERVICES

Tuesday, October 4, 2005
Roughrider Room, State Capitol
Bismarck, North Dakota

Senator Dick Dever, Chairman, called the meeting to order at 9:00 a.m.

Members present: Senators Dick Dever, Tom Fischer, Aaron Krauter, Judy Lee, John M. Warner; Representatives Jeff Delzer, James Kerzman, Gary Kreidt, Ralph Metcalf, Vonnie Pietsch, Chet Pollert, Todd Porter, Louise Potter, Sally M. Sandvig, Gerald Uglem, Alon C. Wieland

Members absent: Senators Richard L. Brown, Russell T. Thane; Representatives William R. Devlin, Lee Kaldor, Jon O. Nelson, Clara Sue Price, Ken Svedjan

Others present: David O'Connell, State Senator, Lansford

See Appendix A for additional persons present.

The Legislative Council staff presented a memorandum entitled *North Dakota's Federal Medical Assistance Percentage - 2007*. The Legislative Council staff said the actual federal medical assistance percentage (FMAP) for North Dakota for federal fiscal year 2007 has been released and will be 64.72 percent, a decrease of 1.13 percent from the 2006 FMAP of 65.85 percent but an increase of 2.35 percent from the 62.37 percent estimate used by the 2005 Legislative Assembly in developing the Department of Human Services 2005-07 biennium budget. The Legislative Council staff said the 2007 FMAP will affect the final 10 months of the 2005-07 biennium appropriation. Each percentage change in the FMAP affects the state general fund matching requirements by approximately $4.5 million. Based on these estimates, the Department of Human Services will have $8.8 million of reduced general fund matching requirements for state fiscal year 2007 as a result of the FMAP change.

PUBLIC HEALTH UNIT STUDY

Ms. Kelly Nagel, local public health liaison, State Department of Health, provided information from national organizations on core functions and essential services of public health units. Ms. Nagel said North Dakota public health units vary in their structure, governance, and funding. She said because state laws are not specific regarding public health units powers and duties, the public health functions of public health units also vary.

Ms. Nagel said the American Public Health Association Committee on Administrative Practice has adopted core functions and essential services to guide public health decisionmaking and operations. She said the core functions include:

1. Assessment - Includes activities to evaluate the current level of health and current threats to health in the community.
2. Policy development - Follows the assessment phase and includes developing policies to address the identified health threats and problems.
3. Assurance - Involves the implementation of policies to improve public health.

Ms. Nagel said a 2002 national survey of local public health units assessed the three core functions of public health. She said the survey results indicated that local public health units serving fewer than 25,000 people do not have the capability to conduct the core functions. She said in North Dakota, 20 of the state's 28 local public health units serve fewer than 25,000 people each.

Ms. Nagel said each of the core functions as identified by the American Public Health Association includes essential services that provide the framework for measuring and improving public health practice. She said the following 10 essential public health services are those that the public should be receiving from the public health system, regardless of where they live. Essential services include:

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.

9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Ms. Nagel said because these essential services are very comprehensive, it would be difficult for a single health unit to provide all 10. She suggested North Dakota's goal should be to provide all 10 essential services through a statewide system. She said the state should determine which programs and activities should be provided at a minimum to all North Dakota citizens, link those programs and activities to essential services, and identify which entities should provide them. She said providing this minimum level of programs and activities may require partnerships among health units and state entities, including the State Department of Health and University System, or may involve regionalization of services.

Ms. Nagel said the State Department of Health is coordinating a statewide assessment of the National Public Health Performance Standards which will be used to determine the components, activities, and competencies of the state's public health system. She said the assessment consists of local, tribal, and state assessments and strategic planning. She said some local health units are unable to complete the process because of limited capacity. She said this project will identify critical needs and gaps in services and resources. She offered to provide additional information on the assessment process at a future committee meeting.

Ms. Nagel said North Dakota Century Code Section 23-35-02 authorizes the State Health Council to issue rules defining the core functions of public health units. She said the State Health Council will also be reviewing this issue.

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

Ms. Mary Kay Herrmann, Director, Fargo Cass Public Health, provided information regarding Fargo's public health ordinances. Beginning in 2003, Ms. Herrmann said the Board of Health in Fargo began a process of developing an ordinance describing the Fargo Cass Public Health's function and role within the city. She said the board used a document from the Turning Point National Program which was a project funded by the Robert Wood Johnson Foundation to review local and state public health infrastructure. She said the Turning Point project resulted in the Model State Public Health Act, which is a tool for assessing public health laws in state and local governments.

Ms. Herrmann provided a copy of the Turning Point document, which is on file in the Legislative Council office.

