2011 SENATE HUMAN SERVICES

SB 2326

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2326
2-1-2011
Job Number 13797

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

To provide for a substance abuse services pilot voucher payment program.

Minutes: Attached testimony.

Senator Judy Lee opened the hearing on SB 2326.

Senator Tim Mathern, prime sponsor, introduced SB 2326. He explained that during the interim the legislative management committee, Health and Human Services, studied the availability of mental health and substance abuse services in ND and made a number of recommendations. One was to begin a pilot project using vouchers. That voucher bill was introduced in the House and defeated this legislative session. A number of problems were determined regarding that bill many of which were related to the clarity or vagueness of the bill and the potential cost of the voucher program. SB 2326 essentially is an attempt to clarify some of those matters and to give that concept another hearing.

SB 2326 clarifies a number of areas which he highlighted.
1. The voucher program relates to substance abuse services. It is to be available for providers only that are licensed and accredited by the state.
2. This limits to one pilot project in one human service region.
3. This bill clarifies the federal program under line 19 – the Federal Access to Recovery Grant.
4. On page 2 lines 3-5 it states that if the Federal Access to Recovery Grant funding is not available the dept. is not required to implement the Pilot Voucher Payment Program.

The Voucher Program addresses two problems in ND as he sees it.
1. Access to services when the regional human service centers may not have the staff or are open at the hours that service is needed.
2. To motivate the private sector to develop more professionals to be available in the state if there is a vehicle for reimbursement for the services they provide.

Senator Dick Dever asked if we are looking at increasing the number of people that are offered services through this.

Senator Tim Mathern responded that the goal is to provide a choice for people so those that need the service can get it.

Senator Dick Dever asked about the fiscal note and if it needed to be sent to appropriations. It's an undetermined amount and all federal money.

Senator Tim Mathern didn't think they needed to send it to appropriations but he didn't mind if they received it. One of the discussions of the committee would probably be on the likely impact.

Senator Gerald Uglem asked if anybody in private industry would work for that same cost.

Senator Tim Mathern didn't know. However, sometimes people in the private sector are delivering a service at no cost. This clarifies that private can't be higher than the state.

JoAnne Hoesel, Dept. of Human Services, provided information regarding SB 2326. Attachment #1

Senator Dick Dever asked if they would set a certain amount the voucher would be good for, the person seeks the services wherever and if the cost is higher they pay the difference.

Ms. Hoesel explained that how the grant has operated in the past has been in two different ways to manage what he was asking about. 1. Set the number of clients, identify the services they want the grant to purchase, and then set a rate for that service. Providers have to sign an agreement that they would then provide that service. 2. The average cost of services per person in the grant effort has to averaged out to a certain number that is pre determined at the time the grant is submitted.

Senator Tim Mathern asked how she would envision this still being a pilot if this is adopted.

Ms. Hoesel replied that could be difficult to arrive at the answer. They have applied for the 2004 Access to Recovery Grant. They were considering applying for the 2010. One of the challenges is if there aren't services in the recovery support area of this grant. ND has some but is not strong in that area. One of the decision making points would be to determine whether there are even providers out there that could be encouraged to start this business. Going into an area that has more options already in place, they could maybe adjust to provide this new version of something they might already be providing. There would be a need to have an area with more population just to be competitive and to truly test out the voucher process. It would also be advantageous to try out some things in the more rural areas because that is the reality of ND.

Senator Judy Lee asked if she had any evidence of who might be interested in participating and whether the human services prices would be a reimbursement they might accept.

Ms. Hoesel believed they did.

Senator Dick Dever asked several questions. What other programs fund addiction services? If there is more demand for services than federal money available is there an obligation to use other funds? How long is the grant and what is our obligation subsequent to that?

Ms. Hoesel addressed those questions. Typically the grants are 3-4 years. There is no match required, it is all federal. It is encouraged that states look at how people access services. There is no requirement that it be maintained.
This is not just a ND issue, it is a national issue. There are more people in need of treatment than seek treatment. The public sector has never been set up to serve all people. When access and choice are increased there is the possibility of bringing in people that might not be accessing services as they are delivered now because they may be delivered in a different way or a different location.
The major funding source for substance abuse treatment in ND is the Substance Abuse Prevention and Treatment Block Grant. Along with that are third party funds through individuals' insurance. Medicaid has some reimbursement.

Senator Dick Dever wondered if this voucher program would be applied by the same methods, same standards.

Ms. Hoesel said it could be. It is one of the things that would have to be developed through the application process.

