NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH SERVICES COMMITTEE

Thursday, January 7, 2016
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., Tyler Axness, Joan Heckaman, Dave Oehlke, John M. Warner; Representatives Rich S. Becker, Alan Fehr, Dwight Kiefert, Gail Mooney, Todd Porter, Karen M. Rohr, Jay Seibel

Members absent: Representatives Gary Paur and Marie Strinden

Others present: Diane Larson, State Representative, Bismarck
Representative Marvin E. Nelson, member of the Legislative Management, was also in attendance
See Appendix A for additional persons present.

It was moved by Representative Porter, seconded by Senator Oehlke, and carried on a voice vote that the minutes of the November 4, 2015, meeting be approved as distributed.

At the request of Chairman Lee, Legislative Council staff presented a memorandum entitled *Additional Duties Assigned to the Health Services Committee - Background Memorandum* regarding additional responsibilities assigned to the committee relating to behavioral health occupational boards. The Legislative Council staff said Section 7 of 2015 Senate Bill No. 2048 provides for a Legislative Management study of behavioral health needs. This study was assigned to the interim Human Services Committee. In addition to the behavioral health needs study, the Human Services Committee was assigned to receive reports from various behavioral health professional boards. The Legislative Council staff said in November 2015, Senator Ray Holmberg, Chairman of the Legislative Management, transferred the responsibility to receive reports from the various behavioral health professional boards to the Health Services Committee. Assignments transferred to the Health Services Committee include:

- Receive a report from the Board of Addiction Counseling Examiners, Board of Counselor Examiners, North Dakota Board of Social Work Examiners, State Board of Psychologist Examiners, State Board of Medical Examiners, and North Dakota Marriage and Family Therapy Licensure Board regarding plans for administration and implementation of licensing and reciprocity standards for licensees and any legislative changes necessary to implement those plans (Section 1 of 2015 House Bill No. 1048).
- Receive a report from the Board of Addiction Counseling Examiners regarding the status of the periodic evaluation of the initial licensure coursework requirements and clinical training requirements (Section 4 of 2015 House Bill No. 1049).

The Legislative Council staff said during the 2013-14 interim, the Human Services Committee was assigned a study of behavioral health needs pursuant to Section 1 of 2013 Senate Bill No. 2243. The interim committee contracted with Schulte Consulting, LLC, to assist with the study and received recommendations from a Behavioral Health Stakeholders Group to improve behavioral health services in the state, including recommendations related to behavioral health professional workforce and training. The Legislative Council staff said the 2013-14 interim Human Services Committee also received a summary of the licensing requirements for various behavioral health-related professions.

Chairman Lee said the number of behavioral health graduates often exceed the number of professional internships available in the state. She suggested the committee receive information from the North Dakota University System regarding the number of behavioral health graduates and the number of internships available to graduates.

Chairman Lee suggested the committee receive updated information from the various licensing boards regarding the requirements for internship programs, including information regarding the Education Standards and Practices Board licensure of school psychologists.

Representative Fehr suggested the committee request information regarding reimbursement for interns.

Chairman Lee said various behavioral health professional curricula could be reviewed to make movement between behavioral health professions more feasible.

Chairman Lee said the Legislative Assembly approved a low-interest loan program at the Bank of North Dakota for behavioral health interns.

Senator Anderson said if internships were part of the curriculum, interns could access conventional student loans.

DENTAL SERVICES STUDY

Ms. Jodi Hulm, Health Tracks and Healthy Steps Program Administrator, Medical Services Division, Department of Human Services, provided information (Appendix B) regarding the number of dentists enrolled in Medicaid and the children's health insurance program (CHIP) and outcomes reported by providers benefiting from the department's loan repayment program. She said there are 331 dental providers enrolled in the state's Medicaid management information system (MMIS) and the state's Healthy Steps program has 289 providers enrolled with Delta Dental of Minnesota. She said the MMIS, implemented in October 2015, enrolls individual practitioners, unlike the previous system which enrolled providers at the organizational level. She said individual practitioner data will allow the department to provide more detailed information in the future, however the MMIS has not been operational long enough to provide accurate claims payment trend data. She said the department developed the nonprofit clinic dental access project in 2012 to increase access to dental services for those enrolled in Medicaid and Healthy Steps. She said the project awards funds to support the recruitment of additional dentists to serve in nonprofit dental clinics. She said Bridging the Dental Gap, a safety net clinic allowing those without coverage to pay on a sliding fee scale, was awarded funding as part of the project. She said funding allowed Bridging the Dental Gap to add a dentist to increase their outreach efforts to the Medicaid and CHIP population and to expand their service area from a 50 mile radius to a 100 mile radius of Bismarck.