Ms. Herrmann reviewed the approved ordinances, which provide for the purpose, authority, duties, and essential services of the public health department in Fargo. Ms. Herrmann said the essential public health services and functions include:

1. Monitor health status to identify and solve community health problems.
2. Investigate and diagnose health problems and health hazards in the community.
3. Inform, educate, and empower individuals about health issues.
4. Mobilize public and private sector collaboration and action to identify and solve health problems.
5. Develop policies, plans, and programs that support individuals and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link individuals to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

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

Mr. Kenan Bullinger, Director, Division of Food and Lodging, State Department of Health, provided information regarding food and lodging investigation services provided by the State Department of Health and food and lodging investigation services provided by public health units. Mr. Bullinger said the mission of the Division of Food and Lodging is to ensure safe and sanitary food and lodging establishments in North Dakota through education and inspection of licensed facilities. He said the division collaborates, networks, and trains with local health units, the industry, and other state and federal agencies.

Mr. Bullinger said the State Department of Health is the primary agency responsible for enforcement of North Dakota's food protection laws which are found in Titles 19 and 23 of the Century Code. He said the division is responsible for protecting public health through the licensing and inspection of restaurants, hotels, motels, bars, mobile home parks, trailer parks, campgrounds, bed and breakfast facilities, retail food stores, meat markets, bakeries, food manufacturers, and assisted living facilities. He said the facilities are licensed annually on a calendar basis. He said the division also inspects child care facilities, schools, jails, and other correctional facilities that prepare food. Generally, he said, one inspection per food facility is conducted each year to ensure that the facility meets both sanitation and certain fire and life safety standards before opening to the public and while in operation. He said nonfood facilities, such as lodging and mobile home parks, are generally inspected about once every two years.

Mr. Bullinger said the division has six staff members--four inspectors located in Dickinson, Jamestown, Fargo, and Grand Forks and two administrative positions in Bismarck.

Mr. Bullinger said state law authorizes the State Department of Health to accept local public health unit inspections through the formation of memorandums of understanding. He said the department has seven memorandums of understanding--three with city/county health units and four with multicounty health units. He said these memorandums allow the health units to provide some of the inspection and licensing functions within their areas of jurisdiction. He said the local health units establish their own license fees to provide funding for their operations. He said the local health units must follow state laws and regulations or have adopted local ordinances that are at least as stringent as state laws and regulations. Mr. Bullinger provided the following listing of the memorandums of understanding:

1. Fargo Cass Public Health - Responsible for all retail food, food service, and lodging facilities in Fargo and West Fargo.
2. Grand Forks Public Health - Responsible for all retail food and food service facilities within the city of Grand Forks.
3. Bismarck Fire and Inspections - Responsible for all retail food, food service, and lodging with food service within the city of Bismarck.
4. First District Health Unit, Minot - Responsible for all food and lodging facilities within its seven-county health unit, including Bottineau, Burke, McHenry, McLean, Renville, Sheridan, and Ward Counties.
5. Custer District Health Unit, Mandan - Responsible for all retail food and food service facilities within its five-county health unit, including Grant, Mercer, Oliver, Sioux, and Morton Counties.
6. Southwest District Health Unit, Dickinson - Responsible for food service facilities within its eight-county health unit, including Stark, Adams, Billings, Slope, Golden Valley, Bowman, Dunn, and Hettinger Counties.
7. Upper Missouri District Health Unit - Responsible for food service facilities within the city of Williston.

Mr. Bullinger said the memorandum with the First District Health Unit provides the unit authority over all food and lodging facilities which results in the State Department of Health not having any jurisdiction or inspection activity within that health unit. He said the State Department of Health has some inspection activity within the other health units mainly in the areas of lodging, mobile home parks, trailer parks, and campgrounds.

Mr. Bullinger said the 2005 Legislative Assembly changed food and lodging fees of the State Department of Health from being set by the Legislative Assembly in statute to being set by the State Department of Health in administrative rules. He said the department is in the process of setting these fees as a result of the changes made by the 2005 Legislative Assembly.

Mr. Bullinger presented the following schedule comparing the license fees for food and lodging facilities across the state.

North Dakota Food and Lodging License Fees

Department or Health Unit	Restaurant	Limited Restaurant	Mobile Food	Retail Food	Bakery
State Department of Health					
Current fees (in statute)	$60, $80, $85	$50	$40	$50, $60	$50, $60
Proposed fees	$75 flat fee $.50/seat, $150 maximum	$75	$75	$75, $85, $95	$75, $85, $95
Fargo Cass	$150 base $1.50/seat, $250 maximum	$100	$125	$75	$75
Grand Forks	$135 base $.30-$1.30/seat		$55	$60, $115, $130	$90, $180, $215
Bismarck	$175	$175	$50	$100, $150	$100
First District	$85, $105, $110	$75	$25, $50, $75 (number of days)	$75, $100	$75, $100
Southwest District	$55, $65	$55	$45		$45
Upper Missouri	$60, $80, $85				
Custer Health	$70, $80, $90	$60		$70, $80	$50, $60

