NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH SERVICES COMMITTEE

Thursday, October 9, 2014
Roughrider Room, State Capitol
Bismarck, North Dakota

Senator Judy Lee, Chairman, called the meeting to order at 9:00 a.m.

Members present: Senators Judy Lee, Howard C. Anderson, Jr., Robert Erbele, Joan Heckaman, Oley Larsen, Tim Mathern; Representatives Alan Fehr, Curt Hofstad, Rick Holman

Members absent: Representatives Dick Anderson, Jon Nelson, Marvin E. Nelson

Others present: See Appendix A

It was moved by Senator Mathern, seconded by Representative Holman, and carried on a voice vote that the minutes of the July 30, 2014, meeting be approved as distributed.

COMPREHENSIVE STATEWIDE TOBACCO PREVENTION AND CONTROL STUDY

At the request of Chairman Lee, Ms. Krista Fremming, Director, Tobacco Prevention and Control Program, State Department of Health, provided information (Appendix B) regarding a summary of the sources of tobacco prevention and control funding, including details of the programs receiving funding from each source, populations served, populations not being served, areas of collaboration between the State Department of Health (DOH) and the North Dakota Center for Tobacco Prevention and Control (Center), and options to improve collaboration to reach populations not served. She said DOH programs that could benefit from collaboration with the Center include the tribal tobacco prevention and control program, the city-county employee cessation program, the North Dakota Public Employees Retirement System (PERS) cessation program, and the Million Hearts Program. She said DOH and the Center plan a joint effort to establish baseline data to measure the prevalence of tobacco use on the reservations. In addition, she, said DOH, and the Center could collaborate to promote cessation programs.

In response to a question from Chairman Lee, Ms. Fremming said DOH will consult with the North Dakota State University American Indian Public Health Resource Center to ensure surveys administered are culturally sensitive and that the tribes are in agreement with the plan to develop the baseline data.

In response to a question from Senator Mathern, Ms. Fremming said all seven federal Food and Drug Administration (FDA) approved cessation medications are available in the PERS cessation program; however, liability concerns limit the NDQuits Program to over-the-counter cessation products.

In response to a question from Senator Larsen, Ms. Fremming said the average Million Hearts Program grant is $40,000 per year per health care system. She said currently the six tertiary hospitals receive funds, but other critical access hospitals could qualify if additional funds are available. She said DOH anticipates including a request for additional funding in its 2015-17 biennium budget request to increase grants available.

In response to a question from Senator Larsen, Ms. Fremming said all tobacco prevention and control programs are evaluated for process and outcomes.

At the request of Chairman Lee, Ms. Jeanne Prom, Executive Director, Center for Tobacco Prevention and Control, provided information (Appendix B) regarding a summary of the sources of tobacco prevention and control funding, including details of the programs receiving funding from each source, populations served, populations not being served, areas of collaboration between the Center and DOH, and options to improve collaboration to reach populations not served. She said the Center provides state aid grants, local policy grants, special initiative grants, and special initiative contracts for policy, public education, and evaluation. She said the Center and DOH collaborate on a workplan to implement the state plan, which outlines which agency is lead on different objectives. She said the Center is working with the Indian Affairs Commissioner to repair relationships with the tribes and to improve collaboration. She said the Center is attempting to expand the number of health care providers asking about tobacco use and referring to NDQuits. She said increased communication and joint planning with DOH will improve collaboration.

At the request of Chairman Lee, Mr. John Quinlan, Sales and Special Taxes Compliance Officer, Tax Department, provided information regarding taxable and nontaxable tobacco products sold in the state and tobacco sales on reservations. He said cigarette sales volume increased 7.3 percent and tobacco revenue increased 11 percent, from $6.2 million to $7 million, from fiscal year 2013 to 2014. He said, based on a compact, the department collects tobacco taxes on the Standing Rock Indian Reservation and shares the proceeds with the tribe.

In response to a question from Chairman Lee, Mr. Quinlan said the recent increase in revenue is likely related to an increase in the state's population.

In response to a question from Senator Mathern, Mr. Quinlan said a tribal tobacco tax agreement with Standing Rock was signed in 1993. He said the agreement provides for the collection of the state tobacco tax on the reservation. He said the state retains 25 percent and returns the remaining 75 percent to the tribe.

In response to a question from Senator Anderson, Mr. Quinlan said, based on reports received from tobacco wholesalers in the state, 1.5 million cigarettes were sold on reservations in the state during calendar year 2013. He said these sales were not taxed and accounted for 8.7 percent of all cigarettes sales in the state.

Chairman Lee asked Mr. Quinlan to submit the information provided in written form (Appendix C) for the committee.

Mr. Scott J. Davis, Indian Affairs Commissioner, said the Center is collaborating with his office to address smoking concerns with the tribes.

In response to a question from Senator Mathern, Mr. Davis said his office continues to work with tribes to establish tax agreements with the state.

At the request of Chairman Lee, Mr. Davis introduced Mr. Patrick Marcellais, Secretary/Treasurer, Turtle Mountain Band of Chippewa Indians, to provide information regarding tobacco sales subject to the Turtle Mountain Band of Chippewa Indians Tribal Council tobacco user's fee. Mr. Marcellais said the fee, adopted in May 2014, was introduced to provide a funding source for medical expenses. He said the fee--five cents per package on both smoke and smokeless tobacco--generates approximately $12,000 to $13,000 per month in revenue. He said the funding provides medical assistance for tribal members receiving referrals for medical care off the reservation.