In response to a question from Representative Becker, Ms. Hulm said Bridging the Dental Gap partners with the mobile dental clinic to provide services in the western part of the state.

Ms. Dana Schaar Jahner, representing the Community HealthCare Association of the Dakotas, provided information (Appendix C) regarding dental services offered at community health centers in the state; plans to expand services in long-term care facilities and schools; workforce challenges; training and technical assistance opportunities for community health center oral health programs; and other opportunities to improve access to dental services in the state. She said three federally qualified health centers (FQHC) provide dental services in Fargo, Grand Forks, Minot, Rolette, and Turtle Lake. In addition, she said Northland Community Health Center received a New Access Point grant in 2015 to open a medical clinic in Ray and is preparing to open a dental clinic. She said these clinics serve patients with or without insurance, regardless of their ability to pay, and discounts are offered based on a sliding fee scale to those who qualify. She said a fourth FQHC, Coal Country Community Health Centers, does not offer dental services, but offers dental vouchers for preventive services for those who are unable to afford services and who qualify for their sliding fee program. She said Community Health Service, Inc. offers occasional mobile dental clinics, evening dental services on a seasonal basis, and dental vouchers for eligible farm workers. She said from 2010 to 2014, the number of dental patients at the three FQHCs that offer dental services has increased 36 percent to 11,869 in 2014 and dental visits have increased 37 percent to 27,259 in 2014. She said limited reimbursement for more complex procedures makes those procedures less profitable. She said unless FQHCs have a number of private pay or insured patients, they provide primarily basic procedures. She said because these providers are not practicing to their full scope of practice, turnover rates are high. She said FQHCs have indicated securing and retaining dental providers and qualified support staff is the most critical factor in maintaining and expanding dental services. She said the National Health Service Corps and state loan repayment programs are helpful, but program application deadlines are before graduation and licensing, making application a challenge for recent graduates. She said Northland Community Health Center is developing systems and collaborations to provide limited dental service in long-term care facilities, but the challenge continues to be federal limitations on scope of service and limited reimbursements. She said school-based services are being considered by several FQHCs, but no formal programs have yet been established. She said collaboration between Family HealthCare in Fargo and the hygiene and assisting programs at Minnesota State Community and Technical College and North Dakota State College of Science provide education for students and enhance patient access to care. She said lack of dental coverage in Medicaid Expansion has proven difficult for implementing patient treatment plans for 20 year-olds and the Community HealthCare Association of the Dakotas supports expanding Medicaid to include dental and vision coverage for adults age 21 and older.

Mr. Jerry E. Jurena, President, North Dakota Hospital Association, provided information (Appendix D) regarding a survey of member hospitals and information regarding emergency room visits related to dental services. He said approximately one-half of the association's member hospitals responded to the survey. He said survey responses indicate most patients access emergency rooms for toothaches, absesses, or other dental issues, most of which could have been addressed by a dentist. He said common reasons patients seek care in the emergency room include conditions that arise outside of normal dental office hours or on weekends, inability to find a dentist enrolled in Medicaid, or access to narcotics. He said most of the patients seeking dental care in emergency rooms were in urban hospitals and either uninsured or covered by Medicaid. He said dental services provided in an emergency room are more costly to the state than if the services were provided in a dental office.