With no further testimony the hearing on SB 2326 was closed.

Senator Tim Mathern moved to **accept the amendment from Dept. of Human Services**.

Seconded by Senator Gerald Uglem

After a short discussion on removing the pilot program, it was decided to leave it. It tends to give the clarification that this might not be a statewide service. It might not be possible to go statewide. There would be too much infrastructure that would need to be built to do it outside of what would be considered a pilot. Keeping "pilot" in wouldn't interfere with the ability to qualify for the grant on its own.

Roll call vote 4-0-1. (Sen. Berry absent) **Amendment adopted**.

Senator Dick Dever moved a **Do Pass as Amended and rerefer to Appropriations if necessary**.

Seconded by **Senator Tim Mathern**.

Roll call vote 4-0-1. (Sen. Berry absent) **Motion carried**. Carrier is **Senator Dick Dever**.

SB 2326 did not need to be rereferred to Appropriations.

FISCAL NOTE

Requested by Legislative Council
01/26/2011

Bill/Resolution No.: SB 2326

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This Bill requires the Department of Human Services to establish and operate a substance abuse pilot voucher payment program in one human service region beginning 7-1-2011 and ending 6-30-2013.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

The Bill requires the Department to establish and operate a pilot voucher system to provide substance abuse services. The program must allow a voucher to be submitted to the beneficiary's provider of choice for payment of services. The payment amount may not exceed the cost of the same service provided by the state. The Department is to offer the pilot program in one human service region as determined by the Department. The potential fiscal impact on the Department for the pilot program is undeterminable and would be limited to the dollar amount of any federal access to recovery grant award received by the Department. If the grant funding is not received by the Department, the Department is not required to implement the pilot voucher payment program.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The Department shall apply for funding available through a federal access to recovery grant. Availability of revenue is undeterminable.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The fiscal impact of the pilot program is undeterminable and would be limited to the dollar amount of any federal access to recovery grant award received by the Department. If the grant funding is not received by the Department, the Department is not required to implement the pilot voucher payment program.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and*

appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.

The Bill provides for a continuing appropriation so no additional appropriation is required for the Department.

Name:	Brenda M. Weisz	**Agency:**	DHS
Phone Number:	328-2397	**Date Prepared:**	01/26/2011

11.0775.01001
Title.02000

Adopted by the Human Services Committee

February 1, 2011

2-2-11

PROPOSED AMENDMENTS TO SENATE BILL NO. 2326

Page 1, line 23, remove "in one human service region of the state as determined by the"

Page 1, line 24, remove "department to provide services"

Page 2, line 2, after "region" insert "or regions"

Renumber accordingly

Date: 2-1-2011

Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 2326

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number Dept. of Human Services

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Mathern Seconded By **Sen.** Uglem

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		**Sen. Tim Mathern**	✓	
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry					

Total (Yes) 4 No 0

Absent 1

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 2-1-2011

Roll Call Vote # 2

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 2326

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 11.0775.01001 Title .02000

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☒ Rerefer to Appropriations ☐ Reconsider

if necessary

Motion Made By **Sen.** Dever Seconded By **Sen.** Mathern

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		**Sen. Tim Mathern**	✓	
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry					

Total (Yes) 4 No 0

Absent 1

Floor Assignment Sen. Dever

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2326: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (4 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). SB 2326 was placed on the Sixth order on the calendar.

Page 1, line 23, remove "in one human service region of the state as determined by the"

Page 1, line 24, remove "department to provide services"

Page 2, line 2, after "region" insert "or regions"

Renumber accordingly

2011 HOUSE HUMAN SERVICES

SB 2326

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SB 2326
March 9, 2011
Job #15155

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

Provide for a substance abuse services pilot voucher payment program.

Minutes: See attachment #1

Chairman Weisz: Opened the hearing on SB 2326.