Department or Health Unit	Food Processors	Lodging	Mobile Home Parks	Bed and Breakfast	Schools
State Department of Health					
Current fees (in statute)	$25	$20-$80	$50-$120	$15	N/A
Proposed fees	$35	$35-$150	$75-$160	$25	$90
Fargo Cass		$100-$400			$60, $85

Department or Health Unit	Food Processors	Lodging	Mobile Home Parks	Bed and Breakfast	Schools
Grand Forks	$105, $195, $230	$75, $145	$115 + $2.15/lot	$75	$70, $140
Bismarck	$50, $75				$75
First District*	$50	$20-$80	$50-$120	$30	$0
Custer Health					$0
Southwest District					$0
Upper Missouri					$0**

*First District does not currently charge a license fee for schools but will be approaching its board to do so in the near future.

**Upper Missouri currently does not charge for school inspections but if reinspections are needed after a couple of visits because of continued problems, a flat $25 fee is charged for those inspections.

Mr. Bullinger said state law mandates an inspection of food and lodging facilities at least once every two years. He said current staffing levels within the department allow the department to meet this mandate. He said federal guidelines recommend inspection frequency for higher-risk food establishments at a minimum of two to three inspections per year. He said high-risk food establishments are those that cook some of their menu items from scratch or prepare large batches of food that are cooled and reheated later for service to the public. He said local health units generally have staff and resources to conduct at least one to two inspections of high-risk food establishments per year.

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

Representative Delzer asked for the funding that will be generated from the proposed food and lodging license fee increases. Mr. Bullinger said the previous statutory fees generated approximately $350,000 per biennium. He said based on the proposed fees, the department estimates generating between $575,000 and $600,000 per biennium.

In response to a question from Senator Lee, Mr. Bullinger said the Division of Health Facilities of the State Department of Health inspects nursing homes and group homes.

Ms. Paula Flanders, Director, Bismarck Burleigh Public Health, provided information regarding its services and funding. Ms. Flanders reviewed the following 10 essential services of Bismarck Burleigh Public Health and related examples of activities:

1. Monitoring health - Community needs assessments.
2. Diagnosing and investigating - Disease outbreaks.
3. Informing, educating, empowering - Health and safety.
4. Mobilizing community partners - Schools and private entities.
5. Developing policies - Security, immunizations, and quarantine.
6. Enforcing laws - Tobacco compliance.
7. Linking to and providing care - Nurse of the day, home health, immunizations, school nursing, nutrition, tobacco programs, and pedicures.
8. Assuring a competent workforce - Emergency preparedness training.
9. Evaluating - Quality assurance and satisfaction surveys.
10. Research - Joint projects with higher education.

Ms. Flanders presented the following information relating to the revenue sources of Bismarck Burleigh Public Health for 2004:

Revenue Source	2004 Funding
City of Bismarck	$348,787
State of North Dakota	76,290
Federal funds	579,521
Other (Medicaid, contract services, patient fees, and miscellaneous)	315,298
Total	$1,319,896

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

In response to a question from Senator O'Connell, Ms. Flanders said in Bismarck Burleigh Public Health tobacco prevention efforts are now focusing on strengthening the "no smoking" bill passed by the 2005 Legislative Assembly and reducing smoking among college-age individuals and in the workplace.

Senator Dever asked whether Bismarck Burleigh Public Health coordinates its programs with the Custer District Health Unit and the Extension Service. Ms. Flanders said many joint projects are conducted with the Custer District Health Unit, and a few joint projects are also conducted with the Extension Service.

Mr. Keith Johnson, Administrator, Custer District Health Unit, provided information on the services and funding of the Custer District Health Unit.

Mr. Johnson said the Custer District Health Unit includes the counties of Grant, Mercer, Morton, Oliver, and Sioux. He said the district's 2005 budget totals $1.9 million and consists of the following revenue sources:

Funding Source	2005 Budget	Percentage of Total
County funding	$370,000	20%
State funding	250,000	13%
Federal funding	891,000	48%
Services	347,000	19%
Total	$1,858,000	100%

Mr. Johnson said the counties and the district are currently levying 4.4 mills. By statute, he said, the mill levy may not exceed 5 mills.

Mr. Johnson reviewed the following major programs of the Custer District Health Unit and provided examples of activities occurring under each program:

- Public health nursing - Home health, immunizations, school nursing, and Health Tracks screening.
- Women, infants, and children programs - Nutrition education and healthy food for mothers and children.
- Family planning - Reproductive health services and contraceptive services.
- Health education - Tobacco cessation, dental health, and workplace wellness.
- Environmental health - Onsite water and sewer licensing, food and beverage licensing and inspection, and nuisances.