Dr. Chris Meeker, Chief Medical Officer, Sanford Health, Bismarck, provided information (Appendix E) regarding dental-related visits to hospital emergency departments. He said in the 10 years he has practiced emergency medicine in Bismarck, dental care has ranked in the top 10 reasons for emergency department visits and usually ranks in the top five. He said emergency departments are only able to provide temporary treatment and the underlying dental problem often remains and requires further treatment. He said during the past 6 months, 75 and 78 percent of patients seeking dental care in the Sanford emergency departments in Fargo and Bismarck, respectively, were either self-pay or covered by Medicaid. He said a Health Policy Institute Brief issued in April 2015 reported the average cost of an emergency room dental visit is $749 which is significantly higher than the average cost of care in a dental clinic.

In response to a question form Senator Heckaman, Dr. Meeker said oral surgeons on staff at hospitals may provide some dental care to hospital patients. He said the hospital has been unable to find dentists who will agree to provide on-call services. He said dentists would have to be privileged to provide a service in the hospital, but hospitals have the ability to grant emergency privilege.

In response to a question from Representative Mooney, Dr. Meeker said oral health professionals and dental clinics in hospitals would increase the availability of services.

In response to a question from Representative Becker, Dr. Meeker said dental pain is difficult to assess. He said most emergency departments will provide pain relief by injection to avoid prescribing narcotics. He said if the patient seeks treatment over a weekend and a prescription is necessary, the emergency department determines whether or not the patient has a history of narcotic prescriptions in the prescription drug monitoring program before providing a prescription.

In response to a question from Representative Fehr, Mr. Jurena said some rural hospitals have a relationship with a local dentist and the dentist will provide a service in the hospital when asked.

Mr. Scott J. Davis, Executive Director, Indian Affairs Commission, said his office invited federal Indian Health Service (IHS) personnel to provide information regarding the IHS personnel process on reservations in the state. He said Ms. Jana Gipp, Service Unit Director, Standing Rock IHS Hospital, Fort Yates, was unable to attend, but provided information (Appendix F) regarding the credentialing and contracting process on reservations. The information indicated applicants must register at USAJOBS.gov and submit all required documentation listed in the job announcement. Incomplete applications are not considered. Professionals that wish to provide services as a contractor, rather than an employee, may receive application assistance from the Small Business Association. When qualified candidates are not available the tribe may underfill a position and provide on-the-job training. The recruitment and selection process is lengthy and time consuming causing candidates to take jobs elsewhere.

Chairman Lee suggested the committee receive additional information regarding dental assistants and dental hygienists providing services on a reservation as federal contractors, including how they would be supervised and whether or not dental assistants and dental hygienists are credentialed separately from the dentists employing them.

Mr. Davis said the Fort Berthold Reservation has assumed responsibility for services on the reservation through a Public Law 93-638 contract and seems to have more flexibility to hire dental professionals. He said some professionals currently employed by the federal government in IHS are apprehensive of the tribes assuming responsibility for services.

In response to a question from Chairman Lee, Mr. Davis said tribes have limited funding available for scholarships which are not specific to a career. He said tribal members can also take advantage of the state's loan repayment programs.

Mr. Bradley Hawk, Indian Health Systems Administrator, Indian Affairs Commission, provided information (Appendix G) regarding the credentialing process for licensed professionals in IHS. He said the requirements seem to follow those required for most health care providers, however licensed professionals providing services in IHS must complete the process annually. He said even thought the Fort Berthold Reservation has a Public Law 93-638 contract, the tribe follows a similar credentialing process as the IHS.

In response to a question from Chairman Lee, Mr. Hawk said the additional work done by IHS and the tribe seems to duplicate screening done by the State Board of Dental Examiners. He said there are efficiencies that could be gained by streamlining the process.