Sen. Tim Mathern: From District 11, Fargo, introduced and testified in support of the bill. Sen. Lee and I co-sponsors of this bill along with Rep. Hofstad. Sen. Lee was under able to attend because she is chairing the Human Services Committee gives you her regards. The concept of vouchers came to our interim legislative committee and I believe it did because there is a serious shortage of mental health and addiction services in this state. Providing vouchers was considered on avenue we could use to try to address this situation of shortage. Your interim committee studied the matter over a number meetings and I am giving to you a copy of that summary of the study. (See attachment #1.) You all received a book at the beginning of legislative session which contained a summary of all of these studies and I excised that portion that deals with the vouchers. With the vouchers, there is a concern about giving clients choices between public and private providers. Also concerns about limitations of treatment services provided in our public and private sector: but what is done between the two sectors, but not all persons are eligible for those different sectors. We also discussed, how is it that we could implement such a project? Essentially going to the private market to provide a public service was a general consideration. We talked about how such a thing could be funded. That is the basis of the report. That subcommittee introduced a bill that was defeated in the House. I believe it was defeated for a number of reasons and SB 2326 was developed to address the concerns that the House had, but still proceed with the concept in hopes that there would be support for moving forward in a way that can address the concerns that the House had. SB 2326 establishes a pilot voucher payment program. One of the original things in the fiscal note was, the House had he question which entities would be in this voucher system. Could anybody just apply and say I'm a mental health or substance abuse specialist and they would be in, well no. This bill clarifies that they would be licensed and accredited under line 12. Another question was raised in terms of the cost. Is it possible that these costs would be a lot higher by a private provider than a public provide? Assumptions were made that they would be higher. This bill clarifies in line 14, that these payment amounts that would be made in these voucher systems could not be higher than what the public sector could provide that

service for. Another question was raised about what matching effort would there be available to us and to fund this. That is clarified in lines 17 and 18. There is a specific program called federal access to recovery grant program and that was addressed in the bill so that it wouldn't be unclear or cost more than what we know about in terms of federal grants. The other issue we put in on the Senate side is the flexibility among areas of the state where this program would be provided. The original House bill that came from the interim committee said three distinct regional human service center areas would be the pilots. This bill clarifies beginning on line 24 that the department will choose one of those eight regions in the state or region to region which could develop the required service. Right now the federal access to recovery grant program has specific criteria. If you get this federal grant you have to provide a certain amount of services. If region 1 in our state doesn't have this list, but a shorter list, they wouldn't be eligible for the grant. This gives the DHS the ability to choose the part of the state that already would fit the grant criteria. So we wouldn't be developing a new state service I order to get the federal grant. SB 2326 was developed to address the concerns of the House of Representative and the DHS while still promoting this concept of looking to vouchers as one way to address the limitations we have in mental health and substance abuse services. I'm asking for your support for this bill. And noting your good work in the House bill that is now in the Senate and that bill is a little different than this. But, frankly we need to do both. We have dramatic changes coming to us in the next few years. I think we need to pass both to provide better services within our state.

Rep. Porter: As a voucher program in anyone of the regions for anyone of the services is developed, that would indicate to me that the number of billable hours at the state run and financed facility would be than less. How do we address the declining number of hours that the state is providing with the same professionals by giving the flexibility elsewhere? Inside of the bill I see a review and a report to legislative management. I don't see a reduction of force of those state employees because their number of billable hours unless you think there is going to be a new influx of individuals, it is the same people. We are just allowing them to move from the centers to someplace else. Someone is going to be working less and someone is going to be working more. How do we address that reduction in force inside of this program?

Sen. Mathern: I believe that is an aspect of the grant development. We have a huge human service system. We have a budget of $2.6 billion and within that context we have an area of programs and when the grant application is put together that would be part of the DHS process. What I foresee happening is whatever reduction there could be billable hours to the public sector, that savings would either be reflected in further turn back; in terms of money not being spent or that we would take up some other area that we didn't fund properly. That would see that being done in the context of the DHS. The concept of a pilot program is to get at that data. The question you raised is data we need for future funding or future determination. The data we receive from doing a pilot project helps you as a policy maker, make the bigger decisions than in the future about, how much does this change, what are the consequences and how does it apply to the entire state? In part a pilot project is to address your question so you and I have data the next time around.

Rep. Porter: I don't see that language in the report that would come back from legislative management the way you explained it. I see cost comparisons between the two, but I don't

see expense comparisons on the savings that the state should then see by not needing as many full-time addiction counselors employed inside the human service centers if people choose to use the voucher system and go to care elsewhere. Then they are sitting there doing nothing with no patients. I don't see that as part of the analysis in section 2 of the bill.

Sen. Mathern: I see that it within that analysis, but if you want to see this more specific I don't see a problem. I thought that analysis would be included there when we do the comparison. The analysis it talks about in that section, I believe what you are trying to get at is literally part of this because we need to know that. We need in our state to make some changes. We have too many people in our state that are dying because of suicide and not actively engaged in employment because of drug addiction or mental illness. We have a future of a reduced reimbursement I believe from the federal government on general human service types of activity. So, we need an answer to the question you are implying. I believe the analysis would be there, but I think that would be an important thing to ask the department when they come up in terms of their analysis or to add if you believe it should be added.