In response to a question from Senator Mathern, Mr. Marcellais said there is concern that raising the tobacco tax to the same level as the state tobacco tax would cause small businesses on the reservation to lose sales to surrounding businesses off the reservation.

Chairman Lee suggested a copy of the tribe's tobacco ordinance be sent to the committee members. Mr. Marcellais said the ordinance is still being revised.

In response to a question from Representative Fehr, Mr. Marcellais said if the state raised its tobacco tax, the tribe would have to consider the concerns of small businesses on the reservation before considering an increase in the tribal tobacco fee. He said raising the tobacco tax will not deter everyone from smoking, but educating youth on the dangers of smoking and adults on cessation programs will yield long-term results.

Senator Anderson suggested the Legislative Assembly review whether the Center could provide funding for prescription medication for the general public in the NDQuits program during the upcoming legislative session.

DENTAL SERVICES STUDY

At the request of Chairman Lee, the Legislative Council staff presented a resolution draft [15.3027.01000] to study dental services during the 2015-16 interim. She said the resolution draft directs the Legislative Management to study dental services in the state, including the effectiveness of case management services and the feasibility of utilizing mid-level providers to improve access to services and address dental service provider shortages in underserved areas of the state.

Chairman Lee provided information (Appendix D) to the committee regarding a comparison of oral health provider's scope of practice and education requirements and a 2013 American Dental Association publication entitled *Looking Back, Looking Forward - An Empirical Look at Access to Dental Care in the United States.*

At the request of Chairman Lee, Ms. Kimberlie Yineman, Oral Health Program Director, State Department of Health, provided information (Appendix E) regarding the estimated cost to provide school-based dental health prevention services to all of the children in the state; estimated cost to provide school-based dental health

prevention services to those children qualifying for free or reduced-fee lunches regardless of the school they attend; and number of schools anticipated to qualify for school-based dental health prevention services each year of the program. She said, based on an average of 2012-13 pilot project costs and Centers for Disease Control and Prevention (CDC) and children's dental health project estimates, DOH estimates the cost of school-based dental health services, including dental sealants, fluoride varnish, and oral health education, to be approximately $85 per child per year. She said, based on the estimated cost per child of $85, the estimated cost to provide school-based dental health prevention services to all children enrolled in North Dakota schools is approximately $9.6 million per year. She said, based on Department of Public Instruction (DPI) reports, 34,692 children qualified for free or reduced-fee lunches in October 2013. She said the estimated cost to provide school-based dental health prevention services to these children is approximately $2.9 million per year. She said when DOH received federal funding to reestablish school-based dental health prevention services in September 2014, the target population was schools where 45 percent or more of the students qualify for free or reduced-fee lunches. She said, based on 2013 information available from DPI, 89 schools would qualify for services during the 2014-15 school year.

In response to a question from Senator Mathern, Ms. Yineman said a federal Health Resources and Services Administration workforce grant will provide $400,000 per year for school-based dental health prevention services. She said part of the funding will be contracted to Ronald McDonald House Charities and Bridging the Dental Gap to expand their service areas and the remainder will be used for the DOH sealant program. She said the additional cost to serve all students eligible for for free or reduced-fee lunches would be approximately $2.6 million per year; however, due to privacy laws, DOH is unable to specifically identify the children qualifying for free or reduced-fee lunches in each school district.

At the request of Chairman Lee, Ms. Mary Amundson, Assistant Professor, Department of Family and Community Medicine, University of North Dakota School of Medicine and Health Sciences, reviewed a chart (Appendix F) summarizing the terms and funding sources for loan repayment programs administered by the state. She said to standardize the repayment programs, differences in award amounts, match requirements, community selection requirements, provider eligibility related to prior practice, and distribution of payments would need to be reconciled.

In response to a question from Senator Mathern, Ms. Amundson said there is a difference between the award amounts for the two types of dental loan repayment programs. She said dentists in public health and nonprofit clinics charging a sliding fee scale often make less than dentists in private practice in rural areas; however, the loan repayment maximum is lower for the public health dentists than the rural dentists ($60,000 versus $80,000). In addition, she said, communities are expected to provide a one-to-one match for medical loan repayments; however, dental loan repayments do not require a community match.

In response to a question from Senator Mathern, Ms. Amundson said the community selection criteria could be revised to include cities in the western part of the state that no longer fall below the 15,000 population threshold, but still experience health professional shortages. She said the committee might consider oil impact criteria. She said Williston recently lost its designation as a low-income population federal health shortage area due to increased earnings in the area. She said designations related to population are difficult to prove as communities attempt to count residents living in hotels and man camps.

At the request of Chairman Lee, Ms. Julie Schwab, Director, Medical Services Division, Department of Human Services, provided information regarding an update on the Department of Human Services (DHS) dental loan repayment program. She said DHS has not received any applications for its dental loan repayment program. She said DHS is attempting to identify the barriers of the program.

At the request of Chairman Lee, Dr. Dale Brewster, Board Member, State Board of Dental Examiners, provided a copy (Appendix G) of administrative code changes proposed by the board to expand the functions of dental assistants and dental hygienists. He said the changes proposed by the board are currently under review by the Attorney General. Dr. Brewster said more than 50 percent of dentists applying for licensure in the state are not originally from North Dakota. He said recent interest in the state's economy nationwide is bringing more professionals to the state and they are establishing practices primarily in the western part of the state.

In response to a question from Chairman Lee, Dr. Brewster said many of the dental assistants in the state have received formal training. He said dentists have not mandated formal training for dental assistants.