Dr. Katie Stewart, President Elect, North Dakota Dental Association, provided information (Appendix H) regarding a summary of North Dakota oral health data gathered as part of an American Dental Association Health Policy Institute study of oral health in all 50 states. She said Medicaid utilization is low for dental services compared to the national average, but is increasing for both Medicaid and insured populations. She said a high percentage of the state's population is receiving fluoridated water and the population's oral health knowledge and status is average. She said Medicaid fee-for-service reimbursement as a percentage of private dental benefit plan charges for child dental services is 68 percent, compared to 49 percent nationally. She said in North Dakota 83 percent of dentists participated in Medicaid for child dental services in 2014, compared to 42 percent nationally. She said improvement is best achieved by the multi-faceted approach in the "Top Ten Solutions" shared with the committee in November 2015. She said solutions address workforce, education, and prevention in a collaborative way. She said the North Dakota Dental Association (NDDA) has several initiatives currently underway to improve the system. She said the "Take Five More" program, which challenges dentists to serve five additional Medicaid patients in a week, a month, or a year, has committed 75 dentists. She said the association has also formed a Medicaid Advisory Committee to meet with the Department of Human Services to eliminate administrative barriers, especially during the department's transition to the new MMIS. She said there are dentists that would serve hospital patients if asked and it is a matter of coordination and connecting dentists to patients needing the service. She said recent graduates setting up a new practice are more willing to provide services outside of their office and normal business hours. She said NDDA and others are working with IHS to streamline credentialing for dental providers on reservations.

In response to a question from Senator Heckaman, Dr. Stewart said NDDA is surveying members to identify dentists willing to donate or contract services at IHS clinics, FQHCs, or other nonprofit clinics. She said the survey will help the association match those willing to provide services to those in need of dental service providers.

Representative Fehr suggested NDDA continue to provide updates on the association's Medicaid outreach efforts.

In response to a question from Chairman Lee, Dr. Stewart said NDDA can encourage dentists to cover call hours at hospitals. She said NDDA will contact Dr. Meeker regarding the framework for a program to provide dental services in hospitals.

STUDY OF EMPLOYMENT RESTRICTIONS IN PUBLIC ASSISTANCE PROGRAMS

Ms. Carol Cartledge, Director, Economic Assistance Policy Division, Department of Human Services, provided information (Appendix I) regarding a comparison of the state's median income and the federal poverty level for recent years; asset limits for public assistance programs, including information regarding the department's flexibility in setting limits; employed public assistance participants by program and region; monthly gross earnings of participants by program, temporary assistance for needy families (TANF) and job opportunities and basic skills (JOBS) program activity hours by type, and a comprehensive report on public assistance programs, including income levels and the effect public assistance programs have on one another. She also provided a map (Appendix J) of unemployment rates in the state by county provided by Job Service North Dakota.

Ms. Cartledge said there are currently no asset limits for the child care assistance program (CCAP) and the Healthy Steps program. She said asset limits for the low income home energy assistance program (LIHEAP), Medicaid, supplemental nutrition assistance program (SNAP), and TANF vary, depending on household size, age, and disability. She said a federal law change requires a $1 million asset limit for CCAP be implemented by October 1, 2016. She said federal law does not require an asset limit for LIHEAP, but an asset limit is set by policy. She said federal law requires an asset test for Medicaid, but the asset limit amount is set in North Dakota Administrative Code. She said SNAP asset limits are set by federal law and TANF asset limits are set by state law. She said an individual's home and one vehicle are exempt from asset consideration in the LIHEAP, Medicaid, SNAP, and TANF programs.

Ms. Cartledge reviewed the activity of an example public assistance case for 1 year. She said housing assistance and Women, Infants, and Children (WIC) benefits may also affect the public assistance benefits in the example, but the Department of Human Services does not administer those programs and would not be able to factor in their effects. She said TANF benefits may vary monthly based on income. She said SNAP benefits are directly affected by TANF benefits, but SNAP reviews occur every 6 months, so effects are not immediate. She said CCAP benefits are determined based on anticipated monthly income and verified, but are paid based on the actual billing for the prior month.

Ms. Cartledge reviewed maps comparing the number of public assistance participants by program and by region for 2014 and 2015, including the number of monthly average case loads for each program for the 2013-15 biennium. She said participants are included in the total if they reported earned income. She said participants are duplicated between programs. She said, from 2014 to 2015, there was a decline in the number of participants employed in many of the programs.

Ms. Cartledge reviewed summaries of public assistance participants by monthly earnings category for 2014 and 2015. She said it is possible for TANF recipients to be in the higher earnings category because transitional TANF assistance is available for 6 months. She also provided information regarding the percentage of participants in the various programs that are working, disabled, elderly, or households with children.