Mike Reitan: Assistant Chief of the West Fargo Police Dept. To provide a law enforcement perspective here in ND. North Dakota has law enforcement officers as safety nets for the mental health and chemically dependent patients. When the family and individual cannot get service they call law enforcement and it is our responsibility to go out and take care of the immediate situation. In the past we did not do such a good job of doing that. Frequently what that involved was that we would beat people down to get them in compliance and arrest them on marginal charges to get them into jail. And we would put them in the backseat of the patrol car and drive them to Jamestown and essentially drop them off at the door. What we do with them now has improved some at the front end; that we are training our officers to appropriately respond to people with chemical dependency and mental health issues. But, we need the follow on care. Now what is happening is that we are responding to the family and crisis and to the individual in crisis and to the criminal that has taken place. We recognize the fact that there is a chemical dependency or mental health issue because we have been trained to recognize those things. We take them to an emergency room and drop them off and then it is up to the system to figure out how to deal with them. It is an enormous expense to the emergency rooms. It provides an increased caseload in the emergency room and a dynamic affect on the medical patients appearing in the emergency rooms. I believe the idea of this voucher system will allow the state to respond to the root cause or problem with this issue and address the availability of treatment for the individuals that have chemical dependency or mental health issues. I ask that you support the pilot project and see how it works. Obviously as Sen. Mathern indicated and Rep. Porter pointed out that there are some unknowns. We don't know what the outcome will be. I think a lot of people have misconceptions of the availability of the staff and the programs there at the State Hospital. On the law enforcement side we don't see the State Hospital as being available to us. The person has to be screened at the human service center before they get to the State Hospital. It is the availability of beds at the State Hospital that result in days or even week delays. The human service centers have case managers with huge case loads. We on the law enforcement side see a shortage in service and feel this voucher program will open up another group or resource to people with chemical dependency or mental health issues.

Rep. Hofstad: We dealt yesterday with an issue to allow the department to contract for detox centers in neighboring Minnesota. You spoke about delivering people with chemical dependency to an emergency room. In your community the push and pull between the hospitals and incarceration, when you have people in need of a medical detox, where do you take them? How do you handle that and how is that handled between the hospitals and the jails?

Mike: When we pick somebody up that is intoxicated, we have two choices. We take them to the Center Inc. that has a social detox center. When they say social detox, they put them in a room with supervision to make sure the person doesn't die and as soon as they are up and functioning again they are put back onto the street. They go back to the bar and get drunk again. With the medical detox bill that you talked to yesterday; over on the MN side, Moorhead has a center that is a medical detox. Frequently what we find is that when we respond to a call of an intoxicated person, that person is laying down. They have either fallen down or run into something or a medical condition that has caused them to collapse. Frequently that medical condition may be a bump on the head or a scrap and not able to be admitted to the social detox setting. That necessitates us to take them to the emergency room and they have to do a work up on them. They may then end up in detox or if a crime was committed they would end up in jail. In Whapeton they are faced with same thing even though they have a hospital in Breckenridge. They have to be driven to Fargo and put them in Fargo detox because that is the closest one available to them.

Rep. Hofstad: In the hospital setting do they continue care through the medical detox process or do they reluctantly keep them or send them to jail? What do they do with that patient?

Mike: Those patients that are seen in the medical facility that have insurance may be admitted to the hospital depending on the level of care that is needed. Those patients that don't have insurance may be admitted to the hospital if they have that medical need and the hospital then either turns to the state or they do, I believe the term is community care, where it is a free service. Once the person is stabilized by the hospital and not going to die, they will be sent by Taxi if in Fargo to the detox center or go to jail if being held on an offense.

Rep. Paur: It sounded like there was a considerable problem with this is your county on accessing medical detoxification help. Do you have any idea about the situation in the rest of the state? The rest of the state has very similar situations and it is a problem each local jurisdiction has developed their own way of handling it. In some locations it takes hours to be transferred a hospital setting or to a detox center. Other places contact somebody in the community like a friend or relative who may in the past have taken care of this person when they have been this state of incapacitated.

Rep. Paur: What I was kind of getting at was that your county is the largest and fastest growing and probably hasn't youngest population and demographically a tenth of the size. Does it have a tenth of the problem or a twentieth of the problem? From testimony we heard it sounded like your county was particularly hit hard with some of these problems.