At the request of Chairman Lee, Dr. Katie Stewart, Vice President, North Dakota Dental Association, provided an update (Appendix H) on a case management pilot project. She said the case management outreach model is a pilot study of a sustainable model where dental assistants and hygienists work with collaborative dental offices in outreach settings, such as preschools, schools, medical facilities, and long-term care facilities. She said the goal of

the pilot project is to provide oral health assessments, fluoride varnish, sealants, and case management services to high-risk dental patients, providing them with a dental home. She said third-party reimbursement is needed for the four outreach services identified to make the model sustainable. Dr. Stewart provided a copy (Appendix I) of a recent concept paper submitted to DentaQuest for grant funding of the pilot project. She said the North Dakota Dental Association supports the five initiatives identified by the Oral Health Coalition. She said assertions that mid-level dental providers be included in the initiatives are not supported by evidence. She said the association feels the issue of mid-level dental providers has received adequate study and it is time to seek targeted solutions.

In response to an earlier question from Chairman Lee regarding dental assistants trained "chairside," Dr. Stewart said most dentists prefer to hire dental assistants with formal training, but they are in high demand because there are fewer dental assistant graduates. She said many of the applicants to the dental assisting program use it as a path to the dental hygienist program and a higher salary. She said dentists either hire a dental hygienist to perform dental assistant duties or train their own dental assistant.

At the request of Chairman Lee, Mr. Brad Gibbens, Deputy Director, Center for Rural Health, University of North Dakota School of Medicine and Health Sciences, provided information (Appendix J) regarding an assessment of the oral health needs in the state. He said the Center for Rural Health was contacted by The Pew Charitable Trusts to complete an impartial assessment of the oral health needs in the state and to identify proposed interventions supported by various oral health stakeholders. He said while the study was paid for by Pew, the Center for Rural Health worked independently to develop methodology and conclusions.

Dr. Shawnda Schroeder, Research Specialist, Center for Rural Health, University of North Dakota School of Medicine and Health Sciences, provided information regarding findings included in the preliminary *North Dakota Oral Health Report: Needs and Proposed Models, 2014*. She said the stakeholder working group included representatives of organizations in the state that work with populations who readily seek access to oral health care and an input group consisting of entities in the state that work with oral health, including provider organizations. She said based on data, input member responses, and stakeholder meetings, three primary oral health needs were identified, including prevention programs, dental insurance revision or care access, and greater workforce and improved access to care. She said the greatest need for oral health literacy and prevention was among special populations--children, aging, Medicaid patients, low-income, homeless, new Americans, American Indians, rural, and those with physical/mental disabilities. She said increased Medicaid reimbursement would provide an incentive for dentists to accept more Medicaid patients and services to long-term care residents could be restructured to meet Medicare reimbursement requirements. In addition, she said, there is a need to adjust the uneven distribution of the current workforce. She said in 2013, 67 percent of all licensed dentists in the state worked in the four largest counties. She said the stakeholder and input groups developed and discussed 24 possible oral health models. She said the stakeholder working group identified the following top five stakeholder priority models:

1. Increase funding and reach of safety net clinics to include services in western North Dakota, using models/ideas/support from nonprofit oral health programs similar to Apple Tree Dental and Children's Dental to promote models of care.
2. Increase funding and reach of the Seal! North Dakota program to include using dental hygienists to provide care and incorporating case management and identification of a dental home as proposed under the North Dakota Dental Association's case management model, including Medicaid reimbursement for services.
3. Expand scope of dental hygienists and utilize dental hygienists at the top of their current scope of work to provide community-based preventive and restorative services and education among populations of high need.
4. Create a system to promote dentistry professions among state residents and encourage practice in North Dakota through a consolidated loan repayment program and partnership/student spots at schools of dentistry.
5. Increase Medicaid reimbursement levels.

Dr. Schroeder said information regarding the remainder of the 24 models developed by the stakeholder and input groups is available in the full report. She said the Center for Rural Health will continue to refine the report and a new version will be available at the beginning of the legislative session.

In response to a question from Representative Hofstad, Dr. Schroeder said the Indian Affairs Commission participated in the stakeholder group and took part in the discussion for each intervention.

In response to a question from Senator Mathern, Mr. Gibbens said the Center for Rural Health will provide information to the committee regarding the cost of the assessment and the report.

Chairman Lee said increasing Medicaid reimbursement for oral health care providers and not other Medicaid providers would be difficult. She said the committee has received information regarding mid-level providers from other rural states where reducing the cost per unit of providing oral health services has made reimbursement more profitable and increased access.

Mr. Josh Askvig, Associate State Director of Advocacy, AARP of North Dakota, provided information (Appendix K) regarding challenges of older adults accessing dental care in the state. He said decreased mobility, declining mental status, lack of financial resources, lack of portable dental service programs in the state, and geography limit access to oral health care for older adults. He said Medicare and Medigap supplemental insurances do not cover routine dental care. He said poor oral health can lead to diabetes, cardiac arrest, stroke and respiratory diseases such as pneumonia. He said the stakeholder recommendation to expand the reach of safety net clinics using models from nonprofit oral health programs could provide access to dental care for seniors in nursing homes and assisted living centers. He said this model uses every member of the dental team, including dentists, dental assistants, dental hygienists, and dental therapists, to increase access to care in a financially sustainable manner. He said AARP of North Dakota supports the resolution to continue the study of dental services in the state.

In response to a question from Senator Anderson, Mr. Askvig said barriers to dental hygienists providing dental cleaning services in a nursing home include lack of appropriate supervision and reimbursement.