Mr. Johnson said the public health units have a good working relationship with the State Department of Health, especially in the nursing program. In the area of environmental health, he said, more direction from the state would be helpful, especially in the areas of regulations relating to body art, swimming pools, and onsite sewer systems. He said local laws vary widely across the state in these areas and it may be beneficial for the state to provide direction for more consistency across the state.

Mr. Johnson said because the State Department of Health general fund support has not been adequate, the department has been forced to pursue more federal funding which does not always match the needs of the state or local government.

Mr. Johnson suggested a more uniform set of services be established for all local public health units. He said currently the level of services varies widely by unit across the state. He said the cities have a very comprehensive set of services while smaller single-county health units have minimal services available.

Senator Lee asked whether the current state statute authorizing joint powers agreements between political subdivisions is adequate to allow health units to jointly provide services. The Legislative Council staff said it would provide information to the committee regarding the authority granted by the joint powers agreement statute.

HEALTHY NORTH DAKOTA STUDY

Ms. Melissa Olson, Director, Healthy North Dakota Program Director, State Department of Health, presented information on the current status of activities relating to the Healthy North Dakota Initiative. Ms. Olson said Healthy North Dakota is currently conducting a strategic assessment process that will determine the long-term operational structure of the initiative. She said the process is being conducted by Novus of Fargo and supported by the Dakota Medical Foundation. She said preliminary results will be available in January 2006.

Ms. Olson said Healthy North Dakota produces and distributes factsheets providing information on health issues. She distributed the most recent copy to the committee.

Ms. Olson provided information on results of the Healthy North Dakota Initiative in its focus areas, including:

1. Healthy weight - Nutrition - Coordinated the development and implementation of a worksite wellness nutrition education and incentive program with the Public Employees Retirement System. In addition, the Healthy Weight Council has developed a position paper on weighing and measuring children in schools.
2. Health disparities - At the request of the Indian Affairs Commission, established a state/tribal task force to examine health issues affecting North Dakota's Tribal Nations and the Trenton Indian service area.
3. Worksite wellness - Coordinated worksite wellness training for 38 North Dakotans and provides ongoing technical assistance to these worksite wellness specialists.
4. Tobacco use - Supported passage of the smoke-free law that provides protection from secondhand smoke in North Dakota.
5. Community engagement - Identified the need to train facilitators to assist with community-directed health change. A proposal was submitted to Dakota Medical Foundation which provided funding at 50 percent of the requested level. Additional funding is being sought.
6. Cancer - Supported legislation authorizing the state cancer registry which enables accurate cancer-incidence data to be collected.
7. Diabetes - Established a statewide list of certified diabetes educators to assist people who have diabetes in finding experts that can help their disease.

Based on an informal study conducted by the Healthy North Dakota Initiative, Ms. Olson said while many states have a healthy state initiative, none are at the level of the Healthy North Dakota Initiative. She said many of the states work internally to share information and avoid duplicating efforts but none are

doing the comprehensive collaboration that occurs with the Healthy North Dakota Initiative.

A copy of the report and the factsheet is on file in the Legislative Council office.

Ms. June Herman, Senior Advocacy Director, American Heart Association, commented on the Healthy North Dakota Initiative. She provided examples of the positive outcomes that have resulted from the Healthy North Dakota Initiative. She said the initiative provides a collaborative platform to better leverage resources within the state to improve the health of all North Dakotans.

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

Ms. Kelly Fisher, Licensed Registered Dietitian, Medcenter One Health Systems, commented on the Healthy North Dakota Initiative. Ms. Fisher said she serves on the Healthy Weight Council. She said the council has prepared a "measuring heights and weights in schools" position paper to provide guidance to schools on when it is appropriate to weigh and measure students in schools in order to address the concern that the percentage of overweight youth is increasing.

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

Senator Lee asked how the information gathered from measuring heights and weights of children in schools will be used. Ms. Fisher said the Healthy Weight Council's position paper only provides guidance to schools on when it is appropriate to weigh and measure children in schools.

Ms. Gayle Hand, Grand Forks, commented on the Healthy North Dakota Initiative. Ms. Hand provided information on the interrelationship of diseases. She expressed support for the Healthy North Dakota Initiative because of the collaboration that occurs among people involved with various types of diseases working toward a common goal. Ms. Hand distributed a letter from Dr. James D. Brosseau, Director, Altru Diabetes Center, Grand Forks, regarding the benefits of the Healthy North Dakota Initiative in improving the health of North Dakotans. A copy of the letter is on file in the Legislative Council office.