Mike: Fargo does have a larger number, talking with Bismarck, their numbers are more. Minot is not more than Fargo, but has a higher number. Part of the reason the bigger communities have more is because we have those facilities within those communities. When people come to the detox center it is likely they will stay in the community there if they have no other ties anywhere else. There is a certain transient population that travels the trains still. That is part of their life still and part of their chemical dependency.

JoAnne Hoesel: From the DHS. I'm available to answer any questions.

Rep. Hofstad: Regarding Rep. Porter's question I think that is a pretty valid question. This is really the essence of this whole thing is trying to serve the public and save money and do it better. In report it talks about the cost of substance abuse and analyzing the affect and that is based on affordability and accountability. Let's say we did this and during the study we found out that private industry does it better and are cheaper and more accountable, would that then in your opinion lead to a reduction in staffing and the cost to the state?

JoAnne: It would be important to note that there are during time requirements for human service center staff and we would be able to trend that and report that to you in terms of what is happening. We would have to take a look at what services would be written into the access to recovery grant. When I look at what other states have wanted to fund when they did this and implemented the grant; much of it is for recovery support. That would be after the traditional treatment which in ND we have very little of. By putting those reports in place you are assisting that person to be successful for the long haul. Then we would have those outcomes to show us hat when you do provide that ongoing support, it does make a difference and they aren't ending up in the emergency room. By person we would be able to identify a change in how they are functioning. From your comments perhaps there is a belief that we are serving everybody that needs treatment in the state and we are not. We have to account for, if you increase access you hopefully will be able to treat some of those individuals sooner than in the later stage of the disease. If for some reason our caseloads and waiting time would say that we don't need that service at the human service centers, we would look at that. As an example, at the developmental center we have decreased by 40 FTEs in our upcoming biennium. Those individuals have been placed out in the community and we no longer need that service. The data would tell us what decisions need to be looked at.

Rep. Hofstad: One of the components of the grant is transportation and after care. Do we have regions within the state that have those components to the program right now?

JoAnne: All regions in the public sector have some aftercare. Most private agencies have after care as well. It would be a matter of if they are needing to limit that time because of insurance or other reasons. It might not be as long as they would wish the aftercare would occur. It terms of transportation, no we do not assist with transportation.

Rep. Porter: You made a comment regarding the department's view as this not being duplication service, but to establish services that aren't currently being provided. That is really not the way I read this bill. It says very specifically that the program you are to establish if you get the grant is a substance abuse service. I'm wondering how you are coming to that interpretation of what this voucher would be?

JoAnne: I'm referring to how the access to recovery grant has been written at the federal level. It is intended to focus on recovery support and how the state and stakeholders view that. We and they are not wanting to duplicate what is already available if it is sufficient, but rather take a take a look at how better to support people in their recovery and after treatment. When I'm talking about transportation support and housing support and case management, we don't have any degree in the state case management for substance abuse clients. Those are addiction and mental health services that many other states have chosen to implement through the HER grant.

NO OPPOSITION

Chairman Weisz: Closed the hearing on SB 2326.

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SB 2326
March 21, 2011
Job #15707

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: SB 2326 is the house version of, Rep. Kilichowski can you refresh me on the number?

Rep. Kilichowski: HB 1395.

Chairman Weisz: We met with Sen. Lee about it and the consensus was they are going to kill 1395 and we are to move forward with 2326.

Rep. Kilichowski: That is correct and really the only difference is 2326 specifies the grant to be used for the pilot project. I move a Do Pass.

Rep. Schmidt: Second.

VOTE: 11 y 1 n 1 absent – Rep. Hofstad

Bill Carrier: Rep. Kilichowski

Date: 3-21-11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2326

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep Kilichowski Seconded By Rep. Schmidt

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ	✓		REP. CONKLIN	✓	
VICE-CHAIR PIETSCH	✓		REP. HOLMAN	✓	
REP. ANDERSON	✓		REP. KILICHOWSKI	✓	
REP. DAMSCHEN	✓				
REP. DEVLIN	✓				
REP. HOFSTAD	A				
REP. LOUSER		✓			
REP. PAUR	✓				
REP. PORTER	✓				
REP. SCHMIDT	✓				

Total (Yes) 11 No 1

Absent 1

Floor Assignment Rep. Kilichowski

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2326, as engrossed: Human Services Committee (Rep. Weisz, Chairman) recommends **DO PASS** (11 YEAS, 1 NAYS, 1 ABSENT AND NOT VOTING). Engrossed SB 2326 was placed on the Fourteenth order on the calendar.