Ms. Jan Anderson, Homeless Liaison, Fargo Public Schools, provided information (Appendix L) regarding the challenges of Medicaid patients accessing oral health services. She said many low-income families seek reactive rather than preventative services. She said accessing these services is often difficult because too few dentists accept Medicaid patients. She said Children's Dental Services provides care at more than 300 sites in Minnesota using an array of dental providers, including dental therapists. She said dental therapists provide basic services cheaper than a dentist and the dentist is able to focus on more complex procedures.

Ms. Rachelle Gustafson, President, North Dakota Dental Hygienists' Association, provided information (Appendix M) regarding the association's support for the authorization of a mid-level dental service provider in the state. She said dental therapists provide quality care and increase access to care. She said the findings of a recent Minnesota Board of Dental Examiners study of the dental therapy program in Minnesota indicate dental therapists appear to be fulfilling statutory intent by serving predominantly low-income, uninsured, and underserved patients. She said clinics report improved quality and high patient satisfaction with dental therapists.

In response to a question from Senator Anderson, Ms. Gustafson said currently it is unclear whether a dental hygienist could provide certain services outside of the dental office without a dentist on site. She said the North Dakota Dental Hygienists' Association is exploring changes to administrative rules to allow for collaborative practice. She said dental hygienists are not able to bill Medicaid for services, but a collaborative agreement with a dentist would allow for the dentist to bill Medicaid for the dental hygienist's services. She said dental hygienists are willing to provide services; however, dentists have been unwilling to employ them in that scope.

Ms. Alayna Eagle Shield, Standing Rock Nation, provided information (Appendix N) regarding the lack of dental care on reservations and the benefit of dental therapists serving reservations. She said according to the federal Health Resources and Services Administration, 13,379 Native American youth in North Dakota live in dental shortage areas. She said while Native Americans are appreciative of the dentists who volunteer their services during organized events, infrequent charity care is not the same as regular routine care. She said dental therapists could provide care beyond prevention education for Native American youth, adults, and the elderly.

Ms. Marcia Olson, Executive Director, Bridging the Dental Gap, provided information (Appendix O) regarding the recommendations of the North Dakota Oral Health Coalition. She said the coalition's recommendations are similar to the models identified by the Center for Rural Health and include:

- Expand the Seal! ND program through DOH oral health programs to target low-income children at public schools;
- Expand funding for dental safety net clinics to include mobile, nonprofit, and federally qualified health centers;
- Expand, simplify, and consolidate the North Dakota dental loan repayment programs;
- Provide funding for the case management outreach model supported through DOH and the North Dakota Dental Association; and
- Facilitate the expansion of duties for dental assistants and hygienists through innovative, nontraditional, outreach education programs to minimize geographic and employment barriers for the current workforce.

In response to a question from Senator Anderson, Ms. Olson said dentists must be credentialed by the Indian Health Service (IHS) to work in an IHS facility on a reservation. She said there are many barriers to becoming credentialed, but difficulties in being recredentialed have caused some dentists to leave the IHS system.

Senator Mathern proposed an amendment (Appendix P) to the resolution draft to continue the dental services study during the 2015-16 interim. He said the amendment would preserve the work of the North Dakota Oral Health Coalition as the study continues during the 2015-16 interim.

Chairman Lee proposed the resolution draft to continue the dental services study during the 2015-16 interim be amended to match the draft (Appendix Q) she distributed. She said proposed amendments to the resolution draft include adding language to identify the study as a continuation of the current study and to include the effectiveness of the state infrastructure necessary to cost-effectively use mid-level providers to improve access to services in a future study. She also proposed language regarding the inability of dentists to sustain a practice in rural areas of the state be removed.

Senator Mathern proposed amending the the resolution draft to continue the dental services study during the 2015-16 interim to incorporate the top five stakeholder priority models recommended in the *North Dakota Oral Health Report: Needs and Proposed Models, 2014* presented by the Center for Rural Health. He said the amendment would preserve the work of the Center for Rural Health as the study continues during the 2015-16 interim.

It was moved by Senator Mathern, seconded by Senator Heckaman, and carried on a voice vote that the resolution draft [15.3027.01000] to continue the dental services study during the 2015-16 interim be amended to include the recommendations of the North Dakota Oral Health Coalition identified by Senator Mathern.

It was moved by Senator Erbele, seconded by Representative Fehr, and carried on a voice vote that the resolution draft [15.3027.01000] to continue the dental services study during the 2015-16 interim be amended to include the recommendations distributed by Chairman Lee.

It was moved by Senator Mathern, seconded by Senator Heckaman, and carried on a voice vote that the resolution draft [15.3027.01000] to continue the dental services study during the 2015-16 interim be amended to include the top five stakeholder priority models recommended in the *North Dakota Oral Health Report: Needs and Proposed Models, 2014* presented by the North Dakota Center for Rural Health.

It was moved by Senator Mathern, seconded by Senator Larsen, and carried on a roll call vote that the resolution draft [15.3027.01000], as amended, to continue the dental services study during the 2015-16 interim be approved and recommended to the Legislative Management. Senators Lee, Anderson, Erbele, Heckaman, Larsen, and Mathern and Representatives Fehr, Hofstad, and Holman voted "aye." No negative votes were cast.