MEDICAID STUDY AND REPORTS

Ms. Maggie Anderson, Director, Medical Services Division, Department of Human Services, presented a report on the final medical assistance-related expenditures by category for the 2003-05 biennium compared to the 2003-05 biennium budget and to appropriations provided for the 2005-07 biennium. In total, Ms. Anderson said, actual 2003-05 medical assistance expenditures for medical services totaled $407.8 million, $37.8 million more than the $370 million appropriated for the 2003-05 biennium. Compared to the 2005-07 appropriations of $397.6 million, 2003-05 actual expenditures were $10.2 million more; however, Ms. Anderson said the 2003-05 actual expenditures include $28.3 million of intergovernmental transfer payments which will not occur in the 2005-07 biennium.

For long-term care expenditures, Ms. Anderson said 2003-05 actual expenditures totaled $336.2 million, which is $21.9 million less than the 2003-05 appropriation of $358.1 million. She said for the 2005-07 biennium, appropriations for long-term care are $394 million, which is $57.8 million more than the 2003-05 actual expenditures.

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

The committee recessed for lunch at 12:00 noon and reconvened at 1:00 p.m.

Mr. Michael Fix, Life and Health Actuary, Insurance Department, provided information on implementation of the Medicare prescription drug program. Mr. Fix said the Insurance Department plan to educate and assist the public in understanding the Medicare prescription drug benefit includes:

1. Presenting and providing information to groups across North Dakota.
2. Advertising through television, radio, and newspaper.
3. Partnering with other agencies to provide education and assistance.

Mr. Fix said 18 companies will be offering 41 prescription drug plans in North Dakota beginning January 1, 2006. He said the average monthly premium among these plans is $32. Mr. Fix distributed the Medicare handbook for 2006 listing the companies and drug plans for North Dakota.

Mr. Fix said beginning October 16, 2005, information will be available from Medicare on the prescription drug plans, including prescription drugs covered and participating pharmacies.

Mr. Fix said if an eligible individual does not enroll in a Medicare drug plan by May 15, 2006, a 1 percent per month penalty will be assessed on the monthly premium payment when the individual enrolls at a later date.

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

Ms. Anderson presented information on the implementation of the Medicare prescription drug program. Ms. Anderson said approximately 11,000 North Dakota residents are eligible for both Medicare and Medicaid (dual-eligibles). Ms. Anderson said the Department of Human Services has established a team of staff members to oversee the transition of dual-eligibles from Medicaid drug coverage to Medicare Part D coverage. She said the department has prepared and distributed factsheets relating to the Medicare Part D prescription drug benefit. She distributed a copy to the committee.

Ms. Anderson said the department is analyzing the prescription drug plans that will be available in North Dakota to determine whether there are any gaps or

areas of the state which will not have adequate access to pharmacies or plans.

Ms. Anderson said House Bill No. 1465 authorizes the department to use general fund dollars to pay for prescription drugs for dual-eligible beneficiaries in emergency situations as part of the transition to the Medicare prescription drug plan. She said the department believes use of this funding will be minimal because:

1. Medicare will auto-enroll all Medicaid recipients if they do not choose a plan by December 31, 2005.
2. Medicare has developed a process allowing pharmacies to electronically request and receive information on which prescription drug plan must be billed.
3. Medicare has directed all prescription drug plans to provide transitional coverage of all medications for all patients to allow exception requests to be processed.

Ms. Anderson said House Bill No. 1459 requires the department to develop a plan to provide information to blind and disabled medical assistance recipients who may be eligible for Part D benefits. She said the department is collaborating with the State Library to inform visually impaired persons of the changes. She said information will be distributed through a newsletter which is delivered to all visually impaired persons and through public service announcements on the Dakota Radio information service program for visually impaired persons. In addition, she said, the Medical Services Division and the Vocational Rehabilitation Division are cross-referencing eligibility information to develop a list of visually impaired Medicaid/Medicare recipients.

A copy of the report and the factsheet are on file in the Legislative Council office.

Ms. Anderson said the department has contracted with Mr. Don Muse, President, Muse and Associates, Washington, D.C., to develop an implementation plan for the department for the transition to the Medicare Part D prescription drug benefit.

Mr. Muse distributed a draft copy of the implementation plan for the Department of Human Services relating to the Medicare prescription drug benefit.

Mr. Muse said issue areas were identified as part of implementation. He said the issue areas include eligibility, management, information technology, communication and outreach, legal, and pharmacy. He said the plan includes over 75 action steps consisting of specific tasks, the staff member responsible, and the due date. He said approximately 25 percent of the tasks have been completed and another 25 percent are ongoing. He said the implementation plan is on schedule.