Ms. Cartledge reviewed summaries of TANF and JOBS activity hours for 2014 and 2015. She said the number of TANF and JOBS participants decreased from 2,809 in 2014 to 2,583 in 2015 and the average time on assistance increased from 10 to 11 months over the same period.

Ms. Cartledge provided a summary of state median income comparisons to the federal poverty level for various household sizes in the LIHEAP and CCAP programs.

Ms. Renee Stromme, Executive Director, North Dakota Women's Network, provided information regarding research on the "cliff effect" done by The Women's Foundation of Colorado and the Women and Family Action Network Coalition (Appendix K) and the Indiana Institute for Working Families (Appendix L). She said child care assistance programs are more sensitive to the "cliff effect." She said Colorado is unique because child care subsidies are determined at the county level. She said Colorado has enacted changes to allow for a phasing out of benefits as income increases. She said the Indiana study included recommendations to smooth out benefit phase outs, implement broad-based categorical eligibility, change monthly income eligibility limits, and raise the income tax threshold for state income tax. She said the employees working in the hospitality industry struggle the most with the effects of increased hours on benefits.

Chairman Lee suggested the Department of Human Services review child care subsidies to determine if benefit reductions could be implemented gradually to reduce the impact of the "cliff effect" on participants when hours of work are increased.

In response to a question from Representative Nelson, Ms. Cartledge said TANF is the only benefit that would react to changes in income on a monthly basis. She said many programs are reviewed every 6 months, so benefit changes are not immediate.

Ms. Karen Ehrens, Bismarck, provided information (Appendix M) regarding a National Commission on Hunger report entitled *Freedom from Hunger: An Achievable Goal for the United State of America*. She said the commission found that the funding, eligibility, and delivery of public assistance programs are often disparate, uncoordinated, and confusing. She said recommendations of the commission to Congress and the Secretary of the United States Department of Agriculture include establishing a mechanism for cross-agency collaboration to facilitate improved public assistance programming and evaluation through enhanced technology, data sharing, and coordinated funding streams that protect effective programs and encourage coordinated efforts to address larger issues of poverty. In addition, she said the commission recommends testing increases in the income disregard for the SNAP program to reduce the danger of families losing benefits before they are ready to transition from the program and to allow states to extend benefits for a period of time while families make adjustments to their household budgets.

Chairman Lee said streamlined eligibility has many benefits, but expressed concern regarding a "one-size fits all" program. She said needs differ by state and even different areas of the same state may not have the same circumstances.

DEATH INVESTIGATION AND FORENSIC PATHOLOGY CENTER STUDY

Mr. Kirby Kruger, Medical Services Section Chief, State Department of Health, provided information (Appendix N) regarding a summary of professionals serving as county coroners in the state and an update on the stakeholder group established by the State Department of Health. He said the stakeholder group has not met since his last report to the committee, but is scheduled to meet January 8, 2016. He provided summaries of the occupations of coroners in each of the 32 western counties served by the State Forensic Examiner in Bismarck and each of the 21 eastern counties served by the University of North Dakota (UND) Department of Pathology in Grand Forks. He said statewide, 22 county coroners are medical doctors, 18 are sheriffs or police officers, 9 are funeral home directors, 2 are emergency medical technicians, 1 is a nurse, and 1 is a rancher.

In response to a question from Representative Rohr, Mr. Kruger said autopsy numbers seem to be related to increases in traffic fatalities and increased access to nearby services in the eastern part of the state. He said the department is unable to determine whether there are service trends related to the occupation of the coroner.

In response to a question from Representative Becker, Mr. Kruger said the distribution of autopsies between Bismarck and the UND Department of Pathology seems appropriate. He said the preliminary total number of autopsies performed by the State Forensic Examiner in Bismarck in 2015 is 258 and he anticipates the number of autopsies performed at the UND Department of Pathology will be similar.

Dr. Mary Ann Sens, Chair, Department of Pathology, University of North Dakota School of Medicine and Health Sciences, said training is important and the goal is to provide the same level of service in each county. She said coroners are encouraged to call the State Forensic Examiner or the UND Department of Pathology when there is a question. She said non-physician coroners are more likely to consult on cases. She said highly trained regional death investigators would be ideal and could provide consultation. She said regulations regarding coroner reporting should be strengthened.