INSURANCE COMMISSIONER'S RECOMMENDATION FOR A PRIVATE ENTITY TO PERFORM COST-BENEFIT ANALYSES OF HEALTH INSURANCE MANDATES

At the request of Chairman Lee, Ms. Mary Hoberg, Legal Counsel, Insurance Department, provided information (Appendix R) regarding the Insurance Commissioner's recommendation for a private entity to contract with to perform cost-benefit analyses of health insurance mandates during the 2015 legislative session. She said the Insurance Department solicited proposals from 10 actuarial firms to provide services as identified in the statute during the period from November 2014 through April 2015. She said the request for proposal included the following requirements:

1. Complete a cost-benefit analysis within two weeks of receipt of the initial request made by the Legislative Council for a given mandate.
2. Complete a cost-benefit analysis within seven days for each request thereafter related to the same mandate.

Ms. Hoberg said Milliman, Inc., was the only contractor to submit a bid, and the Insurance Commissioner recommends the Legislative Council contract with Milliman, Inc., to perform the cost-benefit analyses during the 2015 legislative session.

It was moved by Senator Mathern, seconded by Representative Hofstad, and carried on a roll call vote to accept the Insurance Commissioner's recommendation of Milliman, Inc., as the entity to contract with for cost-benefit analyses on health insurance mandates during the 2015 legislative session. Senators Lee,

Anderson, Erbele, Heckaman, Larsen, and Mathern and Representatives Fehr, Hofstad, and Holman voted "aye." No negative votes were cast.

AUTOPSY STUDY

At the request of Chairman Lee, the Legislative Council staff presented a bill draft [15.0262.01000] to provide appropriations to DOH for travel costs related to the training of county coroners and information technology costs related to the electronic review of death records and a resolution draft [15.3028.01000] to provide for the study of medicolegal death investigation in the state during the 2015-16 interim. She said the bill draft provides funding from the general fund to DOH for certain stakeholder group recommendations presented to the committee at a previous meeting. She said $15,000 is provided for information technology costs related to the electronic review of death records and $39,375 is provided to reimburse the travel costs of county personnel attending county coroner training. She said the resolution draft directs the Legislative Management to study medicolegal death investigation in the state and how current best practices, including authorization, reporting, training, certification, and the use of information technology and toxicology, can improve death investigation systems in the state.

At the request of Chairman Lee, Ms. Hope Olson, Director, Crime Laboratory Division, Attorney General's office, provided information (Appendix S) regarding the estimated cost of developing quantitative toxicology analysis and responses to DOH's recommendations relating to improving the death investigation and autopsy system in the state. She said the toxicology section of the laboratory screens blood and urine samples for the presence of 116 drugs. She said the current completion time is 23 calendar days for drug screening cases and 6 calendar days for blood alcohol samples. She said the estimated cost of implementing quantitative toxicology analysis is $437,028, including 2 full-time equivalent (FTE) positions ($178,514 each) and related operating costs ($80,000). She said implementing quantitative toxicology analysis without additional resources will delay current screening results.

In response to a question from Senator Mathern, Ms. Olson said funding for quantitative toxicology analysis is not included in the Attorney General's budget request. She said the Attorney General anticipates adding the quantitative toxicology analysis in the future when it is determined the additional analysis will not cause delays in current screening services.

Mr. Thomas L. Trenbeath, Chief Deputy Attorney General, Attorney General's office, said the Attorney General is requesting a feasibility study to expand the State Crime Laboratory He said improvements in technology may allow them to implement some quantitative toxicology analysis with minimal staff increases.

In response to a question from Chairman Lee, Mr. Trenbeath said the implementation of quantitative toxicology analysis could be accelerated with added funding and staff.

In response to a question from Chairman Lee, Ms. Olson said if quantitative toxicology services were offered, the demand for the tests would increase. She said law enforcement currently pays other laboratories for quantitative toxicology services.

At the request of Chairman Lee, Mr. Kirby Kruger, Medical Services Section Chief, State Department of Health, provided information (Appendix T) regarding the estimated cost of contracting for the quantitative analysis services. He said currently the State Forensic Examiner sends samples for qualitative drug and toxicology testing to the State Crime Laboratory. He said those samples in which drugs or toxins are detected are then sent to NMS Labs in Pennsylvania for quantified analysis. He said the cost for the State Forensic Examiner's office, the University of North Dakota Pathology Department, and all county coroners to contract for forensic quantitative toxicology testing by an out-of-state laboratory is estimated to total $93,855 for the biennium. He said the DOH budget includes $46,855 for quantitative analysis services, with the remaining amount estimated to be paid by the University of North Dakota Pathology Department and county coroners. He said annual expenditures for toxicology testing requested by the State Forensic Examiner and conducted by outside laboratories increased from $3,501 in 2003 to $33,686 in 2013. He said increases have been the result of an increase in the number of autopsies and increases in the cost of the tests.

Senator Mathern said it appears to be more cost-effective for DOH to continue contracting for quantified analysis than for the Attorney General to implement quantified analysis at the State Crime Laboratory.

In response to a question from Chairman Lee, Mr. Kruger said the University of North Dakota Pathology Department sends qualitative and quantitative testing to out-of-state laboratories, while DOH receives qualitative testing services from the State Crime Laboratory. He said DOH sends positive qualitative tests to the out-of-state laboratory for quantitative analysis.

Dr. Mary Ann Sens, Chair, Department of Pathology, University of North Dakota School of Medicine and Health Sciences, provided information (Appendix U) regarding models and systems for medicolegal death investigation in the state, including potential funding and resources needed for the delivery and establishment of statewide standards and expectations for achieving national standards for death investigation. She said while much has been accomplished and she supports the recommendations of the stakeholder group, there are decisions to be made regarding long-range plans for death investigation in the state. She said issues to be addressed include facilities in Bismarck and Grand Forks, including imaging equipment, biosafety, disaster planning, and accreditation; financing and cost-sharing; and larger health care issues for the state and health care workforce. She said an interim committee study should continue, with physician coroner input, to formulate recommendations for legislation to improve the state's medicolegal death investigation system.