Mr. Muse said North Dakota's "clawback" is the payment amount that the state of North Dakota is required to pay to the federal government for the federal government assuming responsibility for prescription drug payments for dual-eligible individuals beginning January 1, 2006. He said the payment will be a per capita amount for each dual-eligible individual multiplied by the number of eligibles for the preceding month multiplied by a factor of 90 percent for calendar year 2006. He said the factor decreases to 75 percent by 2014. Mr. Muse said the current estimate for North Dakota's "clawback" for the remainder of the 2005-07 biennium (18 months) is $15.8 million. He said he and the department are calculating the anticipated number of persons that will be eligible each month and the per capita amount based on the calendar year 2003 prescription drugs paid claims file of the department to compare to the amounts calculated by the federal government for accuracy. He said the estimated per capita amount calculated by the department is $74.10 per dual-eligible individual per month. He said the number of dual-eligibles for which the state must pay is determined on North Dakota's eligibility data file that is submitted to the federal government each month. He said the federal government will then inform the state of the number of individuals that it certifies as dually eligible. He said the current level of agreement is over 99.7 percent. He said by January 1, 2006, the department and the federal government should rarely disagree on the number of dual-eligibles.

Mr. Muse said the implementation process has begun and the report will be continually updated throughout 2005 and 2006. He said the final step will be to conduct an evaluation of how well the implementation proceeded in North Dakota.

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

Ms. Anderson presented a status report of activities of the prescription drug monitoring workgroup and implementation of a prescription drug monitoring program. Ms. Anderson said the department plans to apply for a federal grant to implement the prescription drug monitoring program. She said the department anticipates notification on the availability of the federal grant by the end of November. She said the department will be drafting a request for proposal which will be released if the department receives the federal grant.

Ms. Anderson reported on the status of the department's amendment to the North Dakota Medicaid state plan allowing the disregard of assets for individuals owning long-term care insurance policies. Ms. Anderson said under current federal law, states are not allowed (except for the original four states) to use federal Medicaid funds to implement a policy allowing for the disregard of assets for individuals owning long-term care insurance policies. She said Congress is considering legislation which would allow this disregard. As a result, she said, the department has not yet submitted its state plan amendment, but will when allowed by federal law.

Ms. Anderson said House Bill No. 1216, approved by the 2005 Legislative Assembly, directs the department to establish a provider appeals process. She said the department has prepared a summary document to outline the process for appeals and a one-page form for the provider to complete as a formal request for appeal. Ms. Anderson distributed copies of the summary and appeal request form. A copy of the report is on file in the Legislative Council office.

Mr. Howard Anderson, Executive Director, State Board of Pharmacy, commented on the prescription drug monitoring program. Mr. Anderson expressed support for the prescription drug monitoring program. He said the program will lead to improved patient care because physicians and pharmacists will have access to a patient's profile of controlled substances. He said it will also allow law enforcement to investigate specific instances of suspected diversion of controlled substances. A copy of the testimony is on file in the Legislative Council office.

Dr. Patricia A. Hill, Executive Vice President, North Dakota Pharmacists Association, commented on the implementation of the Medicare Part D prescription drug benefit. Dr. Hill said the Medicare Part D prescription drug benefit provides pharmacies a competitive market process that allows for reasonable reimbursement rates to be negotiated and attained with pharmacy benefits managers. Under other insurance contracting processes, she said, pharmacies are typically offered either a "take it or leave it" contract.

Dr. Hill said that because not all pharmacies and pharmacy benefits managers can reach an agreement on rates, it is unlikely that all 18 prescription drug plans in North Dakota will be available at every pharmacy in the state. She anticipates that an important factor for an individual choosing a particular prescription drug plan will be the individual's ability to continue to receive medications from the local pharmacy.

Dr. Hill said that North Dakota pharmacies were notified in August 2005 that Blue Cross Blue Shield of North Dakota is terminating its Rx Dakota Network on December 1, 2005. She said all Blue Cross Blue Shield consumers will be transitioned to the Prime National Network at that time which will result in North Dakota pharmacies receiving significantly lower reimbursement rates in order to continue providing pharmacy services to patients who are insured by Blue Cross Blue Shield.

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

In response to a question from Senator Krauter, Dr. Hill said pharmacies under the Rx Dakota Network were reimbursed for brand name prescription drugs at average wholesale price minus 10 percent with a $4.60 dispensing fee while under the Prime National Network, pharmacies will be reimbursed for brand name drugs at average wholesale price minus 14 percent with an estimated $2 dispensing fee.

Senator Krauter expressed concern regarding the negative effect of this change on pharmacies operating in rural North Dakota.

Representative Delzer asked whether prescription drug assistance programs offered by drug companies will continue to be available after implementation of the Medicare Part D prescription drug benefit. Mr. Fix said he anticipates drug companies will continue to offer prescription drug assistance programs but individuals with Medicare coverage will not participate.