2011 TESTIMONY

SB 2326

#1

Testimony
Senate Bill 2326 –Department of Human Services
Senate Human Services
Senator Lee, Chairman
February 1, 2011

Chairman Lee, members of the Senate Human Services Committee, I am JoAnne Hoesel, Director of the Division of Mental Health and Substance Abuse for the Department of Human Services (DHS). I am here to provide information regarding Senate Bill 2326.

Based on a review of previous requests for applications (RFA) issued by the Substance Abuse Mental Health Services Administration (SAMHSA) for the Access to Recovery grants, part of SAMHA's evaluation criteria included listing the number of clients anticipated to be served in each year of the grant. SAMHSA also lists the total number of clients their entire grant effort must serve in order for them to reach their target. In RFA 2010, this number was 225,000 people.

Since SAMHSA historically sets client targets for grants and it is unknown what requirements will be for future Access To Recovery RFAs, DHS suggests that the restriction to one human service region be removed from line 23 in the bill. The target number from one region in North Dakota may create too small of a client count for the grant submission to be competitive.

I would be happy to answer any questions.

PROPOSED AMENDMENT TO SENATE BILL NO. 2326

Page 1, line 23, remove "in one human service region of the state as determined by the"

Page 1, line 24, remove "department to provide services"

Page 2, line 2, after "region" insert "or regions"

Renumber accordingly

Amendments to 11.0775.01000

Sen. Mathern #1 - Jan. 11th 1/27/10

VOUCHER USE AND PROVIDER CHOIC FOR CLIENTS STUDY

Section 1 of House Bill No. 1573 (2009) direct study of voucher use and provider choice for clien various human services and other state progr including programs related to mental health serv addiction treatment, counseling services, trans services, various home services, and other sp services. The study was to explore the extent to w vouchers are currently used in federal and state hu service programs and other programs, how vou systems are implemented, and the advantages challenges posed by the use of vouchers a mechanism for expanding service options maximizing client choices. The study also wa include a comprehensive review of funding for hu services and other state programs focusing on feasibility of improving access to care and provider clients through the use of a voucher system, inclu programs related to mental health services, addic treatment, counseling services, and transition service

Voucher use or provider choice is a metho providing goods and services to a beneficiary with use of a voucher. The voucher can be submitted to beneficiary's provider of choice for the goods services. Federal, state, and local agencies dev service agreements with providers to supply good services in exchange for the vouchers, which presented to the agencies for payment as provide the agreement.

The committee reviewed previous studies relatin voucher use or provider choice for clients, inclu studies by the 2001-02 Budget Committee on Hur Services of the issues and concerns of implemen Charitable Choice and the 2007-08 Long-Term C Committee regarding the long-term care system in N Dakota. Charitable Choice is the privatization federally funded welfare services through faith-ba organizations.

Voucher Use and Provider Choice

The committee reviewed a summary of progr offered by the Department of Human Services. summary included program descriptions, eligib requirements, descriptions of the program's provi choice, and the 2009-11 appropriation for each progr

The committee learned that while the departm does not use the term "vouchers" in its services deliv the department does use the term "individualized serv budgets" in several areas. Individualized serv budgets use the same concept as vouchers and used in the family caregiver support program, s directed support waiver, and child care. The commit learned in addition to the programs that individualized service budgets, client choice is availa in programs relating to:

- Child welfare and mental health when a serv plan is developed;
- Vocational rehabilitation where client-inform choice is a regulatory requirement; and
- Medicaid, where freedom of provider choice is required with few exceptions.

Access to Recovery Grant

The Access to Recovery grant was a federal Substance Abuse and Mental Health Services Administration grant opportunity that used the voucher model for providing substance abuse treatment services. The Department of Human Services Division of Mental Health and Substance Abuse Services, established a recovery council as an advisory committee to the Access to Recovery grant. The committee learned the division and the recovery council determined adequate recovery support infrastructure was not available in North Dakota as required by the Access to Recovery grant. Because the state was not prepared to provide required recovery support, the division and the recovery council decided not to submit the Access to Recovery grant application. The latest round of Access to Recovery grants were awarded in August 2010 and future Access to Recovery grant opportunities are uncertain.

Money Follows the Person Developmental Disabilities Service Demonstration Project

The committee learned the Department of Human Services was awarded an $8.9 million Money Follows the Person demonstration grant in 2007. The committee learned the grant funding is to assist persons with a developmental disability, a physical disability, and older adults in transitioning from an institutional setting to a community setting through the increased use of home and community-based services. The grant funding is available through calendar year 2018, and individuals may receive services through 2019.