In response to a question from Senator Heckaman, Dr. Sens said quantitative toxicology testing is part of the cost of the autopsy and is included in the Medical School's contract with DOH.

In response to a question from Senator Heckaman, Dr. Sens said in some models, governance of the death investigation system is independent of any state department. She said the system is governed by a commission which includes various DOH administrators, academics, and law enforcement professionals.

Dr. John Baird, Coroner, Cass County, said completion time for qualitative testing has improved. He said while death investigation is largely a local function, state support has improved the system.

In response to a question from Chairman Lee, Dr. Baird said the need to transport specimens to the State Crime Laboratory and, after a positive qualitative test, forward an appropriate specimen for quantitative analysis elsewhere delays test results.

It was moved by Senator Mathern, seconded by Senator Erbele, and carried on a voice vote that the resolution draft [15.3028.01000] to provide for the study of medicolegal death investigation in the state during the 2015-16 interim be amended to include a reference to consultation services related to the development of death investigation systems available from the National Association of Medical Examiners.

It was moved by Senator Erbele, seconded by Representative Fehr, and carried on a roll call vote that the resolution draft [15.3028.01000], as amended, to provide for the study of medicolegal death investigation in the state during the 2015-16 interim be approved and recommended to the Legislative Management. Senators Lee, Erbele, Heckaman, Larsen, and Mathern and Representatives Fehr and Hofstad voted "aye." No negative votes were cast.

It was moved by Senator Mathern, seconded by Senator Larsen, and carried on a voice vote that the bill draft [15.0262.01000] to provide appropriations to DOH for travel costs related to the training of county coroners and information technology costs related to the electronic review of death records be amended to allow DOH to use funds appropriated in Section 2 of the bill draft for future planning of coroner services in the state.

It was moved by Senator Mathern, seconded by Representative Fehr, and carried on a roll call vote that the bill draft [15.0262.01000], as amended, to provide appropriations to DOH for travel costs related to the training of county coroners, information technology costs related to the electronic review of death records, and future planning of coroner services in the state be approved and recommended to the Legislative Management. Senators Lee, Erbele, Heckaman, Larsen, and Mathern and Representatives Fehr and Hofstad voted "aye." No negative votes were cast.

COMMUNITY PARAMEDIC STUDY

At the request of Chairman Lee, the Legislative Council staff presented a bill draft [15.0263.01000] relating to medical assistance coverage for the services of licensed community paramedics. The bill draft requires DHS to adopt rules entitling licensed community paramedics to payment for health-related services provided to recipients of medical assistance, subject to certain limitations and exclusions.

At the request of Chairman Lee, Dr. Patricia Moulton, Executive Director, North Dakota Center for Nursing, provided information (Appendix V) regarding a policy brief, including recommendations, relating to the community paramedic study. She said there are gaps in the state's health care delivery system, especially in rural areas, that community paramedics could help fill. She said the North Dakota Center for Nursing recommends the following policies to ensure the implementation of the community paramedicine program will result in every patient receiving safe, quality care through the coordinated effort of all health care providers:

1. Through legislation during the 2015 legislative session, develop a scope of practice to better define the community paramedic role and skill set and to include a provision for advanced practice registered nurses to also supervise community paramedics.
2. Require a uniform education and training program including core components.
3. Define the referral process for each community paramedic program.
4. Require community paramedics to utilize a community needs assessment to identify key focus areas for their work.
5. Establish greater statewide linkages and referrals for mental health and substance abuse services.
6. Develop a realistic, sustainable funding model.
7. Provide limited short-term services only if those services are not available in their geographic location or a patient does not qualify for home health, public health, hospice, school health, or other resources.
8. Establish limited and short-term emergent interventions paired with appropriate community paramedic training.
9. Through legislation during the 2015 legislative session, include provider neutral language in order to ensure that advanced practice registered nurses are able to supervise/delegate to community paramedics.
10. Through legislation during the 2015 legislative session, provide clear definition and reporting lines for accountability and a mechanism for documentation of care, including provider orders.
11. Establish a standardized approach across jurisdictions that facilitates statewide program evaluation using national guidelines for evaluation.
12. Require additional ongoing training reflecting the changing needs of the community or evolving health issues.

Ms. Cheryl Rising, Family Nurse Practitioner, Legislative Liaison, North Dakota Nurse Practitioner Association, provided information (Appendix W) regarding the supervision of community paramedics. She said the North Dakota Nurse Practitioner Association supports new ideas in health care delivery. She said legislation related to community paramedics should be provider-neutral. She said, as primary care providers, nurse practitioners should be authorized to write orders for community paramedics.

In response to a question from Representative Fehr, Mr. Ken Krupich, Essentia Health, Fargo, said community paramedics are registered with DOH Division of Emergency Medical Services. He provided a copy (Appendix X) of the accepted skill guidelines of a paramedic.

At the request of Chairman Lee, Ms. Schwab provided information (Appendix Y) regarding the bill draft and estimated funding required for Medicaid reimbursement of community paramedic services. She said DHS recommends services authorized be based on an individual care plan created by the primary care provider in consultation with the medical director of the ambulance service. She said conditions for authorization of services could be limited to recipients of frequent hospital emergency department services; recipients for whom community paramedic services would likely prevent admission to, or would allow discharge from, a nursing facility; or recipients to prevent readmission to a hospital or nursing facility. She said, based on Medicaid coverage in other states, reimbursable services may include health assessments, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge followup care, and minor procedures. She said services must be coordinated with services from other community providers to prevent duplication. She said for North Dakota Medicaid to enroll and provide payment for services provided by community paramedics, DHS must submit, for federal approval, a state plan amendment to the federal Center for Medicare and Medicaid Services. She said to bill for services, community paramedics would need to enroll as providers with North Dakota Medicaid. She said DHS is unable to determine the estimated funding required for Medicaid reimbursement of community paramedic services. She said DHS would continue to collaborate with community paramedics to estimate the cost of reimbursements for Medicaid services to be provided by community paramedics.