FOSTER CARE FACILITY PAYMENT SYSTEM STUDY

Mr. Paul Ronningen, Director, Children and Family Services, Department of Human Services, presented information on the number of children in foster care and the status of the change in payment procedures for foster care facilities as required by the federal government.

Regarding the change in the payment process, Mr. Ronningen said the department is continuing to meet with the provider groups--residential treatment centers, residential child care providers, and PATH--regarding the impact of the change. He said these meetings have resulted in the following activities:

1. Residential treatment centers will seek accreditation status and become accredited residential treatment centers allowing them to continue to bill using the daily rate.
2. Residential child care facilities will begin billing Medicaid for rehabilitation services on a 15-minute unit basis. Because of the change required by the federal government, providers will be paid the allowable Medicaid rate for the specified service instead of the historic daily rate. He said the federal government has approved a January 1, 2006, effective date for this change.
3. For PATH providers, the department continues to analyze the impact on this service. He said these providers will need to bill social work time on a 15-minute basis. He said the federal government has approved a January 1, 2006, effective date for this change as well.

Mr. Ronningen presented the following schedule regarding foster care placements since federal fiscal year (FFY) 2000:

	Federal Fiscal Year				
Placement Type	**2000**	**2001**	**2002**	**2003**	**2004**
Missing placement*	9	37	18	34	28
Preadoptive home	154	166	157	160	207
Relative placement	237	240	276	328	383
Family foster care	875	835	824	932	912
Group home	125	109	127	125	120
Facility (RTC & RCCF)	577	540	619	604	555
Runaway	1	2	0	0	0
Total	1,978	1,929	2,021	2,183	2,205

*Placement information not available.

Mr. Ronningen presented the following schedule of the number of out-of-state residential foster care placements on selected dates:

Date	Number of Out-of-State Placements
January 2003	33
July 2003	43
January 2004	50
July 2004	56
January 2005	62
July 2005	53

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

Senator Krauter asked how the department is attempting to reduce the number of out-of-state placements. Mr. Ronningen said the changes being made to the facilities' payment system process to pay based on 15-minute units should provide a more appropriate reimbursement for the facilities' cost of services and may result in a reduction in out-of-state placements.

Senator Krauter asked for the reasons residential child care facilities are at times not reimbursed for cost of case management services. Ms. Anderson said that if a county or the Division of Juvenile Services is also providing case management services, the Medicaid program allows only one provider to be paid for case management services and the county or Division of Juvenile Services receives priority for payment for these services.

Senator Warner asked for information on available aftercare services for children leaving the foster care program. Mr. Ronningen said he would provide information on aftercare services to Senator Warner.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS STUDY

Ms. Tamara Gallup-Millner, Director, Children's Special Health Services, Department of Human Services, provided information on children's special health services program statistics. Ms. Gallup-Millner said the primary funding source for Children's Special Health Services is the maternal and child health services block grant. She said to receive the federal funding, the state submits an application each year with its plan for meeting needs identified through a statewide needs assessment process.

Ms. Gallup-Millner said for children with special health care needs, the grant is used for two primary purposes:

1. To provide and promote family-centered, community-based, coordinated care, including care coordination services.
2. To facilitate the development of community-based systems of services for these children and their families.

Ms. Gallup-Millner said Children's Special Health Services offers the following programs:

1. Specialty care diagnostic and treatment services - Payment for medical services for eligible children (medical and financial eligibility criteria applies to this program only).
2. Multidisciplinary clinics - Coordinated management of 10 different types of chronic health conditions.
3. Care coordination - County and public health staff assist families access services and resources in the community, or when needed, across multiple service delivery settings.
4. Metabolic food - Food and formula for individuals with phenylketonuria (PKU) and maple syrup urine disease (MSUD).
5. Russell-Silver Syndrome - Payment for services related to growth hormone treatment and medical food.
6. Information resource center - Public information services, including a toll-free telephone number, resource library, targeted outreach to disseminate health information, etc.

Ms. Gallup-Millner presented the following schedule showing the unduplicated number of children served since federal fiscal year 2000:

Federal Fiscal Year	Unduplicated Number of Children
2000	1,604
2001	1,570
2002	1,514
2003	1,403
2004	1,371

Ms. Gallup-Millner presented the following schedule showing the number of children receiving treatment or diagnostic services since federal fiscal year 2000:

Federal Fiscal Year	Children Receiving Treatment Services	Children Receiving Diagnostic Services
2000	235	174
2001	228	162
2002	238	127
2003	220	92
2004	210	107

Ms. Gallup-Millner said the number of children receiving services has been declining in recent years primarily due to the declining number of children seen in cardiac, cleft palate, and scoliosis clinics. She said the numbers reported do not include individuals served through the metabolic food program, the Russell-Silver program, or the Information Resource Center.