The committee learned there have been 17 transitions from nursing facilities and 14 transitions from intermediate care facilities since the program began in August 2008. Of the 31 total transitions, 6 individuals have completed 365 days of enhanced Money Follows the Person grant funding (3 individuals from nursing facilities and 3 individuals from intermediate care facilities). The cost to Medicaid for the three individuals in a nursing facility averaged $44,245 per individual per year, including institutional, medical, and medication costs. After transition, the average cost was $38,873 per year, including transition coordination, supplemental services, home and community-based services, medical costs, and medication costs. The committee learned the cost to Medicaid for the three individuals in an intermediate care facility averaged $121,194 per year, while the average cost after transition was $100,950 per year. The committee learned one of the primary barriers to the transition of individuals from either nursing facilities or intermediate care facilities is lack of accessible and affordable housing in communities.

Program of All-Inclusive Care for the Elderly

The committee received information on the program of all-inclusive care for the elderly. The program is a capitated benefit program that provides a comprehensive service delivery system. The system

includes all needed preventative, primary, acute, and long-term care services to allow the individual to continue to live at home or in the community. The program of all-inclusive care for the elderly providers assume full financial risk for the participant's care without limits on amount, duration, or scope of services. The program of all-inclusive care for the elderly began operating in Bismarck and Dickinson in September 2008 under the Northland Healthcare Alliance. The program served 29 participants in Bismarck and 19 in Dickinson as of March 2010.

Mental Health and Substance Abuse Treatment Services and Limitations

The committee received a summary of the cost of substance abuse and mental health services in each region, including contract costs and numbers served by race. The committee learned the availability of services and providers varies across the state and each of the human service centers provides some direct services while contracting with private providers for other services. The committee learned of the $97.8 million budgeted at the human service centers for mental health and substance abuse services for fiscal year 2009, $26.5 million or 27 percent is for contracted services. The committee learned 25,289 clients received mental health and substance abuse services at human service centers in fiscal year 2009, an increase of 1.3 percent from fiscal year 2008. Native American clients totaled 2,803 or 11.1 percent of the total clients served.

The committee received information regarding cost-based rates for services provided by staff at selected human service centers and the contract rate for similar services when the department contracts for the service in the same human service region. The committee learned the statewide rate and the contract rates are submitted to Medicaid for reimbursement. Contracted rates include all of the costs to operate the facility and provide the service while the human service center rate is computed statewide and is determined by dividing all of the costs the state incurs to provide that service, including designated staff and supervision, by the total units provided by the state. The committee learned Medicaid requires the state to charge a consistent rate based on cost. As a result, the department calculates a statewide rate rather than different regional rates. The committee learned that the use of a statewide rate for human service centers service costs makes it difficult to compare to private providers rates for similar services.

The committee received a summary by region of mental health and substance abuse residential bed capacity, including the number of available crisis beds. There are 445 residential mental health and substance abuse beds available statewide, including 78 flex beds, which are available for use as mental health crisis or substance abuse residential beds. In addition to the mental health and substance abuse residential bed capacity provided through the regional human service centers, the Division of Mental Health and Substance Abuse Services contracts for 40 residential treatment substance abuse beds at the Robinson Recovery Center.

The committee learned the Robinson Recovery Center reports annually to the division on the number of individuals referred and admitted and on measures relating to completion of treatment, employment, and housing. The committee learned the division compares the center's outcomes to national trends. In addition, the committee received information regarding the Department of Human Services' mental health block grant outcome report, substance abuse prevention treatment block grant outcome report, and outcome information for youth who receive services. Key outcomes reported relate to arrests, levels of functioning, stable housing, employment, independence, school attendance, client perception of care, social support/social connectedness, and abstinence from alcohol and drugs.

The committee received information regarding the challenges facing hospitals that provide inpatient psychiatric services and a summary of the specialty and acute hospitals that provide inpatient psychiatric services. The committee learned a North Dakota Hospital Association study of the behavioral health challenges facing hospitals identified funding of care, physician recruitment, access to the State Hospital, and telemedicine as challenges to be addressed. The committee learned hospitals that provide inpatient psychiatric services face funding challenges that have contributed to the closing of inpatient psychiatric units in Dickinson and Williston. The committee learned the closure of these two units has placed increased demands on other providers and has resulted in an inadequate level of service in the western part of the state.