In response to a question from Chairman Lee, Ms. Maggie D. Anderson, Executive Director, Department of Human Services, said DHS will continue to review the delivery of services by community paramedics to determine reimbursement rates and whether it is appropriate to include the cost of transportation.

In response to a question from Senator Mathern, Ms. Schwab said DHS's recommendations do not require amendment to the bill draft. However, she suggested the bill draft identify that the limitations and exclusions be consistent with limitations set for other medical assistance services.

At the request of Chairman Lee, Ms. Megan Houn, Government Relations Director, Blue Cross Blue Shield of North Dakota, provided information (Appendix Z) regarding the feasibility and desirability of community paramedics providing additional clinical and public health services, particularly in rural areas of the state, and actions required to allow for third-party reimbursement for community paramedic services. She said Blue Cross Blue Shield of North Dakota (BCBSND) supports the overall goals and objectives of the community paramedic pilot program. She said goals must be balanced with costs and services must be provided by trained and qualified health care providers for services covered under BCBSND health plans. She said Medicare does not allow fee-for-service billing from community paramedics, but supports them through accountable care organizations (ACOs). She said hospitals partner with ambulance services for community paramedic programs to reduce emergency room admissions among the uninsured and chronically ill and hospital readmissions to avoid Medicare penalties. She said BCBSND can consider reimbursement when a globally accepted scope of practice, national accreditation and curriculum standards, and Medicaid reimbursement are established; roles are defined so community paramedics complement local public health; outcomes data is available; BCBSND is able to internally establish a defined set of reimbursable services; and there is a demonstrated need by members.

Chairman Lee distributed testimony (Appendix AA) submitted by Ms. Lisa Carlson, Director of Planning and Regulation, Sanford Health Plan. The testimony indicates Sanford Health Plan supports the need to provide care at different levels in rural and urban settings and is in favor of alternative care models that improve patient care and reduce inappropriate use of emergency rooms and ambulance services for nonurgent care. The testimony indicates further dialogue is needed to identify the necessary certification, credentialing requirements, and coding needed for reimbursement in order to provide stable and long-term support for the program.

Mr. Krupich provided information (Appendix BB) regarding the community paramedic program implemented at Essentia Health in Fargo on October 1, 2014. He said Essentia Health is an ACO and the community paramedic is a component of the ACO model. He said the community paramedic practices within the existing scope of practice and services provided must be part of a care plan developed by the patient's primary care provider. He said protocols are reviewed and approved by the medical director. He said referral sources include case management, care coordinator nurses, emergency department, primary care providers, and home health nurses. He said community paramedics in the state have received formal training through Hennepin Technical College. He said the state anticipates adopting the national curriculum when it is developed. He said the community paramedic can practice under existing paramedic licensure. He said changing the community paramedic scope of practice is not necessary because it is defined by the practice environment and the physician medical director. He said supervision by an advanced practice registered nurse is not necessary because supervisors are already in place.

In response to a question from Representative Fehr, Mr. Krupich said because Essentia Health is an ACO, they are paid differently. He said the benefits of decreased readmissions is balanced with the cost of community paramedics. He said they anticipate recovering some of the cost by billing Minnesota Medicaid and Blue Cross Blue Shield of Minnesota, both of which reimburse for the services of community paramedics.

Ms. June Herman, Regional Vice President of Advocacy, American Heart Association, said the association supports the bill draft entitling licensed community paramedics to payment for health-related services. She suggested legislation related to the community paramedic program be the result of a consensus of the Community Paramedic Advisory Committee.

It was moved by Senator Mathern, seconded by Representative Fehr, and carried on a voice vote that the bill draft [15.0263.01000] relating to medical assistance coverage for the services of licensed community paramedics be amended to provide that any limitations and exclusions be consistent with limitations set for other medical assistance services.

It was moved by Senator Mathern, seconded by Representative Fehr, and carried on a roll call vote that the bill draft [15.0263.01000], as amended, relating to medical assistance coverage for the services of licensed community paramedics be approved and recommended to the Legislative Management. Senators Lee, Erbele, Heckaman, and Mathern and Representatives Fehr, Hofstad, and Holman voted "aye." No negative votes were cast.

OTHER COMMITTEE RESPONSIBILITIES

At the request of Chairman Lee, Mr. Raymond Lambert, State Fire Marshal, provided information (Appendix CC) regarding a report regarding findings and recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes. He said North Dakota Century Code Chapter 18-13 took effect August 1, 2010, and specified that any cigarette made available and distributed by wholesalers to retail outlets in the state of North Dakota must be tested in accordance with the American Society of Testing of Materials standard and meet the ignition propensity safety standards for all cigarettes. He said currently, 734 manufacturer

brand styles are sold in the state and all are certified and recertified every three years. He said the State Fire Marshal's office conducts random checks on retail outlets for brand or trade name on the package, cigarette style, Fire Safer Cigarette stamp, and whether the cigarette has been certified and approved for sale in North Dakota. He said data collected from the National Fire Incident Reporting System for the state of North Dakota for the years 2005 through 2009 show that 2,384 structure fires were reported, of which 142 were caused by cigarettes. He said data collected for 2010 through 2014 to date shows there were 2,303 structure fire incidents reported in the state of North Dakota, of which 196 were caused by cigarettes. He said national statistical averages indicate there has been an overall reduction in the number of fires caused by cigarettes and in fire fatalities since all 50 states have adopted laws requiring only fire safer certified cigarettes be sold in their states. He said although the data for North Dakota shows an increase in the number of fires caused by cigarettes over the past 5 years, the state benefits from the overall program to require only certified low propensity ignition cigarettes be sold in the state.