Ms. Gallup-Millner provided a list of the covered medical conditions. The list is attached as Appendix B. She said children with the following five conditions were served most frequently in federal fiscal year 2004--asthma, cleft lip/palate, diabetes, heart conditions, and handicapping malocclusion. Ms. Gallup-Millner said the department supports the

committee's review of the appropriateness of the medical and financial guidelines currently used in determining eligibility for the program. She said financial eligibility is currently set at 185 percent of the federal poverty level. She said families can be eligible with a cost-share similar to the recipient liability for Medicaid. Based on telephone calls received from potential applicants, she said the department believes that the primary reason families do not continue the application process is because they believe the amount they would need to pay each month out of pocket would be too high for the program to benefit them.

Regarding the use of the condition list for determining medical eligibility, Ms. Gallup-Millner said the list is of concern. She said it does identify the population to be served; however, the list is arbitrary and not all-inclusive when using a broad definition of children with special health care needs.

Regarding recommendations and observations on coverage, Ms. Gallup-Millner said the department identified three areas to be considered--financial eligibility, medical eligibility, and covered services. She said based on the department's financial needs assessment data, out-of-pocket costs for children's medical expenses can be a burden for families. Regarding medical eligibility, she said, the department recommends that the Children's Special Health Services continue with the pilot study recommended by the Medical Advisory Council to determine if it is viable to address currently noncovered conditions. She said other areas that could be considered include genetic syndromes, mental health conditions, mitochondrial disorders, and conditions leading to blindness. Regarding covered services, she said, additional services could be covered, including respite care and transportation. However, in all these areas, she said financial constraints are an issue for the program.

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

Dr. Robert Wentz, Medical Director, Children's Special Health Services, commented on the procedures involved in authorizing the program to cover certain medical conditions.

Dr. Wentz said the list of eligible conditions has evolved incrementally over the years but the method of determining which conditions should be included is not consistent.

Dr. Wentz said the advisory council consists of a nine-member group of health care providers that meets annually. He said the council has difficulty agreeing on what constitutes a "special health care need" but typically the conditions chosen have been chronic and complex.

Dr. Wentz said discussions regarding possible expansion of the list is difficult for the members. He said the program always has limited financial resources and is often viewed as a "welfare" program. He expressed concern that the council members are in effect "rationing" health care. He said the committee over the years has been hesitant to add conditions for which care is expensive or services, such as organ transplants, are costly. Therefore, he said, payment for these types of services has been generally excluded.

Dr. Wentz said concerns exist regarding the list of eligible conditions. He said many children are excluded from coverage simply because the condition which affects them has never been discussed before the Medical Advisory Council. Because the council only meets annually, he said, rapid advances in medical care can make it difficult to keep the list current. He said few health care providers have any knowledge of the list or the program as a possible resource for children under their care.

Dr. Wentz said some members of the Medical Advisory Council believe the medical director should be given broader authority to determine medical eligibility and the committee has, with the assistance of the program director, developed a grid which may be used to evaluate potential eligible conditions.

Previously, Dr. Wentz said, the Children's Special Health Services staff has compiled a list of potential conditions to be considered by the council from a variety of sources, including outside parties, applicant screenings, and needs assessment data. He said over the last five years, asthma, celiac disease, seizure disorders, mucopolysaccharidosis, and conditions identified through newborn screening have been added to the list.

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

Ms. Donene Feist, Family Voices of North Dakota, commented on the children with special health care needs study. Ms. Feist suggested the committee consider possible changes to the eligibility criteria for the program to allow additional families to access the program. She said because of the extremely high cost of services for children with special health care needs, an average family's income is not adequate to meet the cost of care along with other family expenses.

Ms. Feist distributed a data disk providing information regarding families with children with special health care needs.

Dr. Wentz commented on the children with special health care needs study. Dr. Wentz said the federal definition of a child with special health care needs includes those who have increased risk for chronic development, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally. He said these conditions generally include:

1. Birth defects.
2. Syndromes.
3. Traumatic.
4. Infectious.

5. Inflammatory.
6. Neoplastic.
7. Metabolic.

Dr. Wentz said that obtaining services for children with special health care needs is difficult, the services are inadequate and inadequately coordinated, and the system needs a major change. He made the following recommendations:

1. Develop a simpler system of accessing quality services.
2. Provide care coordination.
3. Provide transition services.
4. Improve screening services.
5. Address the shortage of specialty providers and expand interdisciplinary clinics.

Dr. Wentz said Children's Special Health Services could serve as a base for expansion of services. He suggested elevating the status and funding for the program either within the Department of Human Services or another agency. He suggested the program be viewed as a health program rather than a welfare program.

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

Chairman Dever announced the next committee meeting is tentatively scheduled for Wednesday, December 14, 2005, in Bismarck.

The committee adjourned subject to the call of the chair at 4:00 p.m.

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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:2