Chairman Lee suggested the committee review recommendations made by Dr. Sens regarding the development of a system approach to death investigation, a regional death investigation system framework, and statewide standards for death investigation.

At the request of Chairman Lee, Dr. Sens provided information regarding a recommendation for the implementation of a statewide peer review committee.

In response to a question from Representative Rohr, Dr. Sens said a peer review committee should be system oriented, but should not include a disciplinary board. She said if discipline is necessary the case could be referred to the appropriate professional board. She said information made available by the review could be used to improve public safety.

Chairman Lee suggested Dr. Sens send additional information regarding the recommendation for a peer review committee to committee members.

Mr. Aaron Birst, Legal Counsel, North Dakota Association of Counties, said counties are supportive of the current regulations related to death investigation and autopsies, including the arrangement whereby the counties pay transportation costs to either the State Forensic Examiner in Bismarck or the UND Department of Pathology.

Representative Jay Seibel, Past Executive Director, North Dakota Funeral Directors Association, said prior to the addition of service at the UND Department of Pathology, bodies were transported to Bismarck for autopsy, adding time and cost. He said funeral directors are supportive of the addition of services at the UND Department of Pathology and support continuing to contract with the UND Department of Pathology for autopsy services.

OTHER COMMITTEE RESPONSIBILITIES

At the request of Chairman Lee, Legislative Council staff presented a memorandum entitled *Survey of Agency Alcohol, Drug, Tobacco, and Risk-Associated Behavior Prevention and Treatment Programs* regarding funds appropriated for prevention or treatment programs relating to risk-associated behavior. The Legislative Council staff said the memorandum includes a summary of actual funding made available during the 2013-15 biennium and funding budgeted for the 2015-17 biennium for programs relating to prevention and treatment of alcohol, tobacco, and drug abuse and other kinds of risk-associated behavior which are operated by various state agencies. Funding budgeted for the prevention and treatment of alcohol, tobacco, and drug abuse and other kinds of risk-associated behavior during the 2015-17 biennium totals $144.7 million, of which $69.3 million is from the general fund. This level of funding from the general fund represents an increase of $11.2 million or 19.4 percent from the 2013-15 biennium. Agencies receiving the largest increases in funding from the general fund are the Department of Corrections and Rehabilitation (DOCR) ($7.4 million) and the Department of Human Services ($3.3 million).

In response to a question from Senator Warner, Mr. Birst said certain counties have begun screening incarcerated individuals for behavioral health issues, but they do not provide treatment. He said the North Dakota Association of Counties plans to work with the interim Incarceration Issues Committee to develop county jail-based solutions for those incarcerated with behavioral health needs. He said counties are willing to provide the services, but there is a shortage of qualified behavioral health providers.

Ms. Pam Sagness, Director, Behavioral Health Services Division, Department of Human Services, said Cass County is currently screening for mental health needs, but not for addiction. She said the department is working with the county and behavioral health providers to expand the county's screening tools to include addiction. She said the department is collaborating on a project with DOCR, Cass County Jail, and a behavioral health care provider. She said part of the solution is the diversion of individuals needing behavioral health treatment from incarceration to the appropriate facility. She said because the department can not use federal funding to provide services in a jail, there is a gap in funding available for treatment. She said the department has been asked to participate in a behavioral health committee established by DOCR.

In response to a question from Representative Fehr, Ms. Sagness said incarcerated individuals are unable to receive Medicaid coverage. She said if individuals received appropriate behavioral health treatment instead of being incarcerated, the state would realize savings associated with fewer incarcerations.

Representative Rohr suggested the committee receive additional information regarding risk-associated behavior programs, including funds appropriated specifically for prevention programs.

Chairman Lee said the next committee meeting is tentatively scheduled for Wednesday, April 13, 2016.

It was moved by Representative Seibel, seconded by Representative Mooney, and carried on a voice vote that the meeting be adjourned. No further business appearing, Chairman Lee adjourned the meeting at 1:54 p.m.

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Sheila M. Sandness
Senior Fiscal Analyst

ATTACH:14