At the request of Chairman Lee, Ms. Nancy Kopp, Executive Secretary, North Dakota Veterinary Medical Association, provided information (Appendix DD) regarding the number of licensed veterinary technicians and veterinary technicians that have received on-the-job training employed in the state and recommendations based on collaboration with the North Dakota Stockmen's Association to improve the state's veterinary loan repayment program and tuition assistance provided through the professional student exchange program (PSEP). She said the North Dakota Veterinary Medical Association surveyed its 230 practicing members in August. She said 139 licensed technicians and 87 nonlicensed or on-the-job trained veterinary technicians or assistants were employed by the 48 respondents. She said the State Board of Veterinary Medical Examiners reported 312 licensed veterinary technicians in 2014. She said some of the 87 nonlicensed or on-the-job trained veterinary technicians or assistants reported may be assistants and some may be recent graduates from an accredited veterinary technician program that have not yet taken the national licensing exam. She said an assistant will often work under the general supervision of a veterinary technician, while the veterinary technician works under the supervision of a licensed veterinarian. Regarding PSEP, she suggested the Legislative Assembly shift some of the PSEP funding to the dental and veterinary medical loan repayment programs. She suggested a repayment provision to PSEP not be implemented.

Dr. Judith Gibbens, President, North Dakota Veterinary Medical Association, provided information regarding the repayment feature in PSEP. She does not support a repayment feature in PSEP because veterinary medicine students graduate with significant debt. In addition, she said, many chose to continue their education by entering a specialty, making repayment even more challenging. She said the cost of equipment and technology is a larger factor in setting up a practice than it has been in the past. She said requiring graduates to return to the state may increase the supply without a significant increase in demand for services, driving down earnings potential and practice viability. She referred to a letter (Appendix EE) from Dr. Dean Christianson, President, Academy of Rural Veterinarians, attached to her testimony, which indicates many applicants seeking to practice in North Dakota are not from the state. Requiring a repayment would force PSEP participants to return to the state for the wrong reason.

In response to a question from Senator Heckaman, Dr. Gibbens said there is an over supply of veterinarians in small animal practice and a shortage of veterinarians in rural large animal practice. She said allocating some of the PSEP funding to the veterinarian loan repayment program to benefit veterinarians willing to practice large animal veterinary medicine in underserved areas of the state would provide a better result than requiring the repayment of PSEP support.

Representative Fehr suggested funding from the veterinarian loan repayment program might be better used to support the the establishment of new veterinary practices. Dr. Gibbens said the veterinarian loan repayment program is important and has attracted veterinarians from all over the country.

Ms. Julie Ellingson, North Dakota Stockmen's Association, said PSEP and the veterinarian loan repayment program have different goals, but both are important to livestock producers in the state. She said PSEP supports the state's students in their pursuit of a veterinary career, while the veterinarian loan repayment program addresses the needs of underserved areas of the state. She said the combination of programs has been successful and the association favors continued support in the current form.

At the request of Chairman Lee, Ms. Brenda Zastoupil, Director of Financial Aid, North Dakota University System, provided information (Appendix FF) regarding the service payback requirement included in the bill draft relating to the repayment of benefits by certain participants of professional student exchange programs, whether students attending the University of North Dakota School of Medicine and Health Sciences have similar requirements, and recommendations for changes to the bill draft relating to the repayment of PSEP benefits. She said the North Dakota University System is neutral on the repayment of PSEP benefits proposal. She said if the Legislative Assembly determines PSEP should include a repayment feature, the University System supports the

repayment feature be in the form of a DEAL loan through the Bank of North Dakota. She said because a note carries many consumer information requirements, it would be important for the Bank to administer the loan from the beginning. She said the School of Medicine RuralMed program has similar requirements for the payback of tuition benefits. She said the RuralMed program provides a state-sponsored tuition scholarship that provides full in-state tuition. She said the program can provide up to eight slots per year and 23 students have benefited from the program to date. She said four students who initially accepted the tuition scholarships later opted out of the program and repaid the tuition benefits.

In response to a question from Chairman Lee, Ms. Zastoupil said, provided funding is available, a RuralMed student entering the program in years two through four of the program could be retroactively reimbursed for tuition already paid.

Senator Heckaman said it may be better to consider expanding the loan forgiveness programs as an incentive to bring professionals to the underserved areas of the state. She suggested the committee not take action on the bill draft.

It was moved by Representative Hofstad, seconded by Representative Fehr, and carried on a voice vote that the Chairman and the Legislative Council staff be requested to prepare a report and the bill and resolution drafts recommended by the committee and to present the report and recommended bill and resolution drafts to the Legislative Management.

It was moved by Representative Hofstad, seconded by Representative Fehr, and carried on a voice vote that the committee be adjourned sine die.

No further business appearing, Chairman Lee adjourned the meeting sine die at 4:18 p.m.

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Sheila M. Sandness
Senior Fiscal Analyst

ATTACH:32