The committee learned addiction counselors must be licensed by the Board of Addiction Counseling Examiners and received information regarding the requirements for licensure. The committee learned 334 addiction counselors were licensed in the state as of January 2010. The Board of Counselor Examiners offers three counseling licenses--licensed associate professional counselor, licensed professional counselor, and licensed professional clinical counselor. The committee received information regarding the requirements for each counseling licensure and learned 359 professional counselors were licensed in the state as of January 2010.

The Department of Human Services' stakeholder report identified shortages of mental health professionals, inpatient bed capacity, and residential options and funding for peer support as major mental health and substance abuse services issues to be addressed by the department. The Department of Human Services' staff, legislators, representatives of private hospitals with behavioral health care services, and others identified the following recommendations:

- Develop a standard purchase of service agreement between the Department of Human Services and private hospitals;

- Establish one contracted rate for services (the Medicaid daily rate);
- Enhance available crisis and residential beds in the state to assure treatment at the appropriate level of care;
- Explore alternative models of crisis intervention and case management, particularly for afterhours services;
- Expand the use of telemedicine to increase client access; and
- Increase the role of higher education.

Implementation of a Voucher System

The committee received information regarding lessons learned from Round 1 of a 2004 federal Substance Abuse and Mental Health Services Administration Access to Recovery grant for which North Dakota applied but was not successful. Each state receiving the grant was asked to provide information regarding its experiences in operating a voucher model for providing substance abuse treatment services. Key lessons identified include:

1. Service provider base:
   a. Treat outreach as marketing via communications. Outreach and communication is required to persuade providers to become part of the voucher network.
   b. Adopt a systems perspective. There is no guarantee of business and reporting, documentation, reimbursement requirements, hands-on targeted training, and support are necessary.
   c. Deliver targeted training.
2. Client base:
   a. Implement client outreach.
   b. Ensure informed client choice.
   c. Define an appropriate client base.
   d. Take advantage of existing structures.
3. Administrative systems and procedures:
   a. Plan ahead. Voucher management is required to issue vouchers, manage claims, integrate procedures, reconcile outstanding vouchers, and monitor voucher activity.
   b. Develop logical procedures.
   c. Understand contextual issues.
   d. Provide oversight.
4. Outcomes of treatment and recovery support systems:
   a. Assess the outcomes of treatment and recovery support services.
   b. Outreach and training are necessary to assure reporting requirements and data collection procedures are in place.

The committee learned private providers support the use of a voucher system for uninsured and underinsured North Dakota residents to access mental health and chemical dependency services. Human service centers often have waiting lists for services. The distance to human service centers may also be an impediment to individuals being able to access the services. In some regions of the state a voucher system may provide more options, but a lack of available providers may require travel to another region to use a voucher. Implementing a voucher system would:

- Empower the patient by allowing the patient to choose the provider.
- Provide the opportunity to receive care closer to home.
- Improve the quality of care.
- Reduce strain on the state system.
- Allow the State Hospital to function as a long-term psychiatric facility.
- Offer patient access to a full continuum of care.
- Better match the level of care to the patient's psychiatric needs.
- Improve public/private partnerships by increasing the network of resources available.

Under a voucher system:

- The state could set the price it will pay for a service and determine the desired outcomes.
- A contract, similar to contracts private providers have with insurance companies, could establish rates.
- Competition among providers for these services could control costs.
- Services must be documented as medically necessary.
- The regional human service centers could provide case management services, determine care needed for clients, and contract with private providers for the necessary services.
- Client choice would increase.
- An increase in choice could result in an increase in access.

Pilot Voucher Payment Program

The committee learned a demonstration voucher payment program in one area of the state could provide an opportunity to evaluate a voucher payment system. The Department of Human Services would need additional funding to implement a pilot voucher payment program for the increased administrative costs to monitor the vouchers and for potential additional treatment costs for individuals currently untreated that may seek treatment under the voucher system. The committee learned the cost of the pilot voucher payment program will depend on the services included.

Recommendations

The committee recommends a bill draft directing the Department of Human Services to establish and operate a pilot voucher payment program to provide mental health and substance abuse services for the 2011-13 biennium. The department is to offer the mental health and substance abuse services pilot voucher payment program in three human service regions of the state; a primarily urban region where a variety of mental health and substance abuse services are available but where access to services is limited, a primarily rural region where a variety of mental health and substance abus

services are not available, and a region including an Indian reservation where the demand for mental health and substance abuse services may exceed the capacity of existing mental health and substance abuse service providers. The bill draft also provides for a comprehensive review of the pilot voucher payment program and a report of the preliminary findings and recommendations to the Legislative Management prior to September 30, 2012.